Board of Directors Meeting

Thursday, 27 July 2017
at 1.00 pm

Boardroom
University Hospital of North Tees
Glossary of Terms

Strategic Aims and Objectives

Strategic Aims

**Putting Patients First** – to create a patient centred organisational culture by engaging and enabling all staff to add value to the patient experience and demonstrated through patient safety, service quality and LEAN delivery.

**Integrated Care Pathways** – to develop and expand the portfolio of services to provide integrated care pathways for the people of Easington, Hartlepool, Sedgefield and Stockton providing equal access to acute care and care as close to home as possible in line with Momentum: Pathways to Healthcare.

**Service Transformation** – to improve and grow our healthcare services to continually review the needs of our healthcare community and transform services. In line with evidence based guidelines we will enhance quality, clinical effectiveness and patient experiences whilst improving clinical outcomes.

**Manage our Relationships** – to ensure our services, and the way we provide them, meet the needs of our patients, commissioners and other partners by proactively engaging with all appropriate stakeholders including our staff, through communications, engagement and partnership working.

**Maintain Compliance and Performance** – to maintain our performance and compliance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of our business.

**Health and Wellbeing** – to embrace the health and well being of the population we serve and ensure that the health needs of the people of Easington, Hartlepool, Sedgefield and Stockton are reflected and catered for in the commissioning of services from the Trust.

Strategic Objectives

**Maintain Compliance and Performance** – assurance around compliance with standards, performance indicators and requirements within the Terms of Authorisation. Requirement to provide Board regulation and self certification on a quarterly and annual basis in accordance with Monitors Terms of Authorisation.

**Seasonal Pressures** – requirement to ensure preparedness for seasonal winter pressures.

**Reduce Hospital Acquired Infections** – supports the Trust’s key strategic theme of; Maintain Compliance and Performance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of the Trust business.

**Effective Board Governance** – corporate oversight and scrutiny will continue to be provided by key management structures; 1. Board of Directors, 2. Executive Team, 3. Trust Directors Group.

**Training** – ensuring the workforce is appropriately trained.
**Workforce** – absence management, ensuring we have adequate staffing levels that provide safe and effective care to our patients.

**Momentum – Pathways to Healthcare** – delivery of a new healthcare system for the people of Easington, Hartlepool, Sedgefield and Stockton.

**Putting Patients First / Patient Safety** – to create a patient-centred organisation by engaging and enabling staff to add value to the patient experience, demonstrated through patient safety, service quality and LEAN delivery.

**Finance** – to maintain our performance and compliance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of our business.
Dear Colleague

A meeting of the Board of Directors will be held on Thursday, 27 July 2017 at 1:00 pm in the Boardroom, University Hospital of North Tees.

Yours sincerely

Paul Garvin
Chairman

Agenda

1. (1.00pm) Apologies for absence Chairman
2. (1.00pm) Declaration of Interest Chairman
3. (1.00pm) Minutes of the meeting held on, 25 May 2017 (enclosed) Chairman
4. (1.05pm) Matters Arising Chairman

Items for Information

5. (1.10pm) Chairman’s Report (enclosed) Chairman
6. (1.20pm) Chief Executive’s Report (enclosed) A Foster
7. (1.30pm) Retrospective Approval of Documents Executed Under Seal (enclosed) A Foster

Quality

8. (1.30pm) Safety, Quality and Infection Prevention Report (enclosed) J Lane

Strategic Management

9. (1.40pm) Sustainability and Transformation Plan Update (enclosed) A Foster
10. (1.50pm) Trust Strategy Development Progress Report (enclosed)  J Gillon

11. (2.00pm) Capital Programme 2017/18 - Quarter 1 Report (enclosed)  P Mitchell

**Performance Management**

12. (2.10pm) Compliance and Performance Report (enclosed)  J Gillon

13. (2.20pm) Financial Performance Report as at 30 June 2017 (enclosed)  C Trevena


**Governance**

15. (2.40pm) Learning from Deaths Update (enclosed)  D Dwarakanath

16. (2.50pm) Guardian of Safe Working Hours Summary Report – (Quarter 4) (enclosed)  D Dwarakanath

**Operational**

17. (2.55pm) Responsible Officer's Report on Medical Appraisal and Revalidation (enclosed)  D Dwarakanath

18. (3.05pm) Nursing and Midwifery Revalidation (enclosed)  J Lane


**Items to Receive**

20. (3.25pm) North Tees and Hartlepool FT Charitable Funds Accounts 2016/17 (enclosed)  C Trevena

21. (3.30pm) Estates and Facilities Management Annual Report (enclosed)  P Mitchell

22. (3.35pm) Research and Development Annual Report (enclosed)  D Dwarakanath

23. (3.40pm) Actual and Potential Organ Donors 2016/17 (enclosed)  K Robinson

24. (3.45pm) Outcome of NHS Improvement Quality Review Meetings (enclosed)  A Foster

25. (3.50pm) Any Other Notified Business  Chairman

26. **Date of Next Meeting**  
   (Thursday, 21 September 2017, Boardroom, University Hospital of North Tees)
North Tees & Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27th July 2017

Executive Summary

Trust Strategy Development - Progress Report

Report of the Chief Operating Officer/Deputy Chief Executive

Strategic Aim and Objectives (the full set of Trust Aims can be found at the beginning of the Board of Directors Reports)

Putting Patients First

1. Introduction

1.1 This report provides an update for the Board of Directors on the current progress relating to the Clinical Services Strategy, a summary of the final stages of the Corporate Strategy refresh, and includes an update on the progress of the Annual Business Planning cycle following the ‘market place’ event in March of this year.

2. Progress Report

The development of the Clinical Services Strategy has been a significant piece of work over a sustained period which benefitted from the input of all Directorates. During the next phase of implementation and delivery of the Clinical Services Strategy, appointed work streams will work with clinical service lines in alignment with developments linked to the Better Health Programme (BHP) and Sustainability and Transformation Plans (STP).

2.1 The NHS Improvement ‘Well Led Framework’ (June 2017), in alignment with the Care Quality Commission well led assessments, outlines one of the key lines of enquiry (KLOE) as the requirement for NHS Providers to have a ‘clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver’. The Trust’s Corporate Strategy has been developed to support the delivery of this key requirement, with over-arching objectives, strategic measures and metrics to influence and monitor delivery.

The Corporate Strategy has now been refreshed in a streamlined, more simplified way, to reflect the future overarching principles, policy change and local health care context and to meet the needs of the external environment.

2.2 The process has been supported through discussion with staff, Governors and key stakeholders, with further planned public engagement. This also involved a review of the Trust’s existing strategic direction, high level aims and objectives. One of the many refinements to the strategy has been the ‘less is more’ approach by streamlining the scope of the strategic objectives and merging the six original objectives into four alongside the introduction of a ‘Valuing our People’ objective.
2.3 Following Board approval, the Trust will conduct a series of communication and engagement sessions with external stakeholders to present the key highlights of the Corporate Strategy.

2.4 The Trust’s Business Planning development process for 2017/18 has been completed, with agreed key milestones for delivery. As a result of the on-going financial challenges and the breadth of service development proposals received from Directorates, a strict criterion has been set to establish priorities for funding which has tied into the overall financial strategy and plan. The delivery of Business Plans and key milestones continue to be monitored through monthly Business Planning and Performance meetings.

3. Recommendations

The Board of Directors is asked to:

- Note the work that has taken place to enable the development of a robust and comprehensive Clinical Services Strategy, and the continuing steps required to support delivery of future clinical, operational and financial sustainability;
- Note the progression of the Business Planning cycle and the implementation of a strict approval criterion for current Service Development proposals.
- Approve the refreshed Corporate Strategy, and support the communication process both internally and externally by promoting the strategy as the means to take the Trust’s confirmed strategic direction forward within the frame of BHP and STP.

Julie Gillon
Chief Operating Officer/Deputy Chief Executive
July 2017
North Tees & Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Trust Strategy Development - Progress Report

Report of the Chief Operating Officer/Deputy Chief Executive

1. Introduction

1.1 This report provides an update for the Board of Directors on the current progress relating to the Clinical Services Strategy, a summary of the final stages of the Corporate Strategy refresh, and includes an update on the progress of the Annual Business Planning cycle following the ‘market place’ event in March of this year.

2. Background

2.1 The vision and aims of the Trust continue to be shaped by the operational and strategic challenges and changes within the local (and national) healthcare economy. The developments of the Better Health Programme (BHP) and Sustainability & Transformation Plans (STP) are jointly supporting the delivery of NHS England’s programme of work to sustain services going forward, with the three key objectives including; improving the health and wellbeing of the population, improving the quality of care that is provided and improving the efficiency of NHS services. Whilst some uncertainties continue with regard to STPs, the Trust remains committed to the guiding principles of the programme by providing a continuous focus on patient safety and quality delivery of care closer to home and service integration.

2.2 The refreshed Corporate Strategy provides the over-arching direction for the Trust’s long term sustainability with the challenges of clinical, operational and financial sustainability also being addressed through the delivery of the Clinical Services Strategy and the annual business planning processes.

2.3 However, the impact of external and other socio-economic factors such as population shifts and deprivation, for example, and workforce challenges on service delivery will require the Trust to develop a broader strategic approach to ensure that the strategic alignment of services meets the challenges of the Five Year Forward View (NHSE, Next Steps on the NHS Five Year Forward View, March 2017) This strategic approach will continue to shape the future alongside the Trust approach captured in the Clinical Services Strategy and Corporate Strategy.

2.4 The continued and increasing financial pressures within the system place additional pressures on the Trust at both an operational and strategic level, and the Trust is currently delivering a focused cost reduction programme with scrutiny across all functions within the organisation to achieve greater clinical and operational efficiencies.

2.5 In addition to this, the Trust is aware of the need to explore greater collaboration across external networks to not only transform the services provided by the Trust but also to collaborate on shared services that may provide greater financial efficiencies longer term. This requires broader partnerships and stronger relationships in some
areas to achieve a more joined-up approach across providers and geographies, culminating in improved quality of care for the population.

2.6 The Trust continues to align the planning and strategic visioning with Commissioner’s Clear and Credible Plans and Local Authority, Joint Strategic Needs Assessments, as well as national policy and guidance.

2.7 The NHS Improvement ‘Well Led Framework’ (June 2017), in alignment with the Care Quality Commission well led assessments, outlines one of the key lines of enquiry (KLOE) as the requirement for NHS Providers to have a ‘clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver’. The Trust’s Corporate Strategy has been developed to support the delivery of this key requirement, with over-arching objectives, strategic measures and metrics to influence and monitor delivery.

3. Clinical Services Strategy

3.1 The development of the Clinical Services Strategy has been a significant piece of work over a sustained period which benefitted from the input of all Directorates, at all levels, to bring about the articulation of the change and transformation of clinical services required to sustain safe, high quality and effective care within both Hospital sites and out of hospital care within the Trust.

3.2 Due to the substantial restrictions on the ageing Hospital estate (particularly at North Tees), Directorates have developed initiatives for the delivery of clinical services to maintain a state of ‘fit for purpose’ beyond 2021. These initiatives create a strategy that combines quality of care for patients with financial viability, resulting in sustainable clinical services.

3.3 During the next phase of implementation and delivery of the Clinical Services Strategy, appointed work streams will work with clinical service lines in alignment with developments linked to the Better Health Programme (BHP) and Sustainability and Transformation Plans (STP). This will include re-visiting the individual services lines which were identified as requiring re-design, to achieve further operational efficiencies, and services which indicated a potential for collaborative working in conjunction with neighbouring providers.

3.4 In order to meet the increasing financial imperatives within the system, difficult choices and decisions may need to be made particularly around those services that are no longer clinically or financially viable/sustainable in their own right. This next stage has only recently commenced and will continue throughout 2017/18, overseen by the Strategy team, working with the directorate teams, Finance, Workforce and Transformation to support the review of each service line. This work will feed into the financial plan for 2017/18 and beyond, and support delivery of the Lord Carter challenges.

4. Corporate Strategy

4.1 The Trust's Corporate Strategy 2013-2018 was last updated in 2014/15 in readiness to embark upon the Clinical Services Strategy development.

4.2 The Corporate Strategy has now been refreshed in a streamlined, more simplified way, to reflect the future overarching principles, policy change and local health care context and to meet the needs of the external environment.

4.3 The Board will recall the evolvement of the Corporate Strategy also discussed at the Board of Directors and Council of Governors within the Business Planning 'Market
Place’ Board Seminar, on 16 March, with further updates provided to the Governors’ Strategy and Service Development Committee on 20th March.

4.4 The process has been supported through discussion with staff, Governors and key stakeholders, with further planned public engagement. This also involved a review of the Trust’s existing strategic direction, high level aims and objectives. One of the many refinements to the strategy has been the ‘less is more’ approach by streamlining the scope of the strategic objectives and merging the six original objectives into four alongside the introduction of a ‘Valuing our People’ objective. This reflects the emphasis that this Trust places on its staff and acknowledges the importance of recruiting and retaining the best staff to meet operational needs and the challenges of the future.

4.5 The refreshed Corporate Strategy has received internal scrutiny at Executive Team, Council of Governors and at Board level with all feedback actioned by the Strategy team resulting in the document attached for approval by Board members.

4.6 The Corporate Strategy incorporates the following changes:

- A comprehensive redesign of the SWOT and PESTL analysis
- Refresh of the Trust’s Corporate Triangle to encompass the Care Quality Commission domains
- Update of the Trust’s key objectives, merging the six original objectives into four future objectives encompassing ‘Putting Patients First’, ‘Valuing Our People’ (new for 2016-2021), ‘Transforming Our Services’ and ‘Health and Well Being’.
- Revised metrics to support the monitoring of delivery of the objectives
- Development of ‘strategies’ on a page for each of the key underlying supporting strategies, which underpin the Trust’s overarching Corporate Strategy
- Development of a draft revised strategy on a page, to reflect the updates incorporated into the main Corporate Strategy.

4.7 One of the focused areas of development has been a review of the strategic measures and metrics particularly in areas where the Trust could drive performance further in line with emerging evidence to achieve better outcomes for the patient.

4.8 As outlined in section 2.7, the Corporate Strategy is a key component of delivery within the NHSI ‘Well Led Framework’, linked to the CQC well led assessments. Board members are therefore asked to review the table of strategic measures attached at Appendix 1. This table will be used to direct deep-dive sessions into each of the strategic measures at Executive Team meetings from August/September onwards, with a timeline of delivery agreed with the respective Director lead(s) for each measure and therefore reported as an aggregate biannually to the Board of Directors.

4.9 Following Board approval, the Trust will conduct a series of communication and engagement sessions with external stakeholders to present the key highlights of the Corporate Strategy. Internally, the focus will be on communicating what the Corporate Strategy means to staff at all levels predominantly through:

- Individual staff groups
- Directorate/Team meetings
- Staff Focus Groups

4.10 The strategy will be made available on the Trust website and intranet with an aide memoir credit card size strategy on a page to convey the key messages.
5. **Business Planning Cycle – Service Developments**

5.1 The Board will recall the launch of the final Business Plans which took place at the joint Board of Directors and Council of Governors ‘Market Place’ event in March 2017, which provided the Executive Directors, Non-Executive Directors and Governors with the opportunity to review and discuss the Directorate annual operational plans.

5.2 As a result of the on-going financial challenges and the breadth of service development proposals received from Directorates, a strict criterion was set to establish priorities for funding which has tied into the overall financial strategy and plan.

5.3 All service developments currently in the system have been reconciled against the capital programme, digital programme and the financial reserves for 2017/18. The delivery of Business Plans and key milestones continue to be monitored through monthly Business Planning and Performance meetings.

5.4 The governance structure for the scrutiny sign off of all Business Cases has been re-evaluated in 2017, with the agreed process overseen by the Executive Team through a dedicated Capital Management Group.

6. **Summary**

6.1 The implementation of the Clinical Services Strategy will serve to not only improve the quality, safety and effectiveness of clinical services for the Trust but will also seek to redesign the way in which some services function currently with a view to working collaboratively with other stakeholders to deliver a service over wider geographies, and this may mean, in some instances, a more strategic focus across provision where financial viability and clinical sustainability requires clinical expertise to improve outcomes.

6.2 The Trust’s Business Planning Cycle, and the proposal and approval of Service Developments, now follows a strict criteria by which to prioritise proposals for funding. The Clinical Services Strategy, and the associated Business Planning Cycle, support on-going operational, clinical and financial delivery, aligned to the Trust’s overarching Corporate Strategy.

6.3 The refresh of the Trust’s Corporate Strategy has progressed to completion and has been supported through a robust development programme with internal stakeholders at all levels within the organisation. The Corporate Strategy sets a blueprint for the long term sustainability of the Trust, in line with the NHSI Well Led Framework. It has been closely aligned to the principles of the BHP and the developing STP in the region, and closely follows the aims of the Five Year Forward View.

7. **Recommendations**

7.1 The Board of Directors is asked to:

- Note the work that has taken place to enable the development of a robust and comprehensive Clinical Services Strategy, and the continuing steps required to support delivery of future clinical, operational and financial sustainability;
- Note the progression of the Business Planning cycle and the implementation of a strict approval criterion for current Service Development proposals.
- Approve the refreshed Corporate Strategy, and support the communication process both internally and externally by promoting the strategy as the means to
take the Trust’s confirmed strategic direction forward within the frame of BHP and STP.

Julie Gillon
Chief Operating Officer/Deputy Chief Executive
27 July 2017
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Foreword

Welcome to our Corporate Strategy for 2016 - 2021. We have refreshed our previous strategy to acknowledge the journey that we are on as a leading NHS Foundation Trust and provider of acute and community services, and to ensure we are concentrating on the things that matter most to our patients.

Like many other Trusts, we’ve faced up to new challenges and pressures without compromising on the quality delivery of our services. We remain one of the top performing Trusts in the North East of England and continue to seek new opportunities which we can take advantage of as we move forward, for example, new model systems, better technology and effective collaborative approaches.

However, we all acknowledge that the healthcare landscape in which we operate is changing at a rapid pace, and we will need to become more efficient in everything we do. That may mean making tougher decisions about what we provide within tightening budgets, but it also means becoming more innovative and making the most of opportunities to improve how we work in order to provide alternative funding streams and resources for our services.

The NHS Five Year Forward View has steered all Trusts towards stronger engagement in order to ensure better targeted services for patients and we will deliver on this during the lifetime of this strategy in collaboration with our Better Health Programme partners through our Sustainability and Transformation Plans (STP).

We have developed our strategy with our staff, our governors, our partners and our patients and they have worked with us to scan the changing landscape of the NHS to ensure that our plans for the future are still the right ones.

Our values haven’t changed, but we have altered some of our strategic aims to reflect our ‘people first’ focus. We are committed to providing more care closer to the patient’s home thereby reducing the length of time they may spend in hospital.

However, whilst we know that we will always need to provide more specialist services within a hospital setting to improve the outcomes and life chances of many of our patients, how and where we provide those specialist services may need to be re-appraised and we will look more closely at this as part of our STP with partners and stakeholders.
Standing still is therefore not an option. We will work closer with our partners across the region to ensure a collective strength in healthcare services and this is our blueprint for the direction we will take.

We’d like to place on record our thanks to the many people who have helped to refresh the strategy, in particular, to all of our staff on the front line who not only drive the organisation forward but provide the care and medical interventions that mean so much to so many.

The NHS remains a cherished part of our way of life and we will work hard to maintain the high standards that our staff, stakeholders and patients expect from us.

Paul Garvin
Chairman

Alan Foster MBE
Chief Executive
1. Introduction

We last refreshed our Corporate Strategy in 2014, and since then a considerable amount has happened during the period on a regional, national and international scale that has impacted in one way or another on the Trust, with still more to come during the next few years.

The economic situation world-wide and in the UK, including the uncertainty around funding and procurement from the planned withdrawal from the European Union, provides the context for the NHS in general and for Foundation Trusts in particular.

The requirement for the NHS to make savings of £22 billion via Sustainability & Transformation Plans (STP) continues to shape the economic backdrop in which the NHS is operating. For this Trust, this equates to a considerable Cost Improvement Programme of circa £18.9m through 2017/18 and similar challenges will exist in the forthcoming years. We have set out our approach and commitment to the Sustainability and Transformation Plan for the area covered later in this strategy.

Delivering the programme will be exciting and challenging, and at times unpredictable; however the rewards for clinical service provision will make it worthwhile.

The Trust has made excellent progress in recent years with regard to its corporate strategy, and the standards that have been set and achieved have been delivered in very challenging circumstances. Many of the challenges such as recruitment and retention of staff, efficiency savings and smaller budgets have been set within a national context and have been experienced by other Trusts.

However, local circumstances preventing the development of a new single site hospital have presented this Trust with operational, clinical and financial challenges and whilst the Trust continually seeks new ways to transform its services, the constant achievement of access targets alongside safe, effective and quality services is all the more impressive. There have been a number of major service improvements that have helped to consolidate the Trust’s performance and breadth of service delivery for our patients during 2016/17 and these are set out in the Trust’s Annual Plan 2017.

Headlines

- Expansion of Rapid Assessment to provide immediate assessment upon admission;
- Front of house comprehensive geriatric assessment and the development of a frailty unit for patients;
- Provision of sub-specialised pathways for complex trauma management;
- Specific work streams with partner organisations for the development of Palliative Care Integrated Pathway;
- Development of a dedicated surgical emergency assessment area;
- Collaboration with South Tees Acute Trust in breast care services;
- Expansion of Obstetric Clinical team to support 98 hour delivery suite cover requirement.
The development of two new Urgent Care Centres at both of the Trust’s hospital sites will provide a level of care and co-ordination that will help to improve Accident & Emergency waiting times and ensure that patients are streamed into the right pathway of care at the right time in collaboration with the Trust’s delivery partners – North East Ambulance Service (NEAS) and Hartlepool and Stockton Health (The General Practitioner Federation).

The Trust continues to see significant improvements in hospital mortality and remains compliant with all regulatory bodies. There has been an improvement in overall patient satisfaction and the Trust’s journey through service transformation towards care closer to home with supporting community facilities continues. In addition to the progress against the strategic metrics we have continued to deliver high performance and build on our already strong foundations, which are recognised later in this strategy.

Delivery of the Corporate Strategy is enabled by many supporting strategies, not least the Clinical Services Strategy which details the quality and safety standards, clinical outcomes and service redesign required so that this Trust remains “ahead of the game”.

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Better Health Programme

In 2013, Foundation Trusts across Teesside and parts of County Durham came together to explore improvements and efficiencies in delivery of services with a focus on collaboration and joint delivery arrangements as part of the Securing Quality in Health Services (SeQiHS) programme. The programme became known as the Better Health Programme in 2015.

The Better Health Programme widely acknowledges that not all patients receive the same quality of care all of the time largely because services are not organised in the same way in all communities, or geographically across each of the Trust’s hospital sites, or because services aren’t available or have reduced staffing levels at different times of the day, or at weekends. The programme began a review of standards across:

- Acute Medicine
- Acute Surgery
- Accident and Emergency
- Critical Care
- Acute Paediatrics, Maternity and Neonatology
- Interventional radiology

The Better Health Programme has set out to improve patient care by meeting patient needs now, and in the future, with constantly improving health and social care delivered in the best place to:

- Improve results for patients
- Ensure care is of the same high standard wherever, and whenever it is provided
- Deliver services with financial sustainability for the next 10-15 years
- Provide services across 7 days a week where necessary
- Make services easier for patients to understand and use
- Improve life expectancy and quality of life for everyone in Darlington, Durham and Tees Valley

Improving the healthcare services available in Darlington, Durham and Tees Valley, however, raises a number of key challenges e.g. the changing health needs of local people, meeting recommended clinical standards, the availability of highly trained and skilled staff and the provision of high quality seven-day services.

The Better Health Programme assumed responsibility for the development and implementation of the acute provision element of the Sustainability & Transformation Plan (STP) as announced by NHS England planning guidance in 2015.
Sustainability & Transformation Plan (STP)

North Tees and Hartlepool Hospitals, as they stand today, have a rich history dating back to the late 60s when local populations were much lower and people had fewer options by which to manage their healthcare. Since then populations have increased, people are living longer with a steep rise in co-morbidities, many are learning to live with long term conditions whilst all Accident & Emergency Departments continue to struggle to cope with the increase in non-urgent attendances.

As part of the Five Year Forward View in 2015, and in response to the growing (and significant) pressures facing the health service, NHS England set out to review the sustainability of all local healthcare services being delivered in isolation, encouraging collaborative approaches in managing limited resources across multiple geographies.

This Trust is part of the Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby „footprint” - which is one of 44 footprints around the country and is made up of – and it has developed ambitious plans to prevent ill health, improve health outcomes, improve quality of care and deliver financial sustainability with a vision of ‘meeting the needs of our communities now, and for future generations, with consistently better health and social care delivered in the best place’

There is a long history of partnership working across Durham and Tees Valley dating back to the late 1980s in health and wellbeing but also in other outcomes such as the economy, housing, education and transport, and this is a positive factor. However, the transformation within the context of the STP will focus on improving „population health” i.e. moving from a fragmented approach to greater integration of care delivery.
The STP maintains that services currently provided in localities cannot continue in their present form.

This Trust’s commitment to the STP is clear and unequivocal. We believe that a transformed system-wide approach where collaboration and joint ownership is at the centre of all partner’s respective plans is the way forward.

Partners and neighbouring Trusts need to work together and explore the most efficient and effective way of delivering key services, particularly where this means reviewing the location of certain services, if future sustainability is to be addressed. It will be challenging, but it is not insurmountable.

In order to develop and sustain the transformational change that has been identified within the health and social care services across the region, there will be many engagement activities that harness the wealth and breadth of talent and expert knowledge throughout the local health economy including the much valued experiences and thoughts of the general population.

This will be a whole system approach with strong leadership born from collaboration between Clinical Commissioning Groups (CCGs) and the NHS Foundation Trusts in order to steer and direct the emergent plan and its implementation. Whilst the STP vision is clearly described in the plan, the realisation of the plan will rely on the joining-up and commitment of key interdependent sectors including Primary Care, Local Authorities, Public Health, Voluntary and Community Sectors and all delivery providers.

The Trust has recently reviewed its Clinical Services Strategy, with a major part of the exercise focussing on alignment of services with the direction of the proposals contained within the STP. As the STP will develop over time, the plans that the Trust has put in place will be sufficiently flexible to incorporate changes in delivery where it is required and agreed i.e. ‘the best place’.
2. Our Strong Foundations

North Tees and Hartlepool NHS Foundation Trust provides health care services to a population of over 400,000 people predominantly covering an area from Easington in the North, Stockton in the South, Hartlepool in the East and parts of Sedgefield in the West.

The Trust provides a wide range of health services covering some specialist acute services, a wide range of acute general hospital services, outreach services into community settings and the full range of support within community services. However, throughout the period of this refreshed Corporate Strategy (2016-21) there will be significant changes and improvements to the services provided by the Trust.

As part of the Trust’s Clinical Services Strategy, elective and diagnostic provision will change, particularly with regard to Outpatients where services will be patient focused with choice, access times and self-management taking priority. The timeliness of clinical decisions will drive the ambition of the service minimising the time that patients spend in contact, and in attendance, with hospital services. In addition, booking appointments will be made easier with a clear point of contact with systems that enable sharing of GP patient records through the Great North Care Record.
Following the Momentum: Pathways to Healthcare programme, and the decision to pause the plans for a new single-site hospital, the Trust has continued to maintain a focus on delivering care closer to home. This is a major focus going forward and is aligned to the proposals within the STP.

The Trust is working with partners to provide community driven services outside of hospital settings in collaboration with local authorities and other health and social care organisations.

The Trust is providing Integrated Urgent and Emergency Care from Urgent Care Centres based at both North Tees and Hartlepool hospital sites from April 2017. The Urgent Care Centres incorporate minor injuries and illnesses, GP services, with Accident & Emergency delivered from North Tees Hospital. This service strengthens the Trust’s capacity but with it comes a number of challenges around educating and informing the population in partnership with primary care providers to ensure patient’s care is delivered in the most appropriate place and at the right time. The Trust employs in excess of 5500 members of staff across the hospital and community services and has an income of £285million (2016/17).

As reported in earlier versions of our strategies, North Tees and Hartlepool NHS Foundation Trust has a strong track record of which has been achieved through the continued exemplary work and dedication of our clinical, support and managerial staff and, despite a culture of increased targets and budgetary pressures, the Trust maintains a commitment to achieving the best possible performance that stands up to external scrutiny.
Since our Corporate Strategy was last updated we have continued to build upon our strong foundations of safe, high quality patient care. The refreshed strategy is summarised as our „strategy on a page“ and this can be found at Appendix 1, with a full suite of templates that set the deliverability and accountability for the Corporate Strategy at Appendix 2. The Trust’s Clinical Services Strategy has enabled the re-shaping of each Directorate’s vision, aims and direction over the coming years and this has been summarised with a short, succinct reminder of Directorate Strategies at Appendix 3, and a one page summary of our Clinical Services Strategy in graphical form at Appendix 4.

The Trust’s operational and financial performance is therefore strong despite the current challenging economic climate and continues to strengthen its corporate responsibility programme including ensuring that training and development of the workforce is reviewed and improved in line with national and international standards. This provides the Trust and its stakeholders with assurances that new and existing Trust staff meet the highest standards of competence.

In addition to this, the Trust puts great store in the way that it purchases goods and services with value for money at the heart of all transactions; how it conducts its relationships with patients, carers, staff, Governors and members of the public.

Every part of the NHS aims to place the patient at the centre of delivery, and this Trust is no different. The „Putting Patients First“ strap line applies equally to all our stakeholders, and especially to our staff, who remain pivotal at the heart of the organisation, and ensure that we provide and deliver the highest quality healthcare services to the public that we serve. The value of our staff cannot be over-emphasised, and we strive to be an excellent employer and become an employer of choice for our staff both now and in the future.

We continue to embed research into the culture of our Trust through more patients being recruited into National Institute for Health Research (NIHR) portfolio studies, more staff benefiting from the Research and Development Incentive fund, increased numbers of staff trained in Good Clinical Practice for research and an increase in the number of staff developing their own research proposals for external funding.
The Trust works closely with the Council of Governors whose membership includes elected public, staff, patient and carers and others appointed to represent a diverse number of stakeholder organisations. The Council has a number of sub-groups which provide challenge and a critical eye on key aspects of Trust business. The Strategy Development Group and Quality Group have contributed to the shaping of the corporate strategy as part of the planned consultation process.

The development of STPs across 44 footprints nationally has provided an opportunity to consolidate and broaden existing collaborative relationships across the Durham, Tees Valley and North Yorkshire area. The Trust has signalled its commitment to the STP process and this has driven the thinking and planning behind this strategy.
3. Developing the Corporate Strategy

Our approach to the Corporate Strategy remains largely as described in earlier versions of this document. Our approach during ‘refresh’ has needed to reflect many of the external factors and significant changes within the system, and across the NHS, for example:

- Spotlight (both nationally and locally) on transformation of services following the postponement of a new, single site hospital
- Five Year Forward View and the development of new systems/models
- Urgent Care Networks and Vanguards
- Better Health Programme
- Sustainability & Transformation Plans
- Better Care Fund
- Development of the Trust’s Clinical Services Strategy
- Plans for major capital investment in North Tees Hospital estate

The Corporate Strategy provides the overarching direction for the organisation over a five year period. This provides the framework and the context within which the organisation plans, conducts, monitors and manages what it does. This is illustrated in the diagram below:

Defining the strategic direction involves a vision, mission statement and values, together with aims and objectives that provide a coherent and consistent framework for co-ordinating activity within an organisation. The period covering the refresh of this strategy has been set against a backdrop of change on a number of levels.
Nationally   The NHS has developed, and is implementing, a vast array of policy changes and frameworks designed to fundamentally transform the way the organisation works within a fast paced and changing environment.

From operational and procedural reviews led by eminent leaders in the NHS through to policy frameworks, planning guidance and quality improvement processes, the organisation is judged against many indicators.

One of the key concerns for many is the "capacity and demand" within the organisation, and this is acknowledged as a major challenge for every NHS Provider on a daily basis.

However, whilst Accident & Emergency (A&E) referrals and attendances continue to create blockages in the system, one of the successes of the Five Year Forward View has been the development of Acute Vanguards and network with regard to integrated urgent and emergency care in localities.

It is expected that the introduction of Urgent Care Centres will assist in managing the flow of patients through clinical navigation where only the real emergencies are filtered through to A&E. This will see a marked improvement in capacity in the system and will be a collaborative approach with General Practitioner (GP) Federation and North East Ambulance Service (NEAS).

Locally   With a focus on improving quality in A&E, the Trust has participated in a programme sponsored by NHS Improvement – *Quality Improvement in Accident & Emergency*.

This has resulted in an energetic period of short term projects aimed at driving up performance and quality throughout the Emergency Department where information and idea sharing between Trusts facilitates new approaches to key elements such as Discharge.

The Trust will continue to use the learning methodology to progress pathway initiatives including the enhancement of a rapid assessment area for all emergency admissions, extended opening for the discharge lounge, and the implementation of additional same day ambulance to improve discharge processes and close working with health and social care to reduce delayed discharges.
Improved discharge processes continue as a priority, with a focus on the resource requirements across acute, primary, health and social care to support effective utilisation of the available step down, rehabilitation, care and nursing home bed base. Change and transformation will play a major part in the Trust’s development and we will work closely with our stakeholders and delivery partners to ensure that all parts of the local health economy are involved in our development. The Directorates responsible for providing acute services within the Trust have developed their strategies which have informed the strategic direction for the Trust.

This includes further collaboration on elective services with neighbouring providers, building on the pathways currently delivered across Breast, Urology and Bariatric services, as well as the delivery of elective Outpatients, Diagnostic, Day Case, In-Patient and Cancer services across both Hartlepool and North Tees sites.

In addition to this, our Out of Hospital Care Directorate providing community services will deliver fully integrated care between acute, community, primary and social care with a single point of access to critical, responsive and interventional teams for community care.

**Supporting Strategies**

As a progressive and forward thinking Foundation Trust we make sure that our strategic direction, and the decisions that inform our future direction, are based on sound, practical evidence not only from within the Trust but from other external sources such as strategic partners and clinical and non-clinical stakeholders. That is why we focus on key areas such as people, quality of care, estates, information management and technology and research and development to inform our development, although this is not an exclusive or exhaustive list.

In the following section, we highlight the key strategies that have helped to influence and shape our strategic thinking.

- People Strategy
- Estates Strategy
- Information Management & Technology Strategy
- Quality & Safety Strategy
- Research and Development Strategy

In addition to the enabling and supporting strategies listed above, the Trust also takes guidance and points of reference from the following strategies:

- Trust Annual Plan
- Communication and Engagement Strategy
- Financial Five Year Plan

Full copies of all of the Trust’s strategies can be found at [www.nth.nhs.uk](http://www.nth.nhs.uk).
We have made further refinement and embedding of the workforce plans and projections for the organisation as part of the Clinical Services Strategy (CSS) and the future requirements of the Sustainability & Transformation Plan (STP). The overarching aim is to ensure people get the right care in the right place from people with the right skills. However, the balancing of an ageing workforce with increasingly attractive career opportunities outside (and inside) the NHS make the recruitment and retention of staff one of the biggest challenges the NHS faces both locally and nationally.

The ability to deliver high quality, compassionate care depends upon the development of an effective Recruitment and Retention Strategy which will underpin the Trust’s People Strategy complement the workforce planning strategy and support delivery of Trust objectives.

The introduction of value based recruitment in 2017 will support the recruitment and retention of quality staff that possess the key skills, experience, values and beliefs integral to the Trust. UK based recruitment campaigns continue with particular focus on utilising social media platforms to assist with advertising vacancies and showcasing the Trust as an employer of choice. Overseas recruitment will continue to be part of the Trusts recruitment and retention strategy.

To provide further focus on maximising workforce productivity, the Trust has introduced a new role of Assistant Director of Nursing, Workforce and Professional Standards who is working closely with the Workforce Department to develop a longer-term strategy for nurse recruitment, taking account of the current challenges and risks.

New ways of working will enable roles to be designed more flexibly and will support the implementation of seven day working, Hospital at Night and other initiatives to develop multi-disciplinary approaches to service planning that is agreeable to existing staff and attractive to future recruits.

Providing extended service delivery hours will also contribute to satisfying the needs and wants of the local patient population. This will continue to be a priority between 2017 and 2019 and beyond, with the sustained integration of workforce planning being a key enabler in this.

People Strategy

- Provide a balanced system of care
- Work across artificial boundaries of hospital and community services
- Encourage staff to adopt People First Values in their working lives
- Introduce value based recruitment to the Trust to support recruitment and retention
- Ensure establishments meet safe staffing standards
- Increase number of substantive appointments
- Improve retention of existing staff within the Trust
- Continue using social media platforms to assist with vacancy filling and promote Trust as employer of choice
- Monitor and minimise staff turnover and reduce reliance on temporary staffing
We will continue to operate from the two main hospital sites at Hartlepool and North Tees, with some services delivered from Peterlee Community hospital. The strategy for the management of the Trust’s estate in the short-term will be to deliver the major capital investment programme to upgrade the engineering infrastructure at North Tees site.

This will ensure the operational safety, effectiveness, and reliability of the hospital’s engineering services and will be aligned to the requirement of the Trust’s business objectives. Energy efficiency measures will be improved, carbon emissions reduced and approximately 10% of electrical consumption will be via renewable, on-site energy sources.

The critical engineering infrastructure will be expanded and future-proofed, ensuring additional capacity is available to allow any future expansion requirements of the hospital estate.

The Trust will substantially reduce the significant backlog maintenance requirements in the light of the new life expectancy of the hospital, ensuring that the estates services remain consistent with the concept of first class facilities.

An estates master plan has been developed to support the medium term ambitions of the Trust articulated through the Clinical Services Strategy and the emerging Sustainability and Transformation Plans.

The long-term estates strategy continues to be to rationalise the existing estate to centralise into core buildings with the disposal of surplus estate, and to seek inward investment to utilise the existing estate, meeting the challenges of the Lord Carter metrics by increasing the proportion of the estate used for clinical activity to above 65% and reducing unused space to below 2.5%.

The estates challenges of the short, medium and long term strategies will be enacted whilst at all times maintaining the current estate in a safe condition while achieving high performance standards and patient satisfaction outcomes.
Information & Technology Services - Digital Strategy

Fundamental to our health and care system transformation, will be the delivery of high quality, cost effective Information and Technology Services (I&TS), otherwise known as „Digital Services”.

Our vision is to have secure, resilient, accurate and timely information at the point of patient care. This will be delivered through an integrated application suite, combining clinical and line of business applications, underpinned by a robust and cost effective information infrastructure.

We will focus on addressing the key health and care objectives from a local and regional perspective, as described in the Better Health Programme (BHP) and the emergent Sustainability and Transformation Plan (STP). Furthermore, we will support the creation of a collaborative health and care system, key elements of which are articulated within the published Clinical Commissioning Group (CCG) Local Digital Roadmaps (LDRs).

Our aim is to enable secure and legitimate information and knowledge sharing, supporting user (Patient and Clinician) access and “self-sufficiency”. We will develop digital services that will shift healthcare from “isolation to integration”.

Our key focus areas will be:

• Integration with the North East and North Cumbria digital health & care programmes, including the Great North Care Record (GNCR) and population health initiatives.
• Unlocking and the power of information to improve decision making at the point of care.
• Exploiting digital technologies to deliver patient centred solutions in neighbourhoods and communities.
• Keeping patient and service user’s information safe, secure and up to date, and only used with appropriate governance and controls.
• Improving organisational digital maturity, and user digital literacy to maximise the benefits of digital technologies.
• Delivering digital services which will be paper free at the point-of-care by 2020.

• Integration with the Great North Care Record and broader system digital initiatives
• Compliments and supports Local Digital Roadmaps (LDRs) objectives
• Shifts health and care from “isolation to integration”
• Digital services that add value to patient outcomes
• Digital access and control for patients and empower carers
• Secure, resilient, timely and accurate information at the point of patient care
• Improve decision making through integration of clinical and line of business systems
• Reduce administrative burden for clinicians and care professionals
• Continually improve our digital maturity
• Improve digital literacy of staff and service users to maximise benefits of digital technology.
• Deliver paper-free Information & Technology services by 2020
• Aligning; People, Process and Technology
• Improve patient safety benefits and efficiencies through Scan4Safety enabling the ability to track and trace Patients, Products and Places.
Quality & Safety Strategy

We are passionate about delivering, maintaining and improving safe, quality care across the organisation.

Hospital mortality has historically been measured using the hospital standardised mortality ratio (HSMR) which reflects deaths in hospital with adjustments for palliative care. The Department of Health, following recommendations from the national review of HSMR, is now committed to using the summary hospital mortality-level indicator (SHMI) as the indicator for the NHS for England. SHMI measures deaths in hospital and within 30-days of discharge and does not adjust for palliative care; deaths after surgery; and deaths in low risk conditions. The Trust now resides in the „as expected“ range for SHMI in the latest time period.

The Trust continues to drive reductions in hospital mortality rates. We aim to reduce the number of deaths expected in our hospitals further and to have the lowest death rates in England. HSMR peaked in 2014/15 with excellent reductions to the current time period, placing the Trust in the „as expected“ range.

The Trust has embedded the national safety thermometer within quality processes with monthly review and reporting on harm free care. The Trust is trialling the Next Generation Safety Thermometer; which covers Medications, Maternity and Children & Young People’s Services.

The Trust has developed and implemented a number of initiatives to ensure identification of good practice and areas to improve patient, carer and staff experience. This includes renewed unannounced and announced Staff, Patient Experience and Quality Standards (SPEQS) visit to inpatients is now aligned with the CQC domains of Safe, Effective, Caring, Responsive and Well-led.

The Trust has fully embraced the Friends and Family test process, covering In-patients, Maternity, Emergency Care, Community Clinics, Community Dental, Outpatients, Day Case Unit, Paediatrics and Radiology to improve service delivery and service user experience.

The Trust has in place a robust complaints process aiming to resolve complaints and concerns at an early stage. Themes and trends are utilised to identify areas for improvement to share across the organisation.
Over the past three years we have aimed to recruit over 800 patients a year into National Institute for Health Research (NIHR) portfolio studies. Whilst we always strive to increase recruitment into NIHR research studies year on year, occasionally this isn’t possible as the availability of studies and resources to support this fluctuates year on year.

In 2017 we will launch a 12 month programme to support the Out of Hospital (Community) directorate to open non-commercial portfolio research studies and also provide dedicated infrastructure and support to develop Chief Investigator led studies and grant applications. If the project is successful we will roll this model out to other directorates for a 12 month period.

Commercial activity will increase with the opening of the North Tees: Synexus Clinical Research Facility in 2017. This joint venture with a commercial research company co-located in an NHS Trust is an innovative collaboration, only seen in one other NHS Trust in the UK. It offers unique opportunities to collaborate and learn from each other so that research participation is optimised in this area.

A longer term strategic aim is to explore possible joint appointments with dedicated (externally funded) research time built into posts, attracting a high calibre of applicants to clinical and nursing/Advance Healthcare Practitioner (AHP) posts.

As part of our commitment to delivering the high quality research delivery and set up that is required form the NIHR and research sponsors, we will ensure our data systems collate the relevant metrics to support monitoring and reporting of our performance.

We will monitor performance against NIHR high level objectives and local network quality improvement targets relating to recruitment to time and target, study set up and recruitment of first patient.

Through our R&D Co-ordinator we will support new investigators to develop trust initiated studies, support research delivery staff in their professional development

Over the next 4 years, our aim is to develop a strategic approach to delivering research opportunities across the STP including:

- ensuring engagement from all staff groups and areas in research provide all patients with an opportunity to participate in research
- maintaining current levels of non-commercial research activity and increase where possible
- increasing our participation in commercially sponsored trials
- ensuring recruitment for commercial and non-commercial research is delivered to National Institute for Health Research (NIHR) time and target metrics and monitor this performance
- developing strategic partnerships across the STP footprint to maximise opportunities for a collaborative and strategic approach to research delivery
- developing Trust sponsored Chief Investigator led studies and a robust research delivery infrastructure
- to ensure the Patient Research Ambassador role actively engages with patients and raises the profile of research with them.
Corporate Strategy 2016 - 2021: The Beginnings

In updating our Corporate Strategy for 2016 – 2021 we have reviewed our existing strategic direction including the high level aims and objectives with particular emphasis on:

- Reviewing Directorate strategies and other enabling/supporting strategies
- Delivery of the strategy as demonstrated by the metrics
- Reconsidering the strengths, weaknesses, opportunities and threats and the political, economic, sociological, technical and legislative analyses
- Modifying the SWOT and PESTL slightly to reflect the current environment in which we operate and ensured they correlate to the high level aims and objectives
- Revisiting the supporting strategies to ensure that a full and appropriate suite is available and that they are aligned to delivering the high level aims and objectives
- Reviewing and modifying the strategic objectives
- Producing an updated Corporate Strategy for 2016-2021

The scoping, review and analysis has been reconsidered by the Executive Directors, Senior Managers, the Governor Strategy Committee and the Council of Governors.
Our Strengths

For this refresh we have engaged with a range of stakeholders to canvass a wider view on new and emerging Department of Health strategy, patient and stakeholder feedback and business intelligence in order to test whether the previous analysis of how we view our organisation need to be revised.

The **Strengths, Weaknesses, Opportunities** and **Threats** (SWOT) are presented in the table below and are felt to describe well the internal and external factors that are either supportive or unfavourable to the Trust in its achievement of its strategic aims and objectives.

The **Political, Economic, Sociological, Technological and Legislative** (PESTL) influences are also presented in the diagram below (surrounding the four SWOT elements) and are used as a guide to strategic decision-making. The ability to understand the current environment and to assess potential changes to the external environment will ensure that the Trust is better placed than its competitors to respond to changes.
Implications for the Corporate Strategy 2016-2021

Some changes have been made to the SWOT and PESTL analyses, however, the overall strategic direction of the Trust remains appropriate.

In the SWOT analysis there have been some changes and additions to reflect the current economic climate, service transformation, the availability of new community facilities, and the new NHS mandate around STPs and the political agenda. There is also recognition of the strong Board of Directors and Council of Governors with skilled, motivated clinical and workforce teams strengthening the ability to overcome the threats and weaknesses to continue to improve and sustain a successful organisation.

For the PESTL changes include the arrival of Sustainability & Transformation Plans and the importance of the Better Health Programme along with the potential changes to the political landscape across Tees Valley and the scheduling of a directly elected mayor for the region taking place in 2017.

The engagement and support of local political stakeholders is crucial in transforming services to provide enhanced quality, clinical effectiveness and patient experience to the people of Easington, Hartlepool, Sedgefield and Stockton whilst improving clinical outcomes.

This will be an important feature of how the Trust develops its communication and engagement strategies particularly in light of the political landscape both locally and nationally. The Trust leaders, and all of the staff that work for the Trust, are keen that the public see and hear of the exceptional life-saving and life-changing work that goes relatively unnoticed on a daily basis and this needs to be balanced within a culture of performance and target setting that is incumbent on all NHS Trusts.

‘The Trust continues to work hard to develop strong and effective relationships across the local and regional health community and with all stakeholders as we work towards developing our Sustainability and Transformation Plan for the years ahead’

Public health is now the overall responsibility of Local Authorities. However, the Trust will continue to work with its partners and stakeholders to share the good practice and information sharing that can help develop better outcomes in public health.
The Trust has supported the development of integrated health and social care services as part of „Hartlepool Matters” and is an active member of Stockton Local Authority Health and Wellbeing Board. In addition to this, the Trust acknowledges that greater emphasis needs to be placed on the external network and partnership agenda to fully maximise the sharing and learning of good practice within the local health economy.

It is also worth noting that whilst there is a general consensus of an improving economy, there remains a significant external financial pressure on the Trust and the NHS as a whole, and there will be further, currently unknown, pressures arising from national and international developments in the coming years. The Trust will continue to manage the on-going constraints through system-wide Quality, Innovation, Productivity and Prevention (QIPP) plans and Internal Cost Reduction Programmes in addition to the longer term plans of STP.
4. Our Corporate Strategy 2016 - 2021

Our Corporate Strategy can be summarised in the following diagram:

**Our Patients**

Our patients are at the pinnacle of our triangle. We will always put our patients first.

**Our Vision**

To be the best healthcare provider in our region by delivering excellent services for our patients.

**Our Mission**

North Tees and Hartlepool NHS Foundation Trust will become the healthcare provider of choice by: putting patients first, delivering efficient, safe and reliable services, enabling excellence, encouraging innovation, embracing learning, knowledge and change.

We will achieve this by operating a LEAN performance focussed organisation that thrives on change and provides:

- Good patient care through safe, modern high quality health services
- Efficient services by recognising that waste in one area compromises patient care in another
- A good place to work by being a good employer, working together and valuing people
- Education and training to enable staff to deliver individual, professional, team and organisational objectives

Our Values

Health care is a people business and therefore we place great emphasis on all the people associated with our organisation, namely, patients, public and our staff. All are key to what we do. This is recognised in our People First Values which underpin our service delivery. We expect our People First Values to drive our behaviour when we are delivering care to our patients and their families as well as in our dealings with colleagues and people in our own and other organisations.

‘Putting Patients First’ is what we stand for, and believe in
Our Direction

As part of our original Corporate Strategy setting, the Trust developed a list of six headline corporate aims that would guide the direction for the organisation and drive the Trust forward, developing a set of measures and metrics from which to monitor and manage progress.

The aims and objectives (set out below) reflected our commitment as a strong performing Foundation Trust to tackle some of the “big picture” issues at a strategic level that sit outside the normal operational performance of a busy district hospital.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
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<tbody>
<tr>
<td><strong>Putting Patients First</strong></td>
<td>Create a patient centred organisational culture by engaging and enabling all staff to add value to the patient experience and demonstrated through patient safety, service quality and LEAN delivery.</td>
</tr>
<tr>
<td><strong>Integrated Care Pathways</strong></td>
<td>Develop and expand the portfolio of services to provide integrated pathways for the people of Easington, Hartlepool, Sedgefield and Stockton providing equal access to acute care and care as close to home as possible in line with Momentum: Pathways to Healthcare.</td>
</tr>
<tr>
<td><strong>Service Transformation</strong></td>
<td>Continually review, improve, transform and grow our healthcare services to respond to the needs of our healthcare community. In line with evidence based guidelines we will enhance quality, clinical effectiveness and patient experiences whilst improving clinical outcomes.</td>
</tr>
<tr>
<td><strong>Manage our Relationships</strong></td>
<td>Ensure our services, and the way we provide them, meet the needs of our patients, commissioners and other partners by proactively engaging with all appropriate stakeholders including our staff, through communications, engagement and partnership working.</td>
</tr>
<tr>
<td><strong>Maintain Compliance and Performance</strong></td>
<td>Maintain our performance and compliance with required standards and continually strive for excellence by good governance and operational effectiveness in all parts of our business</td>
</tr>
<tr>
<td><strong>Health and Wellbeing</strong></td>
<td>Embrace the health and well-being of the population we serve and ensure that the health needs of the people of Easington, Hartlepool, Sedgefield and Stockton are reflected and catered for in the provision of services from the Trust.</td>
</tr>
</tbody>
</table>

Our previous Corporate Strategy reported progress against the aims and objectives above. However, our discussions during refresh have highlighted the on-going development of integrated care pathways and that the focus of this work is now more of a major component of service transformation.

As part of this refreshed strategy we will monitor progress of this objective through Service Transformation. This also takes into account the re-focussing of the service strategy which has been overtaken by the work of the Better Health Programme across Durham and Tees Valley, and latterly, the STP for Durham, Darlington, Teesside, Richmondshire, Hambleton and Whitby.
We are rightly proud of our achievements in recent years but we also recognise that all of our achievements are a result of the dedication, hard work and commitment of the workforce employed throughout the organisation.

We help our staff celebrate their achievements, but we recognise that the organisation will only continue to succeed through the efforts of our staff and that we should make further efforts to acknowledge this. We put our patients first, but our staff remain pivotal at the heart of the organisation, and that is why we have altered our strategic aims and objectives to reflect this.

We have made our strategic aims and objectives more simple and clear in definition and they are set out, along with their priorities, on the following pages. The objectives are aligned to the Care Quality Commission (CQC) key domains of safe, responsive, caring, effective and well-led. We will continue to monitor progress through our internal governance framework and against the measure and metrics set out as part of this process.

One of the cornerstones of the NHS and of this Foundation Trust is to provide excellent quality and safe care for those who need it.

Following the recommendations of the Francis Report (2013) we continually strive to „put the patient at the heart of everything we do”. We firmly believe that engaging with our patients on every level is not only the right thing to do for the patient, but by doing this we are able to understand what changes and improvements are needed e.g. throughout the service, pathway, treatment and discharge etc to help make for a more positive and comfortable patient experience as possible.
Add to this a focus on privacy, dignity and regularly assessing and acting on patient feedback, the Trust is confident that the measures we set out for this objective are not only achievable but critical to our sustainability.

We improve, and ensure the safety of all services by stripping out waste and implementing more "fit for purpose" services by developing our workforce, skill mix and service line management.

However, putting the patient first is not only delivered within the confines of the hospital but through the effective engagement of carers, families and friends, and by linking up with relevant authorities and agencies such as Healthwatch, Patient forum, NHS Choices, and Commissioners. By engaging with all of these stakeholders, we make sure that the patient is central in all of our conversations. The patient's wellbeing is also central when investigating and adopting new technologies and treatments in line with our clinical services strategy and the business strategy of the Trust. All of this means that we need to provide a high quality, clean and efficient patient care environment as we rationalise our current estate and make refurbished improvements to patient support services.

We acknowledge that our staff, and the skills and knowledge that they possess, are the most valuable resources available to the Trust. Everyone plays an important part in the sustainability of the organisation. From "Board to Ward", including all of our support services, our staff are what makes the organisation tick.

### Strategic Objective 2

**Valuing our People**

We ensure that our workforce feel valued, are happy at work, and have access to all developmental and training opportunities to help them do their job effectively.

#### Priorities

- Promote and "live" the NHS values within a healthy organisational culture
- Develop, train and retain our staff
- Ensure a healthy work environment
- Listen to the "experts"
- Encourage the future leaders
We employ over 5,500 people in our Trust and the care that the patient receives is delivered and determined by the actions of many in the organisation including those behind the scenes in corporate services and the many volunteers that work with us in both our hospitals. That’s why we place great emphasis on providing as many opportunities as we can for staff to learn and consolidate new skills, explore new developments and technologies that may enhance their roles and how they perform in the job as well as the many learning, training and development opportunities that are offered throughout the Trust.

We continue to celebrate the way in which our staff excel in their chosen professions through the Trust’s “Shining Stars and the Team and Employee of the Month” awards, and just as important, through our performance and appraisal system, ensuring that we not only listen to what our staff are telling us so we can be alive to the good things and the areas that need improving in equal measure.

The Trust recognises the need to create a positive organisational culture that promotes the values and behaviours needed to be the healthcare provider and employer of choice.

Following feedback from staff, the Trust’s culture group continues to focus on the following four priorities:

- Ensure all staff know how they do/can make a positive impact on patient care
- Building productive and effective relationships between individuals/teams and managers – developing leadership capacity
- Recognise and celebrate good practice
- Communication of the Trust’s strategic vision and how individuals can contribute
As a progressive Foundation Trust with a track record of delivering high quality services, the Trust acknowledges that there is a need to stay ahead of the game and to continue to develop our services in line with the needs of our patients, with a focus on the critical drivers within the local health economy.

We have developed our ten year Clinical Services Strategy to reflect our position now, and where we need to be in the next part of our journey. This journey will be shaped largely by the changes that will take place as a consequence of our partnership with the Better Health Programme across Durham and Tees Valley which will, in turn, influence the delivery of the Sustainability and Transformation Plans for the Trust during this period.

Whilst the prospect of a new single-site hospital is no longer attainable in the current climate, we believe that providing care closer to home is not only deliverable in the short to medium term, but pivotal in the long term in helping us to reduce hospital admissions and the length of time people spend in hospital.

Strategic Objective 3

Transforming our Services

We continually review, improve, and grow our healthcare services whilst maintaining performance and compliance with required standards to enable the development of integrated care pathways and other healthcare services in collaboration with key stakeholders.

Priorities

- Deliver cost effective and efficient services maintaining financial stability
- Make better use of information systems and technology
- Provide services that are fit for purpose and delivered from cost effective buildings
- Ensure future clinical sustainability of services

Clinical Services Strategy 2016 - 2021

North Tees and Hartlepool NHS Foundation Trust
That is why we are determined to provide more services that are as accessible to patients as possible in terms of their location, availability through “choose and book”, and time efficiency with appointments so that, in time, we become a “no wait” hospital.

The development and implementation of new integrated care pathways has seen new patient centred activity within the community specifically targeting respiratory, frail and elderly, diabetes and palliative care services with additional pathways being developed, focussing on long term neurological conditions, stroke and rheumatology. We will maintain our close partnerships with stakeholders in the community to ensure the momentum of the changes continues.

The Trust has developed two new Integrated Urgent and Emergency Care Centres at our Hospitals. Urgent Care Centres provided by our Trust (in alliance with NEAS and the GP Federation) are now located at both hospital sites at North Tees and Hartlepool. This will see a transformation of not only services that we provide but also a physical transformation of our aged hospital estate. We are in the process of planning and developing our strategy ahead of significant changes to the current hospital estate to allow the site to be fit for purpose for the next ten to twenty years. The first stage of this incorporates a major restructuring of our Outpatients Department.

The Trust recognises that better use of data and digital technology has the power to improve health, transform the quality and reduce the cost of healthcare services for patients, carers, care professionals and to support new medicines and treatments.

The Information & Technology Strategy (I&TS) will be used to enable, support and sustain change relevant to the delivery of key areas including the full integration with the [North East] digital health and care record initiatives.

By doing this, the Trust will unlock the power of information to improve decision making at the point of care and will aim to exploit digital technologies whilst continuously innovating to shift care closer to home, supporting self-care. This will serve to establish a platform to manage population health and drive up digital literacy of staff and service users to maximise the benefits of digital technologies.

The financial challenges facing this Trust over the course of the next 5 – 10 years are significant, and we will need to transform our services in a more efficient way in order to maintain delivery of high quality and safe clinical services whilst maintaining innovative practices that benefit the patient but also the clinicians and their development needs. Much of this will centre on the Cost Reduction Programme which will require the Trust to deliver efficiency savings amounting to approximately 7% of our annual budget. This will be challenging, but our staff are committed to delivering more for less in the current economic climate to ensure the services we provide deliver better outcomes for the patient, and thereby maintain the strength of an effective NHS Foundation Trust.
The dramatic increase in the number of people admitted to acute care systems across the NHS has become one of the more intractable problems that the organisation has faced in the last 10-15 years. It is a growing problem that cannot be solved in the short term, but is one that needs a longer term, strategic approach.

Levels of deprivation compound this issue, where the gap in health inequalities within certain communities and neighbourhoods can only be described as “narrowing” at best. However, the gap is not closing quickly enough. High levels of deprivation and lower than average life expectancy continue to add to the pressures on the system which is increasingly fuelled by heart disease, cancer, respiratory and other long term limiting illnesses.

In Stockton, around 8,000 children live in low income families and whilst just over 5,000 children live in low income households in Hartlepool, the Borough continues to be ranked as one of the 20% most deprived authorities in England. Life expectancy for both men and women is lower than the England average. In both Local Authority (LA) areas child obesity remains a constant issue with an average of 20% of Year 6 children across both LA areas classified as obese (Source: Health Profiles, Public Health England, 2016).

The number of smoking related deaths in Stockton (320) and Hartlepool (390) per year is significantly above the national average (274) with a smoking prevalence of 21% of all adults across both LA areas. The number of hospital admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause remains higher than the national average (641) year on year (Stockton 808/Hartlepool 838) with Stockton seeing a 10% increase in 2016 (Source: Health Profiles, Public Health England, 2016).
Healthy lifestyles are a key factor in helping to prevent many of today’s life limiting illnesses, and by addressing some of the key determinants such as smoking, alcohol abuse and obesity levels, the local health economy can focus on tackling the inequalities together to improve the Health & Wellbeing of the region.

Tackling the inequalities faced by the most vulnerable in society e.g. the very young and the very old, are integral to the public health agenda across Durham and Tees Valley. That is why the Trust will continue to work closely with its key stakeholders and delivery partners to help promote healthier lifestyles and strengthen ill-health prevention throughout all of the services delivered by the Trust and this work will be aligned with the Health & Wellbeing strategies covering both Stockton and Hartlepool.

Diagnostic services remain high priority for the Trust, and in particular the screening programmes for bowel, breast, cervical cancers and retinal screening for diabetes patients. The Trust has developed a range of collaborative partnerships developing pathways that deliver improvement to services and outcomes overall. Improving laboratory processes and diagnostic facilities is pivotal to our planning for the future and we will continue to maintain this approach as we move towards the further development of the STP and the alignment with the Better Health Programme.

In order to maximise the delivery of strategic objectives pre and post-STP, the Trust will look to further develop external working relationships with partners and stakeholders across the wider Tees Valley health economy to adopt better practices and share our skills and knowledge for the benefit of the population of the region.
5. Demonstrating Delivery

Corporate Strategy Templates

Whilst the previous section has given the overview of our Corporate Strategy, the detail is set out in the Corporate Strategy Templates that are attached as Appendix 2 and show:

- The Strategic Themes
- The Strategic Aims
- The detailed Strategic Objectives that align with the strategic aims described previously
- The Supporting Strategies and Plans that are the vehicles for delivering the Strategic Objectives and will lead to the aims being achieved
- The accountability for the delivery of the Corporate Strategy; highlighted through the Lead Director for each of the Supporting Strategies and Plans
- The Strategic Measures that will be used to check progress against each theme

It is this detail that enables us to manage and ensure that our Corporate Strategy is being delivered and fundamentally supporting our direction.

Measuring and Managing Progress

Measuring and managing progress in delivering our Corporate Strategy is an essential part of our approach and our strategic planning cycle. How we are going to do this is addressed in this section.

The operational performance of the Trust is critical and there are numerous metrics used to manage this which are reported through Corporate Dashboards regularly throughout the business year.

However, in order to articulate and manage the progress against the Strategic Aims defined in this strategy, eleven strategic measures, each with a single metric, have been carefully selected which cover the breadth of the strategy.
The latest available position against each measure informs the Corporate Strategy Setting step in quarter 2 and the Corporate Strategy Review step in quarter 4. As far as possible, the metrics which have been selected also provide external validity to the measurement and analysis of progress as they are published by independent bodies such as NHI Improvement.

It should also be noted that other areas not covered by any of the specific strategic measures described below such as legality of constitution, growing a representative membership, appropriate board roles and structure, effective risk and performance management and cooperation with NHS bodies and Local Authorities are also important, however, they will be tracked and reported through specific supporting strategies and plans, in particular through the Annual Plan.

**Fig 1** below charts each of the Trust’s strategic measures. Each measure is then translated into a metric that is capable of being quantified. Each metric then has a target linked to managing delivery of the Corporate Strategy. This reflects Directors’ portfolios and latest position on each strategic metric.
<table>
<thead>
<tr>
<th>Strategic Measures</th>
<th>Strategic Metrics</th>
<th>Target</th>
<th>Corporate Lead</th>
<th>Source</th>
<th>Frequency</th>
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<td>SHMI</td>
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<td></td>
<td>Weekend SHMI</td>
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<td>7 Day Services survey benchmarking data</td>
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<td>Test</td>
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<td>Monthly</td>
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<td></td>
<td>Standard 8</td>
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<td>Clinical Sustainability</td>
<td>Collaboration:</td>
<td>Maintain progress</td>
<td>Chief Operating Officer/Deputy</td>
<td>STP Executive Team Trust Director's Group</td>
<td>On-going Annual Planning</td>
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<tr>
<td></td>
<td>e.g. Breast Urology</td>
<td>according to key</td>
<td>Medical Director</td>
<td>Group</td>
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<td></td>
<td>Haematology MSK</td>
<td>milestones and</td>
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<td>risks. Revisit</td>
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<tr>
<td>Quality of Services</td>
<td>CQC Ratings</td>
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<td>Director of Nursing</td>
<td>CQC Assessment (SPEQS)</td>
<td>CQC Timeline</td>
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<tr>
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<td>2) Outstanding</td>
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<td>CQC Well Led</td>
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<td>Single Oversight Framework Self-Assessment External Review</td>
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<td>Director of HR</td>
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<td></td>
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<td>hour standard</td>
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<td>RTT 92% -</td>
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<td></td>
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<td>Incomplete</td>
<td></td>
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<td></td>
<td>Pathways</td>
<td></td>
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<td></td>
<td></td>
<td>Cancer 85% -</td>
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<td></td>
<td></td>
<td>Cancer 62 day</td>
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<td>Standard</td>
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<td>Diagnostic</td>
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<td></td>
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<td>standard 99%</td>
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<td></td>
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<td>within 6 Weeks</td>
<td></td>
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<td>Financial Stability</td>
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<td>1</td>
<td>Chief Executive</td>
<td>Single Oversight Framework NHSI Returns</td>
<td>Monthly Annual Plans</td>
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<tr>
<td>---------------------</td>
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<td>-----------------</td>
<td>------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Improved Facilities &amp; Technology</td>
<td>Capital Investment</td>
<td>Capital investment proposal as part of clinical sustainability and contribution to STP to develop new clinical accommodation to the latest HBN standards</td>
<td>Director of Estates</td>
<td>Trust Internal Plans (Estates and I&amp;Ts)</td>
<td>Milestone Reviews</td>
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<td>Digital Footprint</td>
<td>Achieve Stage 7 of Digital Maturity Assessment (DMA) by 2020</td>
<td>Chief Information and Technology Officer</td>
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<td>Health and Social Care Integration</td>
<td>DTOC</td>
<td>3.5% (nat) 3.3% (local)</td>
<td>Chief Operating Officer</td>
<td>CQUIN Dashboard</td>
<td>Monthly Bi Annual Review</td>
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<td>Stranded Patients</td>
<td>2.5% (Increase in patient discharges &lt; 7 Days)</td>
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<td>1000 - Recruitment into non-commercial studies 1000 60 - Increase recruitment into commercially sponsored studies</td>
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<td>Breast Screening</td>
<td>Maintain or improve uptake rate</td>
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<td>Bowel Screening</td>
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<td>Cervical Screening</td>
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<td></td>
<td>Partnership Working</td>
<td>Influence the shaping of the local health economy by building strong relationships and collaborative vision</td>
<td></td>
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</tr>
</tbody>
</table>
Delivery of 2016-2021 Corporate Strategy

The Trust has selected ten measures from which to monitor how well it has performed with regard to the strategic objectives. A number of metrics are used to allow us to demonstrate progress on our strategy. Each metric is accompanied by an operational definition. The latest position on each of these, compared to previous years, is presented at Appendix 5.

Patient Safety

The Trust continues to drive reductions in hospital mortality rates. We aim to reduce the number of deaths expected in our hospitals further and to have the lowest death rates in England. HSMR peaked in 2014/15 with excellent reductions to the current time period, placing the Trust in the “as expected” range.

Hospital mortality has historically been measured using the hospital standardised mortality ratio (HSMR) which reflect deaths in hospital and adjusts for palliative care. The Department of Health, following recommendations from the national review of HSMR, is now committed to using the summary hospital mortality-level indicator (SHMI) as the indicator for the NHS for England. SHMI measures deaths in hospital and within 30-days of discharge and does not adjust for palliative care; deaths after surgery; and deaths in low risk conditions. The Trust now resides in the “as expected” range for SHMI in the latest time period.

The provision of Seven Day Services continues as a high priority for all Foundation Trusts. North Tees and Hartlepool is performing well in the transition towards providing the fullest range of services across both sites. However, it was agreed that both education and awareness of a number of standards was needed. Individual “deep dive” meetings are now a feature for Consultants and monthly feedback is incorporated into the Clinicians performance dashboard.

Whilst the Trust is performing relatively well with regard to Seven Day Service transition, some elements of the programme are affected by the work currently in development for the STP. For example, the Trust does not provide echocardiograms, histology or MRI scans on a weekend as this provision is covered under more formal arrangements with partner Trusts in line with STP plans. However, this should not detract from the performance of the programme overall which has seen a marked improvement between March – September 2016.
The Trust is delivering year on year improvements in the number of cases that of Dementia and/or Delirium that we diagnose early in the treatment of patients. However, we acknowledge that there is much more to do with regard to early diagnosis and that this can be better achieved through enhanced partnership working with key stakeholders in health and social care. The Trust is a key partner in the Dementia Collaborative within Stockton and is working closely with the Local Authority to help develop strong and robust external networks that will help to increase the early diagnosis of Dementia and Delirium case before they present in an acute care setting.

**Patient Satisfaction**

Whilst this is a quantitative measure, there is an infrastructure of supporting methodology data collected by the Trust. We are passionate about delivering, maintaining and improving quality care across the organisation and has developed and implemented a number of initiatives to ensure identification of good practice and areas to improve patient, carer and staff experience. The senior nursing team, non-clinical staff and governors undertake unannounced and announced Staff, Patient Experience and Quality Standards (SPEQS) visits to inpatients.

The SPEQS process has been renewed to align with the CQC domains of Safe, Effective, Caring, Responsive and Well-led. The Trust will continue to roll out to Outpatients, Community and Emergency Care. The Trust has fully embraced the Friends and Family test process, covering Inpatients, Maternity, Emergency Care, Community Clinics, Community Dental, Outpatients, Day Case Unit, Paediatrics and Radiology looking at both quantity of responses and the qualitative feedback from patients and relatives to improve service delivery and service user experience.

The Trust has in place a robust complaints process which aims to resolve complaints and concerns at an early stage. Themes and trends are utilised to identify areas for improvement to share across the organisation. The Trust has embedded the national safety thermometer within quality processes with monthly review and reporting on harm free care. The Trust has also started to trial the Next Generation Safety Thermometer; the new generation covers Medications, Maternity and Children & Young People’s Services.

**Staff Satisfaction**

The strategic metric measures the staff engagement score (1-5) on the annual NHS national staff survey which highlights the extent that staff believe that the Trust „is a good place to work“. The Trust performed slightly above the national average in 2016/17 but there is still much to do across the organisation to make necessary improvements in the workplace and the environment. The score comprises the following key findings in the annual staff survey:

- Staff recommending the Trust as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute towards improvements at work
As part of this refreshed Corporate Strategy, the Trust is developing a stronger focus on the job and personal satisfaction of people who work within the organisation and this can be measured through the strategic objective for „Valuing our People“. As a result, the Trust will seek to achieve (or better) the 2017/18 notional forecast of staff who would recommend the Trust as a good place to work. The Trust recognises the monumental role staff have in improving the health of the population alongside a very firm patient focus i.e. at the centre of everything we do. The Trust will therefore look to improve the working environment for all staff across both Hospital sites through various initiatives and developments that will seek to involve all staff members in the design and implementation.

**Clinical Sustainability**

The Trust’s key objective is to make best use of resources across both hospital sites, whilst fully utilising the opportunities offered through integrating primary, community and social care services through the Better Care Fund and the future direction of the STP to reduce avoidable admissions and make timely and safe discharges. The Trust recognises the continued need to build upon these established collaborative working relationships if integrated care pathways are to be successfully delivered, reducing the need for acute hospital care.

The Trust has therefore worked closely with the Better Health Programme to model and review acute services as a head start across the local STP footprint, with the influence of strong executive and clinical leadership. The main driver is clinical sustainability with a concentration on condensing expertise through clinical networking to achieve the ever escalating requirements of clinical standards, specifically those within the seven day services framework.

**Quality of Services**

The CQC conducted a planned programme of inspections against the five domains (safe, caring, effective, responsive and well led) in July 2015. The Trust received an overall rating of „requires improvement“ for Effective and Well Led, with Safe, Caring and Responsive rated as „good“. In partnership with key stakeholders, the Trust has delivered a number of improvements to services to ensure demonstrable sustainable improvements in service and quality focussed delivery.

The Trust aims to achieve a rating of „Good“ or „Outstanding“ in all CQC domains and will continue to progress the actions required including the Risk Management Strategy 2015-2018 and the Well-Led Framework. In addition, the Trust has remodelled its approach to clinical leadership at ward and department level, with an emphasis on support and cultural change to take on the challenges of the future. This includes a focus on Quality Improvement initiatives across the Trust which brings together dual and joint ownership with both a clinical and non-clinical leadership focus across all areas.
Governance and Licence Conditions

During 2015/16 the Trust was consistently rated Green for mandatory services i.e. no material concerns. The introduction of the Single Oversight Framework in 2016 replaced Monitor’s Risk Assessment Framework but continues to work within the statutory duties and powers of the organisation segmenting the provider sector according to the scale of issues faced by individual providers from 1 – Providers with maximum autonomy to 4 – Special Measures. NHSI placed the Trust into Segment 2 with targeted support from NHSI to ensure sustainable improvement.

The Single Oversight Framework, aims to help providers achieve and maintain Care Quality Commission ratings of „Good” or „Outstanding” and does not assess performance directly or predict CQC ratings. The segmentation rating acknowledges that support may be needed in one or more themes but there is no breach of licence and no formal action is needed.

In line with the key operational requirements within the NHSI Single Oversight Framework assessment, and supporting delivery of the Five Year Forward View (NHSE, Next Steps on the NHS Five Year Forward View, March 2017), providers must deliver improved and sustained performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards are therefore included as measures of success in the on-going delivery of the Corporate Strategy.

The NHS Improvement „Well Led Framework” (June 2017), in alignment with the Care Quality Commission well led assessments, outlines one of the key lines of enquiry (KLOE) as the requirement for NHS Providers to have a ‘clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver’.

The Trust’s Corporate Strategy has been developed to support the delivery of this key requirement, with over-arching objectives, strategic measures and metrics to influence and monitor delivery.
Financial Stability

SOF Finance and use of resources score

NHS use a number of financial metrics to assess financial performance by scoring providers/Trusts 1 (best) to 4 against each metric, averaging individual scores across all the metrics to derive a use of resources score for the provider. This is a new set of measures introduced within the NHSI Strategic Oversight Framework (SOF) from October 2016.

Where providers/Trusts have a score of 4 or 3 in the financial and use of resources theme, this will identify the potential support need under this theme, as will providers scoring a 4 (i.e. significant underperformance) against any of the individual metrics. The Trust’s financial performance over the next five years will be challenging, but is no different to that facing the majority of trusts and with sound financial control and management, the Trust is well placed to continue to deliver incremental improvements against the financial position.

The Trust aims for a score of 1 in all of the five metrics with a Trust overall score of 1, with the planned performance for 2017/18 and our current position highlighted in the table above.

Improved Facilities and Technology

The Trust took the decision in 2014/15 to place plans for a new hospital on hold following a protracted consultation process. Following the publication of the Five Year Forward View and the likelihood of new services being delivered from the North Tees Hospital site, the Trust embarked on the development of an Outline Business Case (OBC) to Department for Health (DH) for a capital estate investment programme to bring the ageing hospital estate up to a standard where services could be delivered safely and effectively for the long term beyond 2025.

Part of the investment programme focused on infrastructure and engineering works in 2015/16 and 2016/17. The estate reconfiguration as part of STP/BHP will incorporate plans previously developed under the capital estate investment programme covering the same period. The Trust is currently reviewing the capacity of its Information Management and Technology offer including a review of capacity within the North Tees estate which will be influenced by the on-going development of Local Digital Roadmaps (LDR) within the STP for the region. The Digital Maturity Assessment (DMA) provides the Trust with an opportunity to measure its healthcare services to enable better support via the effective use of digital technology. Covering 7 stages, the DMA incorporates a self-assessment process using existing evidence to chart investment and effective use of IT and how this can achieve better patient outcomes, reduction in bureaucracy and deliver greater efficiencies.

Health & Social Care Integration

The Trust, along with our partner’s in Health and Social Care, is committed to reducing the number of delayed transfers of care from our acute Hospital. Partners are working together to deliver an Integrated Discharge Service that will work proactively with Patient’s and their families to reduce the number of delays from Hospital. The Service will work as one to explore all opportunities for safe and effective discharge to help us to reach our target of 2.5% at the end of 2017-18.
The Trust aims to see a reduction in the length of stay for patients over 7 days. The ambition is to integrate Local Health and Social Care Services to support innovative pathway development under the umbrella term of „Discharge to Assess” and this will be further supported by the „Trusted Assessor” pathway. The Trust is working in partnership with colleagues in Social Care towards meeting the „discharge to assess” directive. The pathways are now embedded into the Trust and we are starting to see results coming through. The focus is on building on existing innovative pathways as well as identifying potential new areas of work. The focus for all is making sure that our patients are receiving the right care in the right place at the right time.

Research & Development

Whilst we will strive to increase recruitment into NIHR studies year on year, this isn’t always achievable as availability of studies fluctuates and we are participating in a higher proportion of complex interventional studies (with low recruitment targets) than all other Trusts in the North East and Cumbria research network. Our strategic aim is to ensure that we maintain levels of non-commercial research activity and increase our participation in commercially sponsored trials. Commercial activity will increase with the opening of the North Tees: Synexus: clinical research facility in 2017. In addition we will look to support new principal investigators, develop trust initiated studies, support research delivery staff and promote their professional development.

Over the next 4 years, our aim is to ensure a strategic approach to delivering research across the STP and that we collaborate with STP partners for a provision of research infrastructure and support that serves the entire population of the STP providing equity of access to research opportunities.
Health and Well Being

Health and wellbeing, and the focus on improving public health, continue to act as key determinants of longer term conditions which are impacted by lifestyle choices linked to diet, fitness and smoking/substance abuse. The Trust has recently introduced healthy eating and a sugar-free policy in most areas of the hospital where practicable and now intends to develop a broader No Smoking strategy for the Trust which will improve life chances for many staff and patients who visit or are admitted to our hospitals.

The Breast Screening Service continues to perform well in comparison with local and national screening centres and is compliant with the necessary key performance indicators. North Tees Breast Screening Unit continues to be involved in the age extension trial in which patients aged 47-49 and 71-73 are randomised for inclusion in the programme. The trial is set to continue until 2022, after which the risks and benefits will be evaluated with regard to inclusion in the programme.

The Tees Bowel Screening Centre, hosted by the Trust, has been successfully delivering the service along with national colonoscopy uptake rates since 2007. The centre continues to provide the high quality screening service to the age extended population and to the increasing surveillance population. The service delivers the national CQUIN for improving patient access and equity for all from 2017/18.

The Trust is currently one of the lower performers of Cervical screening across comparable CCG areas nationwide as a result of resource issues with sickness and recruitment in both Pathology and Women’s and Children’s services, however with Directorate plans in place to recover this position in 2017/18. It is acknowledged that there needs to be a step change in the 14 day turnaround of letters despatched to patients in addition to an increase in the number of appointments offered within two weeks in order to deliver a more sustainable screening service across Tees Valley. The Trust will undertake a major review of all of its partnerships and networks by fully mapping the local health economy to better understand the levels of engagement across the healthcare sector and across the Tees Valley. This review will determine the most effective and appropriate engagement strategy that provides the added value for the patient, the Trust, and to improve healthcare in the region. The review and engagement will work within the parameters of the STP process and will take account of any potential/perceived gaps.
Embedding the Corporate Strategy

The Corporate Strategy is a key driver for transformational change and sets the future direction for the organisation, the staff working within it and the services that are provided by the Trust within the region and in collaboration with other partners and stakeholders.

Our employees, including their competence and commitment, are vitally important to the future of the Trust and the wider NHS, and they have the most important role in the organisation in ensuring that the Trust achieves its mission, vision and values. It is therefore important that the corporate strategy is embedded within the culture of the organisation so that all staff can easily understand their role and how it impacts on the performance of the Trust.

The NHS Improvement ‘Well Led Framework’ (June 2017), in alignment with the Care Quality Commission well led assessments, outlines one of the key lines of enquiry (KLOE) as the requirement for NHS Providers to have a ‘clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver’. The Trust’s Corporate Strategy has been developed to support the delivery of this key requirement, with over-arching objectives, strategic measures and metrics to influence and monitor delivery as illustrated in the previous section.

Accountability and ownership of this strategy lies with the Executive Team who ensure alignment between operational activity and the long term strategic direction and provides reassurance to the Trust Board of Directors that the organisation is on track where achievement of strategic aims is concerned. The following table sets out how the corporate strategy will be embedded within the organisation.

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Directors / Council of Governors papers – each paper will include a statement at the beginning that cross references the paper and its subject to the relevant strategic aim</td>
<td>Chief Executive Officer / Directors/Trust Board Secretary</td>
<td>Each Board of Directors / Council of Governors meeting</td>
</tr>
<tr>
<td>The link to the Corporate Strategy will become standard work for all agenda setting and methods of conducting meetings throughout the organisation.</td>
<td>General Managers</td>
<td>Each meeting</td>
</tr>
<tr>
<td>Annual Business Planning launch – the Corporate Strategy to provide the context for the development of directorate annual business plans</td>
<td>Chief Operating Officer / Deputy Chief Executive</td>
<td>Annually – July</td>
</tr>
<tr>
<td>Review of Directorate Business Plans – part of the review and approval process for directorate business plans will be to check alignment with the Corporate Strategy and contribution to delivery</td>
<td>Chief Operating Officer / Deputy Chief Executive / Board of Directors</td>
<td>Annually – February and December</td>
</tr>
<tr>
<td>Task</td>
<td>Owner/Department</td>
<td>Frequency</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>Annual Plan – will be developed in the context of the Corporate Strategy</td>
<td>Chief Operating Officer / Deputy Chief Executive and all Directors</td>
<td>Annually - December</td>
</tr>
<tr>
<td>Corporate Strategy Setting – will check applicability and continued relevance and appropriateness of the corporate strategy and its various elements and update, refresh or renew as necessary</td>
<td>Board of Directors</td>
<td>Annually - July</td>
</tr>
<tr>
<td>Corporate Strategy Metrics – the process for monitoring, measuring and managing delivery of the Corporate Strategy. This mechanism will plot delivery of the strategy and initiate changes as required</td>
<td>Board of Directors</td>
<td>Annually with 6 monthly reviews</td>
</tr>
<tr>
<td>Supporting Strategies and Plans – programme for updating, refreshing and/or producing supporting strategies and plans that will underpin the delivery of the corporate strategy has been established</td>
<td>Chief Executive Officer / Directors</td>
<td>Annually</td>
</tr>
<tr>
<td>New Staff Corporate Induction – presentation about North Tees and Hartlepool NHS FT to provide explanation of the Corporate Strategy</td>
<td>Director of HR</td>
<td>Monthly</td>
</tr>
<tr>
<td>In addition to local departmental/ward objectives the appraisal process will also reflect the individuals contribution to the achievement of the organisation’s strategic aims and the development needs associated with their attainment</td>
<td>Director of Human Resources and OD / Trust Board Secretary</td>
<td>On-going</td>
</tr>
<tr>
<td>The recruitment processes will bring the organisation’s strategic aims and values to the fore. This will be achieved with a mechanism which enables an applicant to demonstrate their ability to do a particular role and also an opportunity to articulate their potential contribution to the achievement of the organisation’s vision and value base</td>
<td>Director of Human Resources and OD / Trust Board Secretary</td>
<td>On-going</td>
</tr>
</tbody>
</table>
6. Conclusion

This document sets out the Corporate Strategy for North Tees and Hartlepool NHS Foundation Trust for 2016/17-2021. It sets out the vision and direction for the organisation for the next five years and provides the appropriate link between the strategy of the Trust and the day-to-day patient care that is delivered and supported by all the staff and people working for the organisation.

We have incorporated and (in some cases) pre-empted the impact of the wider external influences on the local health economy. However, the strategic direction of this Trust will be further influenced by the many changes that will take place during the next period and this strategy will be regularly refreshed to take account of our position.

We therefore continue to ensure that this strategy remains at the centre of everything that we do, and drives us in all of our activities.
Appendices noted throughout this Strategy can be found on the following pages:

Appendix 1 - Corporate Strategy „on a Page"
Appendix 2 - Corporate Strategy Templates
Appendix 3 - Directorate Strategies
Appendix 4 - Clinical Services Strategy Info-graphic
Appendix 5 – Glossary of terms
Putting Patients First

- Improve outcomes, achieve performance targets
- Effective planning
- Develop new approaches that support recovery and wellbeing
- Develop new services to meet peoples’ needs
- Focus on research to improve services

Transforming Our Services

- Deliver cost effective and efficient services maintaining financial stability
- Make better use of information systems and technology
- Provide services that are fit for purpose and delivered from cost effective buildings
- Ensure future clinical sustainability of services

Valuing Our People

- Promote and ‘live’ the NHS values within a healthy organisational culture
- Develop, train and retain our staff
- Ensure a healthy work environment
- Listen to the ‘experts’
- Encourage the future leaders

Health & Wellbeing

- Protect and improve the health of the population
- Promote health services through full range of clinical activity
- Increase health life expectancy in collaboration with partners
- Promote Self-Care

Appendix 1
### Appendix 2 Corporate Strategy Templates

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Strategic Aim</th>
<th>Strategic Objectives</th>
<th>Facilitating Strategies / Plans</th>
<th>Owner / Executive Lead</th>
<th>Strategic Measures</th>
</tr>
</thead>
</table>
| Putting Patients First | We create a patient centred organisational culture by engaging and enabling all staff to add value to the patient experience and demonstrate this through high standards of patient safety and quality of service. | • Improve the clinical outcomes for patients by systematically and regularly reviewing the delivery and outcome of services and implementing changes and improvement accordingly.  
• Improve the safety of all services through the implementation of a range of initiatives including LEAN methodology, workforce development, skill mix, Service Line Management and Service Line Reporting.  
• Develop and implement plans for improving patient experience of services including a particular focus on privacy and dignity and on regularly assessing patient satisfaction and acting on the feedback.  
• Improve services through the regular and appropriate involvement and engagement of patients, carers, Healthwatch, Patient Forums, staff, Governors and from feedback about services from other sources such as NHS Choices, Commissioners, compliments and complaints.  
• Provide services that are as accessible to patients as possible in terms of location; availability through Choose & Book; timeliness of appointments with a view to moving to being a “no wait” organisation; and also accessible in the manner in which they are organised and provided.  
• Enable best practice by being proactive in investigating and adopting new technologies and treatments in line with the business strategy of the Trust.  
• Provide a high quality, clean and efficient patient care environment through site rationalisation and refurbishment and improvements to patient support services. | 1.1 Quality Strategy incl:  
• Quality  
• Patient Safety  
• Patient Relations  
  • Clinical Governance  
  • LEAN Implementation Plan  
  • Infection Control  
  • Privacy and Dignity  
  1.2 Patient Experience Strategy  
  1.3 Nursing Strategy  
  1.4 Clinical Service Strategies  
  1.5 Service Line Management Plans  
  1.6 People Strategy  
  • Organisational Change  
  • Reward & Recognition  
  • Operational Efficiency  
  • Development  
  1.7 Business Development and Marketing Strategy  
  1.8 IT/TS/Digital Strategy  
  1.9 Patient Environment Strategy incl:  
  • Estates  
  • Facilities  
  • Support Services  
  1.10 Medical Equipment / Capital Investment Plans  
  1.11 Directorate Business Plans  
  1.12 Trust Annual Plan and Trust Quality Accounts  
  1.13 Communication and Engagement Strategy | 1.1 DoNPS&Q and MD  
1.2 DoNPS&Q  
1.3 DoNPS&Q  
1.4 COO/DCE  
1.5 COO/DCE and DoF  
1.6 DoHR&OD and TBS  
1.7 DoHR&OD  
1.8 CITO  
1.9 DoE  
1.10 MD, DoF, DoE, COO/DCE  
1.11 COO/DCE  
1.12 COO/DCE, DoF and DoNPS&Q  
1.13 DoHR&OD | Patient Safety  
Patient Satisfaction  
Staff Satisfaction  
Quality of Services  
Governance and License Conditions  
Improved facilities and technology  
Financial Stability  
Research and Development |
### Valuing Our People

We ensure that our workforce feel valued, are happy at work, and have access to all developmental and training opportunities to help them do their job effectively.

- Continue to develop a high calibre workforce able to deliver quality services through being a good employer and invest in staff through: workforce planning and recruitment, training and education, leadership and professional development.
- Encourage staff to identify and participate in self-development and continuous professional development.
- Ensure Research and Development is a key function of staff development.
- Provide opportunities for staff to contribute to Trust-wide quality improvement initiatives.
- Conduct regular and planned staff satisfaction survey on an annual basis.
- Promote the key principles of the NHS Well-led Framework across all levels of the organisation.
- Conduct Well-Led assessments throughout the Trust.

### Transforming Our Services

We continually review, improve, and grow our healthcare services whilst maintaining performance and compliance with required standards to enable the development of integrated care pathways and other healthcare services in collaboration with key stakeholders.

- Identify and explore opportunities for the development of community based services in line with the strengths and competencies of the Trust.
- Review current service provision to streamline and improve integration across the pathways both within the hospital environment and across the community / other agency interface with particular emphasis on the better management of long term conditions.
- Develop and implement plans to locate as many services as possible in the community close to people’s homes.
- Review and modernise integrated care.
- Review the service portfolio for match with need and

<table>
<thead>
<tr>
<th>1.14 Research and Development Strategy</th>
<th>1.14 MD and CEO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 People Strategy</td>
<td>2.1 DoHR&amp;OD</td>
</tr>
<tr>
<td>2.2 Directorate Business Plans/Clinical Services Strategy</td>
<td>2.2 COO/DCE and MD</td>
</tr>
<tr>
<td>2.3 Service Line Management Plans</td>
<td>2.3 COO/DCE and MD</td>
</tr>
<tr>
<td>2.4 Transformation Plans</td>
<td>2.4 DoHR&amp;OD/</td>
</tr>
<tr>
<td>2.5 Well-led Framework</td>
<td>2.5 DoHR&amp;OD, TBS and COO/DCE</td>
</tr>
<tr>
<td>2.6 Strategy Sessions/Joint HR Forum</td>
<td>2.6 CEO and MD</td>
</tr>
</tbody>
</table>
demand and Trust expertise to identify opportunities for service improvement and service development.

- Improve services in the following areas: end of life care, stroke services, diabetes, gynaecology, maternity, cardiology, interventional radiology
- Evaluate all opportunities for improving and or expanding the Trust’s portfolio of services and prepare and submit tenders accordingly.
- Explore opportunities for collaborative working and joint ventures with other organisations to improve services in line with the Clinical Services Strategy of the Trust.
- Develop and implement new patient pathways and, where appropriate new services, based on the best practice and evidence based service models.
- Contribute to the planning and delivery of community based facilities.
- Secure contracts through the Annual Operating Plan with Clinical Commissioning Groups for the provision of services that match and meet the Trust’s portfolio of services.
- Deliver services that meet and seek to exceed the service specifications underpinning the contracts with commissioners.
- Meet legal, statutory, regulatory and policy requirements particularly in respect of emergency preparedness, safeguarding children and adults, governance and clinical governance.
- Deliver Financial Plan / Strategy to address financial targets particularly in relation to efficiency targets. Cost Reduction Programme and delivery of control total.
- Reduce fixed asset cost base in line with estate rationalisation plans and maximum utilisation of estate footprint for clinical.
- Develop a vibrant, engaged and involved governor and membership body to inform the Trust going forward and to act as ambassadors for our services.
- Develop and implement marketing and relationship management methods and techniques for tracking

3.9 Transformation Plan
3.10 Service Line Management Plans
3.11 I&TS/Digital Strategy
3.12 Financial Five Year Plan
3.13 Quality Strategy
- Quality
- Patient Safety
- Patient Relations
- Nursing
- Clinical Governance
- LEAN Implementation Plan
- Infection Control
- Privacy and Dignity
3.14 People and Organisational Development Strategy
- Organisational Change
- Reward and Recognition
- Operational Efficiency
- Development
3.15 Patient Environment Strategy inc:
- Estates
- Facilities
- Support Services
3.16 Integrated Risk Management & Governance Strategy
3.17 Trust Annual Plan
3.18 Governor and Member Strategy

3.9 DoHR&OD
3.10 COO/DCE
3.11 CITO
3.12 DoF
3.13 DoNPS&Q and MD
3.14 DoHR&OD
3.15 DoE
3.16 DoNPS&Q
3.17 COO/DCE and DoF
3.18 TBS
We embrace the health and wellbeing of the population we serve and ensure that the health needs of the people are reflected and catered for in the provision of services from the Trust.

- Protect and improve the health of the population.
- Deliver and contribute to public health services.
- Promote health throughout the full range of our clinical activity by using the multitude of patient contacts that take place every day as opportunities to promote healthier living.
- Increase health life expectancy, taking account of the “Quality of Health” in addition to length of life.
- Reduce differences in life expectancy and healthy life expectancy between communities.
- Engage proactively with GPs, and Clinical Commissioning Groups to understand their requirements of the Trust and its services and use this to market, develop and improve services and exceed requirements of commissioners and patients where possible.
- Contribute to the wider Tees economy and well-being through active engagement and participation in partnerships with stakeholders.

| 4.1 | Representation on Health and Well Being Boards |
| 4.2 | Participate in STP and No Smoking agenda |
| 4.3 | Organisational surveys |
| 4.4 | Joint Strategic Needs Assessments and Annual Plan |
| 4.5 | Health and Wellbeing Reports |
| 4.6 | Clinical Service Strategies |
| 4.7 | Directorate Business Plans |
| 4.7 | Research and Development Strategy |

| 4.1 CEO |
| 4.2 CEO |
| 4.3 DoNS&Q |
| 4.4 COO/DCE |
| 4.5 COO/DCE |
| 4.6 COO/DCE and MD |
| 4.7 COO/DCE and MD |
| 4.8 CEO and MD |

| Patient Satisfaction |
| Quality of Services |
| Health and Social Care Integration |
| Research and Development |

CEO - Chief Executive Officer  
DoNPS&Q - Director of Nursing, Patient Safety and Quality  
DoF - Director of Finance  
DoE - Director of Estates  
DoHR&OD - Director of Human Resources and Organisational Development  
COO/DCE - Chief Operating Officer / Deputy Chief Executive  
MD - Medical Director  
CITO - Chief Information and Technology Officer  
TBS - Trust Board Secretary
Appendix 3

**Directorate Strategies**

**Emergency Care**
- Provide Urgent Care Centre provision from both North Tees and Hartlepool hospital sites
- Minor Injuries, GP services, Emergency Care Practitioners at both hospital with A&E services delivered from North Tees

**In Hospital Care**
- High quality in-patient care – delivering sustainable 7 day services
- Effective relationships across medical and other health and social care teams, reducing delayed transfers of care and avoidable admissions
- Fully integrated care pathway in collaboration with Out of Hospital care, focusing on Frail Elderly and long term conditions

**Elective Care**
- Further develop collaborative elective services with neighbouring providers, building on the pathways currently delivered across Breast, Urology and Bariatric services
- Delivery of elective Outpatient, Diagnostic, Day Case, In-patient and Cancer services across Hartlepool and North Tees sites
- Further develop 7 day therapy support for surgical patients as part of routine management

**Women & Children**
- Remodel Gynaecological, Obstetrics and Neo-Natal services to support nursing staff expansion and fully meet British Association of Perinatal Medicine standards
- Remodel high and low risk Maternity services to include 24 hour assessment unit
- Work with Better Health Programme to review the delivery of women’s and children’s services across the local footprint

**Out of Hospital Care**
- Deliver fully integrated care between acute, community, primary and social care, providing 7 day services in the home
- Provide a single point of access to critical, responsive and interventional teams for community care
- Support the delivery of the Better Health Programme

**Anaesthetics Care**
- Support the delivery of perioperative services across both Hartlepool and North Tees sites, providing pre-assessment and anaesthetic services
- Deliver Critical Care, including outreach service through improved estates solutions
- Support the development of a ‘centre of excellence’ for pain management
Clinical Services Strategy

Clinical Sustainability

Patient Experience & Outcomes

Financial Sustainability

Operational Sustainability

Workforce

Care Closer To Home

Services delivered on a wider geographical basis across parts of County Durham, Darlington, East Durham and the Tees-Wide area

Out of Hospital Community Services

Single Point of Access

Better Health Programme

Sustainability & Transformation Plan

Primary Care
Adult Social Care
Urgent Care Network Vanguards

Appendix 4

Urgent Care Centre; A&E, Minor injuries and illnesses, GP services, Emergency Care Practitioners
Emergency Care; Medical, Surgical, Trauma
Complex Elective Surgery, Day Case Surgery, Elderly Care
Consultant & Midwifery Led Maternity, Paediatric Inpatient and Day Case care
Diagnostics: Radiology, Endoscopy, Cardiology, Pathology
Outpatient Services, Community Services

Urgent Care Centre inc: Minor injuries and illnesses, GP services, Emergency Care Practitioners, Elective Care Unit, Day Case Surgery, Midwifery Led birthing unit, Paediatric Day Unit, Diagnostics: Radiology, Endoscopy, Cardiology, Pathology, Elderly Care, Rehabilitation Unit and Day Unit, Outpatient Services, Community Services
## Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>AHP</td>
<td>Advanced Healthcare Practitioner</td>
</tr>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
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<tr>
<td>BHP</td>
<td>Better Health Programme</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>Cdiff</td>
<td>Clostridum Difficile</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<tr>
<td>CSS</td>
<td>Clinical Services Strategy</td>
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<tr>
<td>DTOC</td>
<td>Delayed Transfer of Care</td>
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<tr>
<td>E.coli</td>
<td>Escherichia coli</td>
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<tr>
<td>GNCR</td>
<td>Great North Care Record</td>
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<tr>
<td>HSMR</td>
<td>Hospital Standardised Mortality Rate</td>
</tr>
<tr>
<td>I&amp;TS</td>
<td>Information and Technology Services</td>
</tr>
<tr>
<td>LCRN</td>
<td>Local Clinical Research Network</td>
</tr>
<tr>
<td>LDR</td>
<td>Local Digital Roadmap</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin-Resistant Staphylococcus Aureus</td>
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<tr>
<td>MSK</td>
<td>Muscular Skeletal</td>
</tr>
<tr>
<td>MSSA</td>
<td>Methicillin-Sensitive Staphylococcus Aureus</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>Research and Development</td>
</tr>
<tr>
<td>SHMI</td>
<td>Summary Hospital Mortality-level Indicator</td>
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<tr>
<td>SOF</td>
<td>Single Oversight Framework</td>
</tr>
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<td>SPEQS</td>
<td>Staff, Patient Experience and Quality Standards</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
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<td>UHH</td>
<td>University Hospital of Hartlepool</td>
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<tr>
<td>UHNT</td>
<td>University Hospital of North Tees</td>
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Executive Summary

Capital Programme Performance 2017/18

Report of the Director of Finance and Director of Estates & Facilities Management

Strategic Aim
(The full set of Trust Aims can be found at the beginning of the Board Reports)

Manage our relationships

Strategic Objective
(The full set of Trust Objectives can be found at the beginning of the Board Reports)

Finance

1. Introduction

1.1 The 2017/18 capital programme allocation was agreed at £21.869m comprising £6.021m internally generated depreciation, £14.696m advanced loan for the Major Engineering Infrastructure Replacement Scheme, £1m PDC for the Integrated Urgent Care Centres and £150k donated funds. The NHS Improvement Compliance Framework requires that a minimum of 85% and a maximum of 115% of the original capital allocation should be spent on a monthly basis. Only goods and services that have been received or invoiced may be counted as expenditure. At the end of Q1, expenditure (invoices and accruals) was £1.538 m which equates to 35% of the total allocation for the year.

2. Key Issues & Planned Actions

2.1 The Major Engineering Infrastructure Replacement Scheme is progressing well and costs remain below budget allocation. The completion date is currently anticipated to be June 2018. The first phase of work involving the upgrade of the electrical infrastructure is complete with the electrical switchgear installed and energised within the new substations. The second phase of work concerns the construction of a new energy centre and full planning consent and building control approval have been received. Design work was completed last year and tender invitations were issued in October 2016 with tenders being returned in January 2017. Evaluations and clarifications took place in January and February and a recommendation was made to the Project Board in March 2017 to award the contract to NG Bailey Limited. Following expiry of the compulsory standstill period, and without any challenge against the award, NG Bailey Limited were advised of their appointment as principal contractor for the scheme, and the construction work will commence in July 2017 with anticipated completion in June 2018. The anticipated combined outturn cost for the electrical infrastructure project and the energy centre remains consistent at £21m.

2.2 In December 2016 the Trust acquired a 99 year lease agreement for the former Hardwick Health Centre site. The development of a 153 space car park progressed to plan with completion by the end of April 2017, increasing car parking capacity, generating income and supporting potential future clinical expansion.
2.3 The significant elements of the programme to comment upon are:

- Financial expenditure was aligned to the annual programme and capital cash flow projections/expenditure is in-line with the annual financial forecast.
- Schemes have been completed in a timely manner with good outcomes and positive feedback.

3 Recommendation

3.1 The Board is requested to receive this report and note the progress on capital schemes up to 30 June 2017.

Caroline Trevena
Director of Finance

Peter Mitchell
Director of Estates & Facilities Management
1. Introduction/Background

1.1 To provide an update as at 30 June 2017 (Quarter 1) on the progress of delivering the 2017/18 capital programme.

2. Main content of report

2.1 The four work-streams of Medical Equipment, ICT, Service Development and Estates Backlog Maintenance have performed as anticipated in Quarter 1. A narrative summary of each work-stream is shown in Appendix 1.

2.2 Significant work has been undertaken on the Major Engineering Infrastructure Replacement Project and the programme of work has progressed as planned.

2.3 Work was successfully completed on the development of Urgent Care Centres at both UHH and UHNT, post-scheme user evaluations received were very positive.

2.4 Work to create a new 153 space car park on the former Hardwick Health Centre site was completed in early April. The car park provides additional car parking spaces to meet the requirements of the new Urgent Care services and future clinical developments. The car park has been well used and has generated £35K in revenue in the Quarter 1.

2.5 During Quarter 1 significant work has been undertaken to plan and cost the various Estate options within the Sustainability and Transformation Plan (STP). The strategic outline business case with capital costs associated has now been submitted to NHS Improvement for their considerations.

3. Conclusion/Summary

3.1 The significant elements of the programme to comment upon are:

- Schemes have been completed in a timely manner with good outcomes and positive feedback.
- Financial expenditure has been achieved in-line with the annual programme.
- The Major Engineering Infrastructure Replacement scheme is progressing in line with the project plan. Phase 1 of the scheme is complete and Phase 2 is about to commence.

3.2 The capital programme has progressed on schedule and the expenditure and cash flow projections closely aligned with the Trust annual plan.

3.3 The overall financial summary for the period to 30 June 2017 is presented at Appendix 2.
4. Recommendation

4.1 The Board is requested to receive this report and note the progress on capital schemes and delivery of the NHS Improvement financial risk rating at the year end.

Caroline Trevena  Peter Mitchell
Director of Finance  Director of Estates & Facilities
Management
Appendix 1 - Work Stream Reports

1. Medical Equipment

1.1 For the first time the capital medical equipment replacement programme was agreed prior to the beginning of the financial year. Medical equipment being considered for replacement was initially identified within the clinical directorates’ annual business plans. An assessment was subsequently undertaken by the Clinical Engineering Manager, with approval of the programme based on clinical need and priorities by the Medical Director. The procurement of the equipment within budget allocation will be equally phased over the first three quarters of the financial year.

1.2 There have been 3 replacement Auricles purchased for community teams. These devices are used to test patients hearing and configure hearing aids to the patients’ needs.

1.3 A replacement video trolley has been purchased for the endoscopy unit. This replaces one of the old machines that is no longer supported. The new machine provides the Endoscopists with a much clearer image.

1.4 As part of a rolling program, the first 10 replacement Bladder Scanners have been bought to replace the current bladder scanners. The current machines are over 10 years old and are costly to maintain.

2. Information Communication & Technology

2.1 The Capital ICT allocation for 2017/18 was split into three main streams, one of which supports the wider EPR programme for mobile working and the second and third is to replace “legacy” systems approaching their “end of life”, to ensure continuity of normal business functions within ICT.

2.2 Further extension of the Trust’s wireless systems and replacement of the majority of the wired LAN is being invested in this year to provide increased network coverage to support the EPR programme mobile working project, and to support RFID projects. The number of active wireless network points at the North Tees site has increased from 145 to 418. A further 400 wireless network points will be installed this year, increasing the total at UHNT to 814. Also a further 150 wireless points will be installed at UHH to increase coverage in clinical areas.

2.3 The “legacy” PABX analogue telephony systems at both UHH and UHNT have been replaced in 2017. Further investment has been this year to take advantage of the new technical features of an IUPT system such as Jabber access outside of the Hospital wireless network and multi point video / audio conferencing facilities.

2.4 Implementation of the Trust’s new EPR system ‘TrakCare’

There have been some changes to priorities within the “roll out” for phase 2, primarily due to limited resource being available from the supplier for theatres and Order Comms, which resulted in the scheduled “go live” dates becoming unachievable. A re-plan was carried out and whilst Theatres is still the first priority in order to move from an unsupported legacy system, Ordercomms was moved to “go live” after EPMA is rolled out. In the interim period the ICE system will be linked contextually through TrakCare, thus making it more seamless for clinicians to access all information from the same place.
TrakCare integration with the Medical Interoperability Gateway (MIG), giving clinical colleagues in emergency care access to view patients’ primary care records (with explicit consent from patients at point of care) is now complete and is being used by senior clinicians. Feedback received has been really positive and the intention will be to share access with all healthcare professionals in the near future, once the relevant Information Sharing Gateways (ISG) have been amended to allow for this.

Development work has also commenced to make clinical letters produced within WinVoicePro accessible from TrakCare. This will be an automated upload into TrakCare but will rely on strict naming conventions being followed. The functional specification has been written and will be shared with both suppliers.

The milestone certificate attached to the Theatre development work has now been achieved and will trigger the relevant payment milestone in Q2. The teams are carrying out the 2nd iteration of testing with training due to start end of July. The “go live” date is now scheduled for w/c 4th September 2017.

A number of mobile devices are in place across different areas of the Trust which are trialling the devices before we progress with EPMA roll out. This will ensure the Trust purchases the right size/type of device for staff.

Electronic Prescribing and medicines administration is progressing well and on target. Clinical representation to support the various groups is very encouraging and will be a real driver to making this a successful deployment. TrakCare version 2017.2 has been received and testing of the software is underway. The priority for the “roll out” across all in-patient wards has now been agreed and a five day simulation event has been scheduled for the end of August. This will allow staff to gain a real understanding on how their day to day work will change by moving from paper to an electronic process. Risks have been identified and these are being mitigated and managed appropriately by the Project Board.

The Trust has been formally accepted into InterSystems Reference Programme. This will allow the Trust to demonstrate some of its key achievements to other prospective and existing customers which will attract a financial incentive for each visit made to the Trust.

3. Service Developments

3.1 The new Integrated Urgent Care centres on both the UHH and UHNT sites successfully opened on the 1st April. Feedback from users and commissioners of the facility has been very positive.

3.2 Work to create a new clinical trials research centre within the Middlefield Centre was completed in April. Although this facility was funded by Synelex Ltd. the Trust design and Development Department and Capital Planning team played a significant role in ensuring the refurbishment works were completed to a high standard and met all the Trust’s requirements. The first patients used the facility in June.

3.3 Significant work has been undertaken to plan and cost the various Estate options within the Sustainability and Transformation Plan (STP). The strategic outline case, including associated capital costs, has now been submitted to NHS Improvement for their considerations.

3.4 The work to create a new 153 space car park on the former Hardwick Health Centre site was completed in early April. The car park has been completed to a high standard and has created additional car parking spaces to meet the requirements of the new Urgent Care Service and future clinical developments. During Quarter 1 patronage
has steadily increased, permitted parking durations have been increased from 12 to 14 hours and income generated exceeds business case projections.

4 Estates Programme

4.1 Electrical HV Infrastructure replacement

The project reached practical completion on the 30th June with Local Authority Building Control approval achieved on 29th June, with formal certification to follow in due course.

The new and existing high voltage ring mains are now energised. The new low voltage (LV) substations are now energised and available to provide additional non-essential electrical capacity. This arrangement will remain in place until the later stages of the energy centre project, when the new stand-by generators will be available and the existing substations and generators will be de-commissioned. The site will then have all its electrical requirements backed up by the standby generators.

The final account for the Electrical Infrastructure project was agreed on 30th June 2017 at the original order value.

4.2 Energy Centre Replacement

The contract terms and conditions have now been fully reviewed and accepted by N.G. Bailey Ltd. and are with the Trust Procurement department ready for formal issue to NG Bailey Ltd. for signing and returning to the Trust for Trust signature.

The order value will be £14,406,363.91+VAT (£17,287,636.69 inc. VAT) which includes a £500,000 contingency sum which is typical for projects of this size and nature.

During June, NG Bailey Ltd. has commenced detailed planning and extensive survey work on site, whilst continuing to appoint and mobilise its supply chain.

It is anticipated that there will be, at peak, 80-100 operatives on site, working on the Energy Centre project. Management control of such a number of operatives and access to the construction site is controlled by bio-metric access controls.

This project has significant civil engineering elements with circa 150,000 tonnes of soil being levelled, excavated and moved to allow the project to be completed. Some of this soil will remain on site to be used for the later landscaping stages of the project.

Traffic management plans have been developed by the Principle Contractor to ensure that construction traffic causes minimal disruption to the Trust’s activities. To achieve this, no wagons will enter site between the busy 8.00am till 9.30am period and all wagons will have left site for the day by 4pm.

4.3 Other Infrastructure Replacement projects include:-

4.3.1 The design and detailed planning for the replacement of the UHNT fire alarm system has commenced and is progressing to plan. The design is anticipated to be completed to allow the procurement phase to commence in Quarter 2.

4.3.2 A lift survey report has been commissioned and undertaken to determine the condition of the lifts on the UHNT site. This report will make recommendations that will help form the scope of the UHNT lift replacement project. It is anticipated that the final solution will include the replacement of two Tower block lifts with bed fire evacuation lifts.
4.3.3 Work has begun to plan the replacement of the aging UHNT medical gas plant with a replacement nitrous oxide manifold emergency reserve manifold being ordered in June.

4.4 Audit Review

AuditOne have reviewed the infrastructure programme during Quarter 1, one minor observation was made which was to formally report any health and safety concerns raised and formally closed out. This action has been addressed.

4.5 Backlog maintenance

4.5.1 Work has been undertaken on improvements to fire compartmentation within the Podium area at UHNT.

4.5.2 The commencement of the ward decant programme has allowed access to replace all the light fittings within the wards 40, 41 and 42 with low energy LED light fittings, improving light output and reducing energy consumption. Additionally, further measures to improve the patient environment concerning ‘dementia-friendly’ decoration and signage have been carried out. Access control systems to the wards were also installed/replaced.
## Appendix 2

North Tees and Hartlepool NHS Foundation Trust

### Capital Programme 2017/2018 - as at 30 June 2017

<table>
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<tr>
<th>Category</th>
<th>Funding Allocation £’000</th>
<th>Invoices £’000</th>
<th>Accruals £’000</th>
<th>Orders Committed &amp; Raised £’000</th>
<th>Approved Business Cases / Allocations £’000</th>
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Original NHS I Plan £22.174m - 85% = £18.85m - 115% = £25.50m
Amended Plan £21.869m - 85% = £18.588m - 115% = £25.149m

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Subtotal: Per Board Report 21,869

Additional Charitable Funds (donations during year) 0

Total Allocation 21,869

Reporting against NHS I Metric 2017/18 achievement of 85%/115% of planned Capital Spend

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Cumulative Position 53% 37% 35% 35%

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</tr>
<tr>
<td>%</td>
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<td>0%</td>
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Cumulative Position 0% 0% 0% 0% 10%

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<tr>
<th></th>
<th>Mth 10 £'000</th>
<th>Mth 11 £'000</th>
<th>Mth 12 £'000</th>
<th>QTR 4 TOTAL</th>
<th>TOTAL</th>
</tr>
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<td>1.937</td>
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<td>21.869</td>
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<td>0.000</td>
<td>0.000</td>
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</tr>
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Executive Summary

Compliance and Performance Report

Report of the Chief Operating Officer/Deputy Chief Executive

Strategic Aim and Strategic Objective (the full set of Trust Aims and Objectives can be found at the beginning of the Board of Directors Reports)

Maintain Compliance and Performance

1. Introduction

1.1 The Compliance and Performance Report highlights performance against a range of indicators against the Single Oversight Framework and the Foundation Trust licence conditions for the month of June 2017/18.

1.2 The Corporate Dashboard and reporting framework reflects both the mandatory performance frameworks for 2017/18 and the additional internal reporting requirements, including the Lord Carter Model Hospital review and key objectives.

1.3 The Sustainability and Transformation Funding (STF) conditions for 2017/18 relate solely to achievement of the control total however in June 2017 the Trust was informed of arrangements for allocating 30% STF to performance related to delivery of the 4 hour standard (15%) and Primary Care Streaming (15%). Performance against STF can be found in ‘Index 7’ (See section 3.1 for more details).

2. Key Issues and Planned Action

2.1 In June and Q1 the overall performance against key operational standards and trajectories remains persistently challenging.

2.2 Emergency Activity (including GPs) across the organisation has seen a slight decrease of 1.09% (n=117) in Q1 compared to the same time last year.

2.3 The overall emergency activity in Q1 included 2509 patients who were treated via Ambulatory Care, equating to 23.19% of the total emergency admissions.

2.4 Performance against the emergency care standard achieved in June and Q1 reporting at 98.93% and 98.24% respectively against the national requirement of 95%, a significant improvement compared to previous months.

2.5 The Trust achieved against the RTT Incomplete standard for June reporting at 94.12% and for the quarter reporting at 94.24%.

2.6 The Trust continues to experience significant pressures within the delivery of the cancer standards across all tumour groups. A tentative position indicates the Trust
underachieved against the two week rule (see main report section 3.4.3) and the 62 day consultant upgrade (see main report section 3.4.4) standards for June and Q1.

2.7 There were 4 cases of Clostridium Difficile reported in June which exceeds the trajectory for the month and Quarter 1 with a cumulative position of 13, equal to the annual trajectory.

3. Key Challenges

3.1 Continuous and sustainable achievement of key access standards across elective, emergency and cancer pathways, alongside patient choice, complex pathway management and other variables outside of the control of the Trust within the context of system pressures and financial constraints.

3.2 Delivery against the Lord Carter operational efficiency recommendations and validity of benchmark.

4. Conclusion

4.1 The Trust has performed relatively well against the majority of key operational standards during June and Q1, despite the considerable challenges associated with on-going operational, clinical, financial and system wide pressures. The Trust continues to develop the performance reporting framework to ensure it meets the needs of both corporate and directorate level delivery, reflecting the multiple internal and external performance requirements.

4.2 Whilst the Trust has robust governance processes in place for the monitoring and management of all performance standards there is recognition that current pressures across the whole health economy may ultimately impact on consistent and sustainable delivery, therefore presents an on-going risk.

4.3 This risk is outlined within the Trust’s Risk Register and Board Assurance Framework, with supporting mitigation and recovery plans, alongside internal and external governance assurance processes.

5. Recommendations

5.1 The Board of Directors is asked to note:

- The detail in the Corporate Dashboard and performance against the Single Oversight Framework requirements and the key national indicators for June and Q1 2017/18.
- The amended approach to STP Trajectories set for 2017/18.
- The on-going operational performance and system risks to regulatory key performance indicators and the intense mitigation work that is being taken forward to address these going forward into 2017/18.
- The due diligence in assessing on-going compliance and that of new requirements, specifically that illustrated in regular seminars and committee discussion.

Julie Gillon
Chief Operating Officer/Deputy Chief Executive
July 2017
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Compliance and Performance Report

Report of the Chief Operating Officer/Deputy Chief Executive

1. Introduction

1.1 The Compliance and Performance Report highlights performance against a range of indicators against the Single Oversight Framework and the Foundation Trust terms of licence for the month of June and Quarter 1 (Q1) 2017/18.

1.2 The Corporate Dashboard and reporting framework reflects both the mandatory performance frameworks for 2017/18 and the additional internal reporting requirements, including the Lord Carter Model Hospital review and key objectives.

1.3 Appendix 1 illustrates the trend and variance analysis against targets/trajectory profiles; with due consideration given to both positive and negative variances and progress against monthly, annual and in year improvement targets.

1.4 Appendix 2 illustrates a high level view of the Corporate Dashboard and progress against key performance indicators.

1.5 Appendix 3 illustrates the Single Oversight Framework (SOF) and the triggers of governance concern.

1.6 This report must be read in conjunction with the additional information as detailed in the Safety, Quality and Infection Prevention Performance Report, the Human Resources (HR) Report and the Finance and Contract Report. This report will concentrate on the operational performance only.

1.7 The Sustainability and Transformation Funding (STF) conditions for 2017/18 relate solely to achievement of the control total however in June 2017 the Trust was informed of arrangements for allocating 30% STF to performance related to delivery of the 4 hour standard (15%) and Primary Care Streaming (15%). Performance against STF can be found in ‘Index 7’ (See section 3.1 for more details).

2. Performance Context

2.1 In June and Q1 the overall performance against key operational standards and trajectories remain challenging.

2.2 Emergency Activity (including GPs) across the organisation has seen a slight decrease of 1.09% (n=117) in Q1 compared to the same time last year.

2.3 The overall emergency activity in Q1 included 2509 patients who were treated via Ambulatory Care, equating to 23.19% of the total emergency admissions.

2.4 A&E attendances (Type 1 only) saw an overall decrease of 34.82% (n=6240) in comparison with the same period last year though mindful of a change to the emergency care pathway with the opening of the Integrated Urgent Care Services. Admissions via A&E (Type 1) reported a slight decrease of 1.55% (n=70).
2.5 Integrated Urgent Care Services activity in June reported 4779 attendances including 238 admissions at North Tees with the Hartlepool site reporting 3886 attendance and 181 admissions (aggregate 8665 attendances; 419 admissions) (Un-validated to time of reporting).

2.6 Performance against the emergency care standard achieved in June and Q1 reporting at 98.93% and 98.24% respectively (un-validated to time of reporting) against the national requirement of 95%, a significant improvement compared to previous months. The Trust remains above the national average, reporting in 5th position nationally for May (based on latest available data). Full details are described in section 4.3.

2.7 The Trust is committed to sustainable achievement and continuous improvement against all access targets. Appropriate mitigation plans are in place where appropriate to manage the position in line with set targets and to provide assurance with regard to remedial action and on-going improvement.

3. Compliance Indicators

3.1 Sustainability and Transformation Plans (STPs) – Improvement Trajectories 2017/18

3.1.1 As part of the STP conditions 2017/18 trajectories were agreed against key access standards with the main KPI attached to the 4 hour emergency care standard and initially no monetary incentives were applied, with funding conditions related solely to achievement of the financial control total.

3.1.2 Given the national importance of improving urgent and emergency care performance, 30% performance incentive will now focus on A&E rather than requiring providers to deliver on multiple objectives. The method of apportioning the 30% will be:

- 15% - based on A&E 4 hour performance (To access the 15% performance based element of the fund, Trusts will need to achieve performance of 90% in quarter 1, that is, either above 90% or above their performance in Q4 (whichever is higher).
- 15% - based on front door streaming to GPs (To access the element based on streaming, Trusts will need to report on the service offer, volume of patients streamed and the number of minors breaches, links to GP services in their area and provide plans to further develop their service where required).

3.2 Referral to Treatment (RTT) Pathways

3.2.1 The Trust has seen an improvement against the 92% RTT standard reporting at 94.12% for the month of June and 94.24% for Q1.

3.2.2 National RTT data, May position (latest published data) indicated the Trust performed above the national average which reported at 90.4%. See Appendix 1, ‘Index 5 - Benchmarking’.

3.2.3 Median and 92nd percentile waits have remained relatively consistent and within target, reporting lower than the national average, demonstrating that more patients are generally waiting less than 18 weeks.

3.2.4 A zero tolerance approach to any incomplete RTT non-adjusted pathways over 52 weeks remains a national measure with contract penalties attached to under achievement, alongside the 92% standard. The Trust reported no over 52 week waits.
3.2.5 NHSI recently reviewed all providers’ *Referral to Treatment (RTT) waiting list policies* to ensure standardisation and interpretation of national guidance. The Trust received positive feedback with slight amendments required. That said the Trust has sought further clarity over the recommendations.

3.3 Emergency Care Standards

3.3.1 The Trust achieved the ‘4 hour arrival to discharge or admission’ standard in June reporting at 98.93% against the 95% standard and 98.24% for Q1 (Un-validated to time of reporting).

3.3.2 Graph 1 demonstrates the Trust’s performance has remained above the national average for April and May.

**Graph 1 – Trust Comparison to National and Regional Position**


3.3.4 Whilst Q1 saw a decrease in attendances in A&E (Type 1 only) compared to the same period last year, the conversion rate in relation to admissions remained consistent, demonstrating continued pressures within the service. These pressures continue both Nationally and Regionally.

3.3.5 Appendix 1 ‘Index 5’ indicates that the England average has remained below the 95% standard with the May position (latest available data) reporting at 89.7%. The North East position also reported below at 94.1%, with only 3 out of 9 Regional Trusts achieving in May 2017.

3.3.6 Integrated Urgent Care Services activity in June reported 4779 attendances including 238 admissions at North Tees with the Hartlepool site reporting 3886 attendance and 181 admissions (aggregate 8665 attendances; 419 admissions) (Un-validated to time of reporting).

3.3.7 The Trust achieved 97.53% compliance against the 2 hour Integrated Urgent Care standard “once clinically streamed, patients to be treated within 2 hours”, which is an excellent achievement within the first quarter of this new service going live. Split by site, Hartlepool achieved 99.04% and North Tees achieved 96.32% (Un-validated to time of reporting).

3.3.8 Q1 of 2017/18 continues to see bed pressures, with occupancy reporting at an average 89.82% for the quarter 1 period, remaining above the recommended 85%. Graph 2 indicates how occupancy throughout the past two years has remained above the national standard of 85%, reflective of the pressures within the system. This is despite the Trust’s resilience plan being fully implemented with an appropriate utilisation of existing resources to support surge pressure, minimising financial impact. A bed re-profiling exercise is underway to support resilience, patient flow and reduction in occupancy.
3.3.9 Delayed Transfers of Care (DTOC) ranged between 1.95% and 6.64% during 2016/17, with June position reporting at 3.56%, averaging 19 per day. Delayed Transfers of Care have continued to impact on bed occupancy; Graph 3 highlights the percentage of delayed transfers of care (per 10,000 bed days).

3.3.10 The Trust has extended its focus to the ‘stranded patients’ (LOS>7 days) to improve discharge processes and medical optimisation for all extended lengths of stay. A clinically led audit is underway to support a preferred clinical model going forward.

3.3.11 Despite significant pressures on the emergency care services, the Trust managed to keep ambulance handovers greater than 30 and 60 minutes to a minimum. In June the Trust reported 1 ambulance handover greater than 30 minutes and none greater than 60 minutes. In comparison, the North East average handovers greater than 30 minutes reported at an average of 38 (range 1-148), with the average over 60 minutes reporting at 3 (range 0-20). The Trust’s overall performance in June indicated 99.59% of ambulance handovers (with a valid arrival time) were completed within 15 minutes.

3.3.12 The Trust reported 44.7% ambulance turnaround times (valid) within 30 minutes during June, in comparison the North East’s position at 35.8% with performance ranging between 28.4% and 44.7%.

3.3.13 The Trust saw the successful opening of the Integrated Urgent Care Centre on 1 April 2017 implementing close monitoring of outcomes, activity, pathway management and compliance. Early analysis indicates successful management of patient flow with compliance against key indicators and positive feedback from commissioners.

3.3.14 The Trust also participated in the ‘Action on A&E’ launch in March and June with key actions continuing to be embedded in 2017/18. The Trust is committed to sharing and
adopting good practice to support the whole system approach to addressing key challenges faced in emergency care.

3.4 Cancer Standards (Q1 un-validated position)

3.4.1 The Trust continues to experience significant pressures within the delivery of the cancer standards across all tumour groups. A tentative position indicates the Trust underachieved against the two week rule (see section 3.4.3) and the 62 day consultant upgrade (see section 3.4.4) for June and Q1.

3.4.2 The number of two week rule referrals remained fairly consistent in May and June, however Breast Symptomatic saw a significant increase in referrals in June (n=318) compared to May (n=257) an increase of 23.7% (n=61), however all referrals were accommodated within two weeks, with the exception of patient choice. Pressures remain within Colorectal and Upper GI with patient choice being the main factor.

3.4.3 The two week rule standard reported at 92.63% against a 93% standard for the month of June and 91.83% for Q1 (tentative). The significant increase in referrals seen in March, ultimately impacted on April's position, and was a key factor in the underachievement of the standard for Q1. Table 1 demonstrates the two week rule performance from June 2016 to June 2017, with patient choice being the main reason for breaches, all impacting on sustainable delivery of the cancer standard.

Table 1 – Two Week Rule Performance

<table>
<thead>
<tr>
<th>Month</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
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<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>90.80%</td>
<td>92.90%</td>
<td>93.70%</td>
<td>93.00%</td>
<td>94.70%</td>
<td>95.40%</td>
<td>95.50%</td>
<td>95.20%</td>
<td>94.20%</td>
<td>89.60%</td>
<td>93.08%</td>
<td>92.63%</td>
<td></td>
</tr>
<tr>
<td>Total Breaches</td>
<td>80  67  60  66  51  49  46  43  40  43  61  68  71  66</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Choice</td>
<td>64%</td>
<td>100%</td>
<td>93.90%</td>
<td>94%</td>
<td>94.20%</td>
<td>80%</td>
<td>80%</td>
<td>88.40%</td>
<td>95.50%</td>
<td>95.00%</td>
<td>62%</td>
<td>100.00%</td>
<td>95.45%</td>
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<tr>
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<td>0%</td>
<td>6.10%</td>
<td>6%</td>
<td>5.80%</td>
<td>0%</td>
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<td>11.60%</td>
<td>4.50%</td>
<td>5.00%</td>
<td>38%</td>
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3.4.4 The 62 day consultant upgrade standard reported at 80.00% (provisional) for June and 75.00% for Q1. Breach reasons were due to complex pathways and tertiary capacity, acknowledging numbers were low (4 patients with 1 accountable breach).

3.4.5 Table 2 demonstrates performance against the 62 day referral to treatment cancer standard for Q1 2017-18.

Table 2 – Trend Performance against Cancer Standards

<table>
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<tr>
<th>Standard</th>
<th>Target</th>
<th>April 17</th>
<th>May 17</th>
<th>Jun 17 Un-validated</th>
<th>Q1 Un-validated</th>
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<tr>
<td>62 day referral to treatment</td>
<td>85%</td>
<td>84.69%</td>
<td>81.60%</td>
<td>(49/7.5 breaches)</td>
<td>(62.5/11.5 breaches)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(64/7 breaches)</td>
<td>(64/7 breaches)</td>
<td>(175.5/26 breaches)</td>
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</table>

3.4.7 The latest published data (May position) indicates the national average for the 62 day urgent referral to treatment standard reporting at 80.8%. The North of England Cancer Network (NECN) reported 84.64% against the target of 85%, with three out of the nine regional organisations under achieving the standard. Comparative data against national and local data can be found in Appendix 1, Index 5.

3.4.8 The Trust has implemented a number of actions to support the improvement of the 62 day cancer standard in alignment with the NHS England 62 Day Cancer Standard – Operating Model and Recovery Plan as follows:

- Executive led recovery group with a key focus on pathway management, leadership and governance processes.
- A revisit and review of action plans are currently in place across all tumour sites, with monthly monitoring of progress reported via the Cancer Strategy Group.
- Review of key themes across all breaches.
• Close monitoring of the ‘Breach Reallocation’ policy and the risk to the organisation's performance.
• A focus on working with commissioners with regard to patient choice; patient surveys revisited.
• Ensuring the 10 High Impact Actions are being followed.
• A capacity and demand exercise is also underway to assist in capacity management.

3.4.9 The Trust has managed a cancer standard recovery plan to support improvement in compliance, with a focus on key areas of service delivery across all tumour specific groups. Despite intense pathway management the projected consistent achievement remains a residual risk as there are many variables affecting these standards, some out with of the Trusts control.

3.5 Diagnostic Waiting Times

3.5.1 Diagnostic pathways continue to be monitored closely to ensure maximum contribution to RTT pathway management and to reduce waiting times. The Trust under achieved against the 99% national standard in June reporting at 98.76% however achieved the quarter reporting at 99.49%.

3.6 Health Care Associated Infections

3.6.1 Clostridium Difficile (CDI)

3.6.2 There were 4 cases of Clostridium Difficile reported in June which exceeds the trajectory for the month and Quarter 1 with a cumulative position of 13. Work is underway to identify reasons for the increase including genetic typing and environmental screening. A programme of support from NHS Improvement is under discussion, with recommendations awaited and an external independent visit has taken place to include review of the current actions to mitigate risk, appropriateness of the antibiotic stewardship activities and compliance with national guidance around sampling, testing and management of cases. All completed root cause analysis will be considered for appeal under the new system implemented by commissioners from April 2017.

3.6.3 NHSI has announced that the Trajectory set for 2017/18 will remain at 13, with the same objectives/penalties applied as 2016/17. The emphasis will continue on governance and a system approach to CDI management linked to lapses in quality of care. The focus will be on the rate of CDI improving year on year.

3.6.4 The Trust reported zero cases of MRSA in Q1. This standard is no longer included in the Single Oversight Framework. However there is an expectation of zero tolerance towards MRSA cases.

4. Lord Carter – Productivity and Efficiency

4.1 The following section provides a summary of the Trust’s compliance against a number of key operational indicators, supported by the Health Evaluation Data (HED) benchmarking data available in Appendix 1. The report indicates the Trust is performing above or within expected for the majority of indicators and also demonstrates improvement in indicators where performance has previously been below the national average.

4.2 The Lord Carter recommendations require Trust Boards to review internal operational efficiency dashboards for 3 clinical or medical specialties each month, to benchmark and track progress. This is an extension of the Directorate focused reviews contained
within previous Board of Director reports, and as such is now presented to the Planning, Performance and Compliance Committee.

5. **Outpatient Attendance Indicators**

5.1 The aggregate New to Review ratios reported at 1.17 in May (latest available position), showing a positive performance against the current target of 1.45 and a relatively consistent downward trend. Work has commenced within the organisation to further reduce this ratio to increase capacity for new appointments and is part of the wider transformation project.

5.2 The Trust’s performance against New Outpatient DNA rates reported above the agreed target of 5.40%, at 9.16% with Review DNA rates reporting at 10.72% against the 9% target. Work continues to further reduce DNAs and the impact of Trakcare communications supported by the automated reminder service and partial booking system and as part of the ‘Transforming Outpatients’ group.

6. **Choose and Book Appointment Slot Issues (ASIs)**

6.1 The National reporting system for Choose and Book migrated to e-booking in May 2015. Latest available data for May 2017 indicates the Trust reported within the 4% target, at 2.70%.

6.2 **Cancelled Operations**

6.2.1 In June non-medical cancelled operations reported at 0.29% (n=10) within the target of 0.80%. All patients were reappointed within 28 days.

6.2.2 June and Q1 reported no ‘urgent’ procedures had been cancelled for a second time.

7. **Readmissions**

7.1 The Trust recognises emergency readmissions as an area requiring further work, in line with national drivers to reduce avoidable admissions. The Trust is currently reporting emergency readmission rates at 11.46% post emergency admission, with the internal target set at 9.73%, and 4.83% post elective admission, set against a zero tolerance (April 2017 position, latest available data). The aggregate emergency readmission rate reports at 8.94% against the internal stretch target of 7.70% (based on peer average and year on year improvement) though this is under review with a view to reset stretch targets.

7.2 Further work is being pursued to address the focus of the Better Care Fund and Social Care allocations which has resulted in a pilot (for 12 months) with the appointment of a community matron. This has been well received and already having a positive impact on readmissions.

7.3 In general, the Trust has demonstrated a relatively positive position against its overall operational efficiency performance indicators, which is attributed to the constant effort by service lines and clinical teams to improve quality, efficiency and patient safety and experience. However there are further opportunities to improve efficiency and productivity across the organisation and these continue to be explored through the Lord Carter programme of work to encompass the 15 key recommendations.

7.4 Internal stretch targets remain under review and will be added to Corporate Dashboard in Q2.

8. **Out of Hospital**
8.1 The Corporate Dashboard includes a number of Transforming Community Services Indicators, to provide an overview of the progress being made in delivering improvements across community care with further developments expected in 2017/18.

8.2 Community Information Dataset (CIDS)

8.2.1 Performance indicators for Community Services, with data completeness used as a measure for the three elements of Referral to Treatment (RTT), referral information and treatment activity information, with a target of 50% completeness remaining for 2016/17.

8.2.2 May position (latest available data) indicates the Trust has achieved all three CIDs targets for the period, reporting 96.42% against RTT data, 95.73% for Referral data and 94.74% against the activity data. A target of 50% is set for all three indicators.

8.2.3 The Trust continues to shadow monitor End of Life Pathway and Patient Identifiable Information with achievement against both indicators. The Trust has successfully achieved money to fund work on the Amber Care bundle from the Academic Health Science Network.

9. Contract Key Performance Indicators

9.1 The Trust agreed a significant number of key performance measures for 2017/18 within the NHS standard and local contract negotiations. In line with the NHS England Commissioning Board structure, these are reported to multiple commissioning bodies including:

- Clinical Commissioning Groups
- Area Team
- Local Authority
- Specialist Commissioning
- Public Health

9.2 The KPIs cover quality requirements across both acute and community services, with financial penalties attached against non-compliance. The Trust reports performance to the commissioners on a monthly basis.

9.3 The Trust performed relatively well across the majority of the contract KPIs during the month of June and Q1. The main areas of pressure are reflective of the Trust’s overall position on key STP targets including, cancer waits and specialty level RTT performance.

9.4 The CCGs have requested a particular focus on the under-achievement against the Electronic Discharge Summaries within 24 hours standard, reporting at 83.53% against the 95% target. Whilst this has not been achieved, a month on month improvement is now evident and an action plan has been initiated, together with a focus group led by the Deputy Medical Director, to address on-going issues associated with delivery of this standard.

9.5 The performance against the contract KPIs for all commissioners are available via a link within the Corporate Dashboard.

10. NHS Improvement (NHSI)

10.1 Single Oversight Framework (SOF)

10.1.1 Under the Single Oversight Framework, providers are given a segmentation score based on the level of support each provider needs across five themes of ‘finance and
use of resources’, ‘operational performance’, ‘leadership and improvement capability’, ‘strategic change’ and ‘quality’. The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of ‘Good’ or ‘Outstanding’. The Framework does not give a performance assessment in its own right (See Appendix 3 for full details).

10.1.2 Whilst reporting mechanisms have not been confirmed by NHSI, the expectation is that all Trusts will continue to be rated in this vein. The Trust remains in Segment 2.

11. Conclusion/Summary

11.1 The Trust has performed relatively well against the majority of key operational standards during June and Q1, despite the considerable challenges associated with on-going operational, clinical, financial and system wide pressures. The Trust continues to develop the performance reporting framework to ensure it meets the needs of both corporate and directorate level delivery, reflecting the multiple internal and external performance requirements.

11.2 Whilst the Trust has robust governance processes in place for the monitoring and management of all performance standards there is recognition that current pressures across the whole health economy may ultimately impact on consistent delivery, therefore presents an on-going risk.

11.3 This risk is outlined within the Trust’s Risk Register and Board Assurance Framework, with supporting mitigation and recovery plans, alongside internal and external governance assurance processes.

12. Recommendations

12.1 The Board of Directors is asked to note:

- The detail in the Corporate Dashboard and performance against the Single Oversight Framework requirements and the key national indicators for June and Q1 2017/18.
- The amended approach to STP Trajectories set for 2017/18.
- The on-going operational performance and system risks to regulatory key performance indicators and the intense mitigation work that is being taken forward to address these going forward into 2017/18.
- The due diligence in assessing on-going compliance and that of new requirements, specifically that illustrated in regular seminars and committee discussion.

Julie Gillon
Chief Operating Officer/Deputy Chief Executive
July 2017
<table>
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<tr>
<th>ID</th>
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<th>QTR 2</th>
<th>QTR 3</th>
<th>QTR 4</th>
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<td></td>
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<td>Jul 17</td>
<td>Aug 17</td>
<td>Sep 17</td>
</tr>
<tr>
<td></td>
<td>Oct 17</td>
<td>Nov 17</td>
<td>Dec 17</td>
<td>Jan 18</td>
</tr>
<tr>
<td>RTT incomplete pathways wait (92%)</td>
<td>Target</td>
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</tr>
<tr>
<td></td>
<td>Actual</td>
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<td>-1.9</td>
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<td>2.89%</td>
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<td>A&amp;E Time to departure (95th percentile)</td>
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<td>New Cancer 62 days (consultant upgrade)*</td>
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<td>New Cancer 62 days (screening)*</td>
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<td>Variance</td>
<td>-6.25%</td>
<td>1.55%</td>
<td>3.54%</td>
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## Appendix 1 - Single Oversight Framework (Index 2)

| ID | MERSA - Bacteraemia (Cumulative)*** | Clostridium Difficile Patients - diagnosed after 72 hours all ages (Cumulative)*** | Methicillin Sensitive Staphylococcus Aureus (MSSA) (Cumulative)*** | E-Coli (cumulative)*** | Stroke admissions 90% of time spent on dedicated Stroke unit* | High risk TIAs assessed and treated within 24 hours * | Readmission rate 30 days (Emergency admission) | Readmission rate 30 days (Elective admission) | Readmission rate 30 days (Total) | Emergency c-section rates | TAL's - (No SLOT analysis) (March position) | Eliminating Mixed Sex Accommodation | Friends & Family - (Ward) | Friends & Family - (A&E) | Friends & Family - (Birth) | Readmission within 28 days of non medical cancelled operation * | Number of patients waiting less than 6 weeks for diagnostic procedures | Delayed Transfers of Care | Sickness absence % * |
|----|----------------------------------|-------------------------------------------------|-------------------------------------------------|----------------------|----------------------------------|-------------------------------------------------|----------------------------------|----------------------------------|-----------------------------------|----------------------------------|-------------------------------------------------|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|----------------------------------|----------------------------------|----------------------------------|
|    | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       | Target                           | Actual                                          | Variance                                       |
| 1  | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0       | Apr 17  | 0     | 0 |
| 2  | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0       | May 17  | 0     | 0 |
| 3  | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0       | Jun 17  | 0     | 0 |
| 6  | Sep 17  | 8     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10      | Sep 17  | 10     | 10 |
| 8  | Nov 17  | 8     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10      | Nov 17  | 10     | 10 |
| 9  | Dec 17  | 2     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3       | Dec 17  | 3     | 3 |
| 10 | Jan 18  | 4     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5       | Jan 18  | 5     | 5 |
| 13 | QTR 1   | 2     | 3       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4       | QTR 1   | 4     | 4 |
| 15 | QTR 3   | 4     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6       | QTR 3   | 6     | 6 |
| 16 | QTR 4   | 8     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10      | QTR 4   | 10     | 10 |

**Target Data**: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Actual Data**: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Variance Data**: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

***Figures may change after validation process***
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<th>QTR 3</th>
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<td>100.21%</td>
<td>99.87%</td>
<td>99.72%</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td>5.21%</td>
<td>4.87%</td>
<td>4.72%</td>
</tr>
<tr>
<td>07</td>
<td>TCS 19 - % of Community Patients that have had an unplanned admission LOS &lt;=2 days (Defined set of conditions)</td>
<td>Target</td>
<td>17.00%</td>
<td>17.00%</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>26.11%</td>
<td>18.08%</td>
<td>22.90%</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td>9.11%</td>
<td>1.08%</td>
<td>5.90%</td>
</tr>
<tr>
<td>02</td>
<td>TCS 24 - % of Patients achieving improvement using a EQ5 validated assessment tool</td>
<td>Target</td>
<td>93.50%</td>
<td>93.50%</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>08</td>
<td>TCS 35 - % of standard wheelchair referrals completed within five days</td>
<td>Target</td>
<td>50.00%</td>
<td>50.00%</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>10</td>
<td>The % patients treated within 18 weeks of referral to audiology (Hpool site)</td>
<td>Target</td>
<td>95.00%</td>
<td>95.00%</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Variance</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>11</td>
<td>Audiology non admitted wait (92nd percentile)</td>
<td>Target</td>
<td>18.30</td>
<td>18.30</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>4.00</td>
<td>4.00</td>
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<tr>
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<td>Variance</td>
<td>-14.30</td>
<td>-14.30</td>
<td>-14.30</td>
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</table>

* Data collection, validation and reporting processes prevent these standards from achieving a more timely result

** Percentage greater than 100% possible, when total number of appointments offered exceeds the number of patients
### Appendix 1 - Benchmarking (Index 5)

<table>
<thead>
<tr>
<th>May-17</th>
<th>National</th>
<th>North East</th>
<th>North Tees &amp; Hartlepool</th>
<th>South Tyneside</th>
<th>Sunderland</th>
<th>N Cumbria</th>
<th>Gateshead</th>
<th>Newcastle</th>
<th>Northumbria</th>
<th>S Tees</th>
<th>Durham &amp; Darlington</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT</td>
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<td></td>
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<tr>
<td>Incomplete Pathways waiting &lt;18 weeks</td>
<td>93.4%</td>
<td>94.4%</td>
<td>95.5%</td>
<td>94.3%</td>
<td>92.0%</td>
<td>94.8%</td>
<td>93.8%</td>
<td>93.0%</td>
<td>93.1%</td>
<td>92.8%</td>
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<tr>
<td>Half of patients wait less than 7 weeks</td>
<td>8%</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>10 weeks</td>
<td>11 weeks</td>
<td>12 weeks</td>
<td>6 weeks</td>
<td>7 weeks</td>
<td>8 weeks</td>
<td>5 weeks</td>
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</tr>
<tr>
<td>Half of admitted patients wait less than 5 weeks</td>
<td>33 weeks</td>
<td>27 weeks</td>
<td>26 weeks</td>
<td>28 weeks</td>
<td>26 weeks</td>
<td>27 weeks</td>
<td>33 weeks</td>
<td>27 weeks</td>
<td>33 weeks</td>
<td>31 weeks</td>
<td></td>
</tr>
<tr>
<td>Half of Non admitted Pathways waited less than 3 weeks</td>
<td>6 weeks</td>
<td>3 weeks</td>
<td>5 weeks</td>
<td>5 weeks</td>
<td>4 weeks</td>
<td>6 weeks</td>
<td>5 weeks</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 out of 20 patients wait less than 23 weeks</td>
<td>14 weeks</td>
<td>15 weeks</td>
<td>17 weeks</td>
<td>21 weeks</td>
<td>20 weeks</td>
<td>18 weeks</td>
<td>18 weeks</td>
<td>19 weeks</td>
<td>16 weeks</td>
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<td></td>
</tr>
</tbody>
</table>

**A&E**

**A&E 4 hour target**

| Cancer | 89.7% | 94.1% | 98.1% | 96.6% | 93.8% | 95.4% | 93.8% | 96.5% | 93.1% | 92.6% | 94.9% | 90.8% |

**Cancer 62 Day Standard**

| Breast | 93.2% | 97.27 | 100 (11/11) | 0 (0/0) | 76 (1,5/2) | 100 (6/8) | 94.23 (24.5/26) | 95.24 (10/10.5) | 100 (20/20) | 100 (10.5/10.5) | 97.92 (23.5/24) |
| Lung   | 72.2% | 84.29 | 71.43 (7.5/10.5) | 100 (2/2) | 40 (3/7.5) | 38.44 (7.5/6.5) | 71.43 (5/7) | 70.27 (13/18.5) | 56 (2/4) | 62.86 (11/17.6) | 78.19 (8/10.5) |
| Gynae  | 76.1% | 85 | 66.67 (11.5) | 0 (0/0) | 100 (1.5/1.5) | 60 (1.5/2.5) | 84 (10.5/12.5) | 100 (4.5/4.5) | 73.33 (5.5/7.5) | 94.12 (16/17) | 80.77 (10/5.13) |
| Upper GI | 72.6% | 84.31 | 84.62 (5.5/6.5) | 100 (2/2) | 57.14 (2.5/3.3) | 71.43 (2.5/3.5) | 100 (3/3) | 92 (11.5/12.5) | 100 (3/3) | 80 (8/10) | 78.57 (5/5.7) |
| Lower GI | 68.4% | 83.72 | 76.47 (6.5/8.5) | 100 (8/6.5) | 73.33 (5.5/7.5) | 100 (4/4) | 100 (5/5) | 83.33 (10/12) | 61.54 (8/13) | 82.86 (14.5/17.5) | 100 (12/12) |
| Uro (exc testes) | 75.2% | 79.43 | 88.24 (15/17) | 0 (0/0) | 64.44 (29/45) | 93.62 (22.5/23) | 90.91 (10/11) | 71.11 (16/22.5) | 75 (12/16) | 86.89 (26.5/30.5) | 94.44 (8.5/9) |
| Haem (exc AL) | 78.8% | 88.73 | 33.33 (1/3) | 100 (3.5/3.5) | 100 (8/8) | 100 (1/1) | 100 (2/2) | 100 (6/6) | 100 (4/4) | 71.43 (2.5/3.5) | 77.78 (3.5/4.5) |
| Head & Neck | 65.4% | 64.71 | 0 (0/0) | 0 (0/0) | 92.31 (6.5/7) | 66.67 (2/3) | 0 (0/0) | 60 (6/10) | 0 (0/0) | 66.67 (6/9) | 36.36 (25.5) |
| Skin | 96.1% | 98.62 | 75 (1/5) | 0 (0/0) | 100 (2.5/2.5) | 100 (9/9) | 0 (0/0) | 100 (6/64) | 100 (2/2) | 96.28 (25.5/29) | 97.26 (35.5/36.5) |
| Sarcoma | 65.3% | 71.43 | 75 (1/1) | 0 (0/0) | 50 (1/2) | 100 (1/1) | 0 (0/0) | 50 (2/3) | 0 (0/0) | 0 (0/0) | 0 (0/0) |
| Brain/CNS | #NA | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) |
| Other | 73.3% | 71.43 | 66.67 (11.5) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 0 (0/0) | 100 (1/1) | 100 (1/1) |
| All | 80.8% | 84.64 (672.5/794.5) | 81.6 (51/62.5) | 100 (14/14) | 69.77 (60/86) | 85.12 (51.5/60.5) | 90.23 (60/66.5) | 87.46 (143/163.5) | 81.56 (125.5/147.5) | 85.08 (125.5/147.5) | 89.43 (110/123) |

| Appendix 1 - Benchmarking (Index 5) | Menu |
# Appendix 1 - Benchmarking (Index 6)

<table>
<thead>
<tr>
<th>Segment Name</th>
<th>Indicator</th>
<th>Period</th>
<th>Trust</th>
<th>Peer</th>
<th>Score</th>
<th>Performance</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operational Efficiency</strong></td>
<td>Day case rate</td>
<td>March 2016 - February 2017</td>
<td>0.83</td>
<td>0.7</td>
<td>-0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Day case conversion rate</td>
<td>March 2016 - February 2017</td>
<td>0.04</td>
<td>0.04</td>
<td>-0.01</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Elective average length of stay</td>
<td>March 2016 - February 2017</td>
<td>1.81</td>
<td>3.26</td>
<td>-0.56</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Non-elective average length of stay</td>
<td>March 2016 - February 2017</td>
<td>3.93</td>
<td>4.4</td>
<td>-0.48</td>
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<tr>
<td></td>
<td>Zero day length of stay</td>
<td>March 2016 - February 2017</td>
<td>0.35</td>
<td>0.29</td>
<td>0.58</td>
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<td></td>
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<tr>
<td></td>
<td>Elective pre-operative length of stay over 3 days</td>
<td>March 2016 - February 2017</td>
<td>0.03</td>
<td>0.93</td>
<td>-0.54</td>
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<tr>
<td></td>
<td>Average excess bed days</td>
<td>March 2016 - February 2017</td>
<td>0.43</td>
<td>0.59</td>
<td>-0.79</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of inpatients with a length of stay over 30 days</td>
<td>March 2016 - February 2017</td>
<td>0.02</td>
<td>0.02</td>
<td>-0.65</td>
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<tr>
<td></td>
<td>Trust outpatient appointment cancellation rate</td>
<td>March 2016 - February 2017</td>
<td>0.08</td>
<td>0.08</td>
<td>-1.27</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient appointment patient non-attendance rate</td>
<td>March 2016 - February 2017</td>
<td>0.1</td>
<td>0.06</td>
<td>0.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ratio of first and follow-up outpatient appointments</td>
<td>March 2016 - February 2017</td>
<td>2.34</td>
<td>2.11</td>
<td>0.17</td>
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<tr>
<td></td>
<td>Day Case Rate - Arthroscopy of the knee</td>
<td>March 2016 - February 2017</td>
<td>0.92</td>
<td>0.84</td>
<td>-0.39</td>
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<tr>
<td></td>
<td>Day Case Rate - Coronary angiography</td>
<td>March 2016 - February 2017</td>
<td>0.97</td>
<td>0.89</td>
<td>-0.67</td>
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<td></td>
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<tr>
<td></td>
<td>Day Case Rate - Pacemaker implantation</td>
<td>March 2016 - February 2017</td>
<td>0.61</td>
<td>0.93</td>
<td>0.07</td>
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<tr>
<td></td>
<td>Day Case Rate - Repair of hand tendon</td>
<td>March 2016 - February 2017</td>
<td>0.21</td>
<td>0.81</td>
<td>0.95</td>
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<tr>
<td></td>
<td>Day Case Rate - Repair of inguinal hernia</td>
<td>March 2016 - February 2017</td>
<td>0.68</td>
<td>0.73</td>
<td>0.53</td>
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<tr>
<td></td>
<td>Day Case Rate - Repair of umbilical hernia</td>
<td>March 2016 - February 2017</td>
<td>0.76</td>
<td>0.75</td>
<td>-0.12</td>
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<tr>
<td></td>
<td>Day Case Rate - Surgery for Dupuytren contracture</td>
<td>March 2016 - February 2017</td>
<td>1.0</td>
<td>0.91</td>
<td>-1.08</td>
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<table>
<thead>
<tr>
<th>Segment Name</th>
<th>Indicator</th>
<th>Period</th>
<th>Trust</th>
<th>Peer</th>
<th>Score</th>
<th>Performance</th>
<th>Trend</th>
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<tbody>
<tr>
<td><strong>Operational Efficiency</strong></td>
<td>Day Case Rate - Surgery for haemorrhoids</td>
<td>March 2016 - February 2017</td>
<td>0.75</td>
<td>0.79</td>
<td>0.29</td>
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<tr>
<td></td>
<td>Day Case Rate - Conservative Surgery for Breast Cancer</td>
<td>March 2016 - February 2017</td>
<td>0.88</td>
<td>0.64</td>
<td>-2.12</td>
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<tr>
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<td>Length of Stay (Unadjusted) - Heart Failure</td>
<td>March 2016 - February 2017</td>
<td>9</td>
<td>9.27</td>
<td>-0.16</td>
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<tr>
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<td>Length of Stay (Unadjusted) - Coronary Angiography</td>
<td>March 2016 - February 2017</td>
<td>0.92</td>
<td>2.37</td>
<td>-0.65</td>
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<tr>
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<td>Length of Stay (Unadjusted) - Alcoholic Liver Disease</td>
<td>March 2016 - February 2017</td>
<td>9.26</td>
<td>9.98</td>
<td>-0.24</td>
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<tr>
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<td>Length of Stay (Unadjusted) - Surgery on the Lower Back (Lumbar Spine)</td>
<td>March 2016 - February 2017</td>
<td>2.22</td>
<td>2.88</td>
<td>-0.01</td>
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<td>Length of Stay (Unadjusted) - Fractured Neck of Femur</td>
<td>March 2016 - February 2017</td>
<td>19.24</td>
<td>18.18</td>
<td>0.19</td>
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<tr>
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<td>Length of Stay (Unadjusted) - Mastectomy to treat breast cancer, without immediate reconstruction</td>
<td>March 2016 - February 2017</td>
<td>2.6</td>
<td>1.85</td>
<td>0.34</td>
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<tr>
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<td>&gt;2 Day Non-Elective LoS for patients aged 75+</td>
<td>March 2016 - February 2017</td>
<td>14.85</td>
<td>14.72</td>
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<tr>
<td>ID</td>
<td>Description</td>
<td>Quarter 1 Incentive</td>
<td>Quarter 2 Incentive</td>
<td>Quarter 3 Incentive</td>
<td>Quarter 4 Incentive</td>
<td>Annual Incentive</td>
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<tr>
<td>A</td>
<td>Emergency Care 4 hr standard</td>
<td>97.11%</td>
<td>98.10%</td>
<td>98.93%</td>
<td>98.24%</td>
<td>2.71%</td>
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<tr>
<td>B</td>
<td>Implement streaming in A&amp;E Department</td>
<td>Compliance</td>
<td>Awaiting confirmation from NHSI</td>
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<th>Quarter 1 Incentive</th>
<th>Quarter 2 Incentive</th>
<th>Quarter 3 Incentive</th>
<th>Quarter 4 Incentive</th>
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<tbody>
<tr>
<td>15.0%</td>
<td>£154,800</td>
<td>£206,100</td>
<td>£309,600</td>
<td>£360,900</td>
<td>£1,031,400</td>
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<tr>
<td>15.0%</td>
<td>£154,800</td>
<td>£206,100</td>
<td>£309,600</td>
<td>£360,900</td>
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*Based on achievement of control totals
### Compliance & STP Monitoring - Responsive

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<th>Period</th>
<th>Target</th>
<th>Act</th>
<th>QTR</th>
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#### Quality - Caring & Safe

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#### Finance - Our Money

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**Lord Carter/ Model Hospital - Effective**

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<th>Period</th>
<th>Target</th>
<th>Act</th>
<th>Cum</th>
<th>Trend</th>
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**Friends & Family**

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<th>Period</th>
<th>%</th>
<th>Target</th>
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**Measures**

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<th>Target</th>
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**Lord Carter/ Model Hospital - Effective**

<table>
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<th>Target</th>
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**Friends & Family**

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<th>%</th>
<th>Target</th>
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**Measures**

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<th>%</th>
<th>Target</th>
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**Lord Carter/ Model Hospital - Effective**

<table>
<thead>
<tr>
<th>Measure</th>
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<th>%</th>
<th>Target</th>
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**Friends & Family**

<table>
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<th>%</th>
<th>Target</th>
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**Measures**

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<th>Target</th>
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### Single Oversight Framework – Governance Measures and Triggers for Concerns

<table>
<thead>
<tr>
<th>Theme</th>
<th>Information used</th>
<th>Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of care</strong></td>
<td>• CQC information&lt;br&gt;• Other quality information to inform our view of a provider (see Appendix 2)&lt;br&gt;• 7-day services</td>
<td>• CQC ‘inadequate’ or ‘requires improvement’ assessment in one or more of:&lt;br&gt;• ‘safe’&lt;br&gt;• ‘effective’&lt;br&gt;• ‘caring’&lt;br&gt;• ‘responsive’&lt;br&gt;• CQC warning notices&lt;br&gt;• Any other material concerns identified through, or relevant to, CQC’s monitoring process, eg civil or criminal cases raised, whistleblower information, etc&lt;br&gt;• Concerns arising from trends in our quality indicators (Appendix 2)&lt;br&gt;• Delivering against an agreed trajectory for the four priority standards for 7-day hospital services</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>• Sustainability&lt;br&gt;  o Capital service cover&lt;br&gt;  o Liquidity&lt;br&gt;  o Efficiency&lt;br&gt;  o I&amp;E 14 margin&lt;br&gt;• Controls&lt;br&gt;  o Performance against plan&lt;br&gt;  o Agency spend&lt;br&gt;• Value for money information</td>
<td>Poor levels of overall financial performance (average score of 3 or 4)&lt;br&gt;Very poor performance (score of 4) in any individual metric&lt;br&gt;Potential value for money concerns</td>
</tr>
<tr>
<td><strong>Operational performance</strong></td>
<td>NHS Constitution standards&lt;br&gt;Other national targets and standards</td>
<td>For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard&lt;br&gt;For providers without STF trajectories: failure to meet any standard for at least two consecutive months</td>
</tr>
<tr>
<td><strong>Strategic change</strong></td>
<td>Review of sustainability and transformation plans and other relevant matters</td>
<td>Material concerns with a provider’s delivery against the transformation agenda, including new care models and devolution</td>
</tr>
<tr>
<td><strong>Leadership and improvement capability</strong></td>
<td>Findings of governance or well-led review undertaken against the current well-led framework&lt;br&gt;Third party information, eg Healthwatch, MPs, whistleblowers, coroners’ reports&lt;br&gt;Organisational health indicators&lt;br&gt;Operational efficiency metrics&lt;br&gt;CQC well-led assessments</td>
<td>Material concerns with a provider’s delivery against the transformation agenda, including new care models and devolution</td>
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</tbody>
</table>

14 Income and expenditure, or surplus/deficit margin
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Executive Summary

Financial Performance Report as at 30 June 2017

Report of the Director of Finance

Strategic Aim (The full set of Trust aims can be found at the beginning of the Board Reports)

Maintain Compliance and Performance

Strategic Objective (The full set of Trust objectives can be found at the beginning of the Board Reports)

1. Introduction

1.1 The purpose of this report is to inform the Board of Directors of the Trust’s financial performance for June 2017 (Month 3).

Use of Resources

The Trust has received a year to date UoR rating of 3, calculated as follows:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
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</thead>
<tbody>
<tr>
<td>Capital service cover rating</td>
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</tr>
<tr>
<td>Liquidity rating</td>
<td>1 1</td>
</tr>
<tr>
<td>I&amp;E margin rating</td>
<td>2 4</td>
</tr>
<tr>
<td>Distance from financial plan</td>
<td>1 4</td>
</tr>
<tr>
<td>Agency rating</td>
<td>2 1</td>
</tr>
<tr>
<td>Overall</td>
<td>1 3</td>
</tr>
</tbody>
</table>

2. Key Issues & Planned Actions

Summary Financial Position

2.1 The Trust’s in month position is a deficit of £1.293m, improving by £0.128m against plan (excl. STF). The year to date position is a deficit of £5.825m which is £2.338m behind plan (excl.STF). This position assumes no achievement of planned Sustainability and Transformation Funding (STF) income. The in-month improvement against plan relates to the rephasing of CRT targets for expected delivery later in the financial year.

2.2 Optimus has an in month surplus of £0.008m and a year to date deficit of £0.015m, meaning the Group has an in month deficit of £1.286m and a year to date deficit of £5.840m.

Operating Income (excluding STF)

2.3 Income is behind plan by £1.184m at Month 3, with in-month performance in line with plan.

2.4 NHS Clinical Income is behind plan by £1.059m. This represents actual income for Months 1 and 2 (Month 1 data frozen and flex Month 2 data). Income is accrued to planned levels for Month 3.
2.5 Non NHS Clinical Income is behind plan by £0.048m mainly due to Injury Cost Recovery.

2.6 Non-Clinical income is behind plan by £0.077m. The main variance relates to the stretch target set as part of the Cost Reduction Target £0.297m.

**Expenditure - Pay**

2.7 The year to date pay expenditure is lower than plan by £0.075m. Agency expenditure for the year now totals £1.320m and Bank expenditure totals £0.935m. This is offset by underspends on substantive Nursing and Midwifery staff of £1.588m.

**Expenditure - Non Pay**

2.8 Year to date non-pay is over spent by £1.407m. CRT aligned to Non Pay is behind plan by £1.601m (including centrally held CRT). Clinical Supplies lines are underspent by £0.064m.

**STF Income**

2.9 STF income is behind plan by £1.032m. As the year to date financial target has not been met no STF income is assumed to have been achieved.

**Cost Reduction Target**

2.10 In Month 3 £0.503m of savings have been delivered (67%:33% recurrent: non-recurrent) against the internally phased target of £0.322m. The CRT programme is significantly behind plan. The over-achievement in Month 3 was solely due to the rephasing of the plan due to expected savings delivery later in the financial year relating to potential establishment of a further subsidiary company.

**Cash**

2.11 The Trust’s cash balance is £20.509m which was £1.586m ahead of plan.

**Balance Sheet – Statement of Financial Position**

2.12 **Assets** - There have been additions of £0.521m within the month on non-current assets total expenditure year to date is £1.538m this is £2.795m behind plan. Although receivables have increased in month and accrued income has decreased. Negotiations to agree and clear significant inter NHS balances with South Tees NHS FT and local CCG’s are ongoing and still not resolved.

2.13 **Liabilities** - Trade payables are £15.469m, which is a decrease of £0.297m and £4.062m less than the opening balance of £19.531m.

2.14 The Trust has drawn £6.000m against its planned capital loan agreement - £4.000m in 2016/17 and £2.000m in Month 3.

**Capital**

2.15 As at Month 3 the Trust has spent £1.538m against the plan of £4.333m.

3. **Recommendation**

3.1 The Board of Directors is requested to note the financial position at the end of June 2017.

**Caroline Trevena**  
**Director of Finance**
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Financial Performance Report as at 30 June 2017

Report of the Director of Finance

1. Introduction/Background

1.1 The purpose of this report is to inform the Board of Directors of the Trust’s financial performance position for June 2017 (Month 3).

2. Main content of report

Use of Resources

2.1 The Trust has received a year to date UoR rating of 3, calculated as follows:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital service cover rating</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;E margin rating</td>
<td>4</td>
</tr>
<tr>
<td>Distance from financial plan</td>
<td>4</td>
</tr>
<tr>
<td>Agency rating</td>
<td>1</td>
</tr>
<tr>
<td>Overall</td>
<td>3</td>
</tr>
</tbody>
</table>

Summary Financial Position

2.2 The Trust’s in month position is a deficit of £1.293m, improving by £0.128m against plan. The year to date position is a deficit of £5.825m which is £2.338m behind plan. This position assumes no achievement of planned Sustainability and Transformation Funding (STF) income. The in-month improvement against plan relates to a rephasing of the STF income target in line with NHSI guidance and the rephasing of CRT targets for expected delivery later in the financial year.

2.3 Optimus has an in month surplus of £0.007m and a year to date deficit of £0.015m, meaning the Group has an in month deficit of £1.286m and a year to date deficit of £5.839m.

2.4 The summarised financial performance is shown in Appendix 1. A monthly run rate analysis is shown in Appendices 2 and 2b.

Operating Income (excluding STF)

2.5 Income is behind plan by £1.184m at Month 3. A full breakdown of income is provided in Appendix 3.

NHS Clinical Income is behind plan by £1.059m

2.6 This represents actual income for Months 1 and 2 (Freeze data for Month 1 and flex data for Month 2). Income accrued to planned levels for Month 3. At the time of writing this is the best available estimate, as we await a complete Month 3 activity dataset. This position assumes that QIPP schemes included in the contract by the CCG are not yet delivering. The Trust has recently received impact assessments from the CCG for its QIPP plans.
Trust is currently assessing these plans for realism and likely impact on income and expenditure. Income from HAST CCG is down against plan by £0.443m and from DDES CCG £0.227m across most inpatient and outpatient points of delivery. The underperformance in the main relates to Month 1. Activity in Month 2 is close to plan.

2.7 Work is on-going to cash up 2016/17 in year performance with commissioners. The position includes risk associated with 2016/17 contract. Reconciliation statements from the CCG relating to Months 1 – 7 income have been received. CCGs are currently seeking to cash up performance on these months at £1.410m less than the Trust’s position. The Trust is currently disputing these reconciliation differences based on compliance with timescales outlined in the NHS standard contract. Risk also exists relating to the billing for urgent care mobilisation costs, exit costs from the Assisted Reproduction Unit Service and the IC+ service with DDES.

2.8 Significant progress has been made in agreeing cash up processes with commissioners and a process had been agreed in principle. Commissioners have changed their approach to cash up without prior consultation with the Trust, increasing time available for commissioners to challenge data. The Trust has disputed the revised approach and is currently assessing options to mitigate the additional risk. Month 12 ‘freeze’ data is now available and work is currently being completed to ascertain a finalised contract position and settlement for 2016/17.

Non NHS Clinical Income is behind plan by £0.048m

2.9 The Injury Cost Recovery scheme is behind plan at Month 3 by £0.070m, as is Private Patient Recovery at £0.020m. This is offset by additional income from the Metal On Metal scheme of £0.029m.

Non-Clinical income is behind plan by £0.077m

2.10 Some additional income against a stretch income target (part of CRT) has been achieved in Month 3, relating to Resilience Funding of £0.144m, resulting in a year to date £0.297m variance. Education and Training income is also behind plan by £0.049m at this stage of the year; although this is likely to be recouped throughout the remainder of the year as Health Education England have historically identified additional non-recurrent income to allocate to the Trust. Research and Development income is ahead of plan by £0.029m and this is likely to continue for the rest of the year as the contribution from the Network is higher than anticipated. Directorate Income is ahead of plan year to date with increased contributions from Pathology £0.013m and Pharmacy £0.018m above plan.

Expenditure - Pay

2.11 The year to date pay expenditure is lower than planned by £0.075m. There is unachieved CRT totalling £0.085m. Agency expenditure for the year totals £1.320m. This is under the agency ceiling set by NHSI by £0.110m. Bank expenditure totals £0.935m. This is partially offset by underspends on substantive Nursing and Midwifery staff of £1.588m. Substantive Medical staff expenditure is £0.220m above plan. The Month 3 pay expenditure is £0.070m higher than the average expenditure of the previous 12 months. This is mainly due to the new Integrated Urgent Care Service (£0.205m in Month 3) and the 1% pay award in 2017/18, partially offset by CRT savings made elsewhere in the Trust.

Expenditure - Non Pay

2.12 Year to date non-pay is over spent by £1.407m. Non-Pay CRT (including centrally held and unallocated targets) is behind plan by £1.601m, with various over and underspends throughout non-pay largely offsetting each other.
STF Income

2.13 The Trust has been notified that STF funding of £6.876m will be allocated during 2017/18 if financial, A&E and primary care streaming targets are met. No income can be recognised unless the Trust achieves its phased control total. As the Month 3 financial target has not been met no STF income has been assumed against the planned income of £1.032m. This has added a further adverse variance to plan. In order to simplify reporting the Trust’s financial position the STF is excluded from operational performance.

Directorate Performance

2.14 Directorate performance is provided in Appendix 4.

2.15 In Hospital Care – The Directorate is behind plan by £0.703m year to date. Pay expenditure is overspent by £0.159m mainly due to medical usage of agency covering consultant vacancies, nursing/health care assistants' usage of agency/bank covering escalation beds, sickness, maternity leave and vacancies. Some wards continue to have high levels of sickness above budget levels included in the headroom of 4.0% e.g. there are 9 wards above this percentage in month 3. Although the Directorate experiences high levels of maternity absences they do not tend to back fill these as they recruit into permanent vacancies before backfilling fixed term posts e.g. there are 10 wards with parental leave in month 3. Unachieved Pay CRT of £0.060m also contributes to the pressure and NHSP shifts of £0.037m that were not accrued in the 2016/17 position. Non-pay is behind plan by £0.515m due to drugs (there is a national shortage of 2 antibiotics and the replacement drugs are more expensive). Unachieved Non Pay CRT of £0.297m also contributes to the pressure within this Directorate.

2.16 EAU and Ambulatory – The Directorate is behind plan by £0.312m year to date. Pay expenditure is behind plan mainly due medical pressures and nursing/health care assistants. Medical staffing pressures are due to sessional payments and locum cover for seasonal pressures, vacancies and long term sickness and maternity costs for trainee grades which are not funded. Nursing/health care assistants' usage of agency/bank costs relates to sickness and vacancies – band 6 and 7 nursing staff are helping to cover some tasks that medical staff would usually fulfill. The Directorate has 21.99 wte nursing vacancies in Month 3 which is being offset by bank and agency expenditure. Unachieved vacancy factor CRT of £0.021m also contributes to the pressure and NHSP invoices that were not accrued in the 2016/17 position is an additional cost of £0.028m. Non pay expenditure is behind plan due to pressures on drugs (there is a national shortage of two antibiotics and the replacement drugs are more expensive), general supplies in relation travel claims (these are offset by additional income) and unachieved CRT of £0.046m.

2.17 Orthopaedics – The Directorate is behind plan by £0.455m year to date. The MSK Income target is showing a negative variance of £0.362m year to date, however, SLA income relating to Orthopaedics is higher than planned by £0.364m. Pay is marginally overspent by £0.012m year to date which is due to increased Healthcare assistant resource used to cover sickness and maternity leaves. Unachieved Pharmacy and Procurement CRT is £0.126m for April to June.

2.18 Surgery and Urology – The Directorate is behind plan by £0.326m year to date. Pay is overspent by £0.240m, which is partially offset by an over recovery of income of £0.029m. Ward 30 and Ward 28 both continue to staff unfunded beds. Sickness rates for ward areas are between 8% and 11% which is also contributing to the pressure on nursing budgets. RMO rota at Hartlepool continues to be a significant risk with only two doctors out of seven currently in post with all gaps being filled at premium cost. Possible solutions to mitigate this risk are currently being explored. Unachieved Pharmacy and Procurement CRT is £0.053m for April to June.

2.19 Pathology – The Directorate is £0.163m behind plan year to date. Expenditure budgets are overspent by £0.203m whilst Directorate income targets are over recovered by £0.040m. Pay is overspent by £0.120m due to the difficulty in recruitment of Consultants; locums have
been used in order to cover the workload created by vacancies in Microbiology and Haematology. Agency costs and additional hours in Central Specimen reception, and additional locally agreed out of hour premium payments have created a further pressure, however new rotas are being developed to mitigate the requirement for agency staff going forward, and a consultation has been completed to negate the locally agreed out of hours premium payments. Non-pay is overspent by £0.084m, which is partly offset by the over-recovery on income.

**Cost Reduction Target**

2.20 In Month 3 £0.503m of savings have been delivered (67%:33% recurrent: non-recurrent) against the internally phased target of £0.322m. The CRT programme is significantly behind plan. The over-achievement in Month 3 was solely due to the rephasing of the plan due to expected savings delivery later in the financial year relating to potential establishment of a further subsidiary company. There is a slight weighting of savings in the NHSI plan towards the end of the financial year to provide an element of headroom in reporting. The allocation of the CRT to Directorates is an iterative process as further schemes are identified. The delivery of the CRT is reviewed on a weekly basis by the Executive Team. The phasing of the plan is shown in the graph below.

![Trust Monthly CRT Plan and Actuals as at Month 3 2017/18](image)

*Note the significant increase in savings in March relates to the FM subsidiary company.

**Cash**

2.21 The Trust’s cash balance is £20.509m which was £1.586m ahead of plan; in month the Trust drew down a further £2.000m of the capital loan due to the delay in receiving the 2016/17 STF funding. The Trust also received £1.000m on 30 June from HAST CCG relating to old year invoices. In year working capital movements show debtors have increased in month due to invoices being raised for income which had previously been accrued. As a result accrued income decreased in month by £1.285m, creditors also decreased in month.

2.22 NHS Debtors and conversion of accrued income into actual invoices is a key priority to achieve planned cash balances and minimise the use of the existing loan facility requirement. Payment of NHS debt to the Trust poses a sizable risk to achieving treasury targets. Tight credit control is in place to mitigate this risk and a monthly Cash Committee has been established, chaired by the Director of Finance, to monitor achievement of the cash plan and facilitate the control of working capital.

2.23 The Cash Flow Analysis is shown in **Appendix 5**. Year-end cash balances are forecast to be £20.230m, based on the assumption of full CRT delivery, and the drawdown of the capital loan of £14.000m.
Balance Sheet – Statement of Financial Position

2.24 **Non-Current Assets** - There have been additions of £0.521m within month on non-current assets; however this is £2.795m year to date behind plan – planned expenditure is £4.333m against an actual of £1.538m. Detailed proposals including phasing are currently being worked up.

2.25 **Current Assets** – Receivables have increased in month due to invoices being raised for £1.448m income which had previously been accrued this has resulted in a decrease in accrued income in month. Negotiations to agree and clear significant inter NHS balances with South Tees NHS FT and local CCG’s are on-going and still not resolved. Although the Trust received Quarter 1, 2 and 3 payments for 2016/17 STF funding within year a further accrual of £3.028m has been made in Month 3 relating to the Quarter 4 payment. This includes a bonus of £0.866 due to the Trust achieving the year end control total. The Trust is expecting payment for this on 14 July 2017.

2.26 **Current Liabilities** - Trade payables are £15.469m, which is £0.297m less than the previous month and £4.062m less than the opening balance of £19.531m. The Trust continues to focus on protecting its cash balances and consequently is not currently meeting the Better Payment Practice Code (BPPC) of 95%.

2.27 Within month the Trust has drawn down a further £2.000m against its planned capital loan agreement taking the total draw down amount to date to £6.000m. The Trust has previously deferred drawing down on the loan facility to reduce the impact of interest payments. The Trust will continue to manage cash tightly to minimise the impact of the current and future loan drawdown where operationally viable.

2.28 The Month 3 Balance Sheet and 31 March 2017 comparator is shown in **Appendix 6**.

**Capital**

2.29 The Trust’s original planned capital allocation for 2017/18 was £22.174m. This has recently been reviewed and a revised capital plan has been approved by both Executive Team and the Finance Committee. The new capital allocation for 2017/18 is £21.869m. The Trust is permitted to operate within the capital tolerances of 85% to 115% of the original capital plan value (£18.848m - £25.500m). The capital funding allocation consists of £6.021m internally generated ‘block capital’, £14.698m from the ITFF loan to fund an upgraded infrastructure and energy centre at UHNT, £0.150m additional capital from charitable donations and £1.000m PDC allocation relating to the Integrated Urgent Care Service.

2.30 At Month 3 the Trust has spent £1.538m against the plan of £4.333m. The variance against plan relates to the delay in invoices being received from suppliers against orders placed, this has no adverse effect on patient care or safety. The Trust currently has a commitment for orders raised against the capital programme of £3.376m. The majority of this commitment relates to the Electrical Infrastructure and Energy Centre scheme.
2.31 Estates capital is committed to cover professional design services relating to electrical and mechanical services, architectural services and civil and structural services associated with the new Energy Centre.

2.32 A full schedule of equipment replacement is included in the Capital Plan.

2.33 The capital position is shown in Appendix 7.

3. Conclusion/Summary

3.1 The Month 3 financial position of the Trust is a deficit of £5.824m (excl. Optimus). This is largely attributable to unachieved CRT and income underperformance relating to April. Excluding STF the Trust had planned an operational deficit of £3.487m; therefore the position is £2.338m behind plan.

3.2 Optimus Health Ltd the Trust’s wholly owned subsidiary has been incorporated into this report. At Month 3, Optimus Health Ltd has operated at a £0.015m deficit meaning the overall Group position (excluding Charitable Funds) is a £5.839m deficit. As the Trust has not met its financial target no STF income has been assumed.

3.3 Month 3 delivery of CRT totals £0.503m against a target of £0.322, with £0.339m on a recurrent basis and £0.164m on a non-recurrent basis.

4. Recommendation

4.1 The Board of Directors is requested to note the financial position at the end of June 2017.

Caroline Trevena
Director of Finance
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<th>NHSI Annual Plan (£'000s)</th>
<th>Annual Budget (£'000s)</th>
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<td>Variance (£'000s)</td>
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<td>6,658</td>
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<td>Non Clinical Income (excluding STF)</td>
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<td>20,570</td>
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*Other Pay - Budget is Pay Reserves and the Trust Board. Actual captures the cost of Non Exec Trust Board Members.

Appendix 1
## Run Rate Trend

### Month 3

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<th>Sep-16 (£’000s)</th>
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<th>Feb-17 (£’000s)</th>
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**High Cost Drugs and Devices - Missing data from UHH in April has been reflected in May.
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<th>Aug-16 (£'000s)</th>
<th>Sep-16 (£'000s)</th>
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<th>Nov-16 (£'000s)</th>
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<th>Jan-17 (£'000s)</th>
<th>Feb-17 (£'000s)</th>
<th>Mar-17 (£'000s)</th>
<th>Apr-17 (£'000s)</th>
<th>May-17 (£'000s)</th>
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## Trust Income Position Month 3

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<td>18</td>
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<td>76</td>
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<td>Current Month</td>
<td>Year to Date</td>
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<td>Budget (£'000s)</td>
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<td>Variance (£'000s)</td>
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<td>114</td>
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## Statement of Cash flow

### Month 3

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<th>Description</th>
<th>March 2017 £'000s</th>
<th>YTD Actual £'000s</th>
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<td>Surplus/(deficit) from operations</td>
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<td>(4,729)</td>
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<td>Non-cash flows in operating surplus/(deficit), Total</td>
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<td>Operating Cash flows before movements in working capital</td>
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<td>Increase/(Decrease) in working capital, Total</td>
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<td>Net cash inflow/(outflow) from operating activities</td>
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<td>Net cash inflow/(outflow) from investing activities, Total</td>
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<td>(1,447)</td>
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<td>Net cash inflow/(outflow) from before financing</td>
<td>(6,641)</td>
<td>(1,706)</td>
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<td>Net cash inflow/(outflow) from financing activities, Total</td>
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<td>Net cash inflow/(outflow), Total</td>
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<td>Closing Cash</td>
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<td><strong>Statement of Financial Position (Balance Sheet)</strong></td>
<td><strong>March 2017</strong></td>
<td><strong>Prev Month Actual</strong></td>
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<td>------------------------------------------------</td>
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<tr>
<td><strong>£’000s</strong></td>
<td><strong>£’000s</strong></td>
<td><strong>£’000s</strong></td>
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<td><strong>ASSETS</strong></td>
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<td><strong>Assets, Non-Current</strong></td>
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<td>Intangible Assets, Net</td>
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<td>78</td>
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<td>Property, Plant and Equipment, Net</td>
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<td>113,620</td>
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<td>NHS Receivables (Related Party), Non-Current</td>
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<td><strong>ASSETS, TOTAL</strong></td>
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<td><strong>Liabilities Current</strong></td>
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<td>Deferred Income, Current</td>
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<td>Provisions, Current</td>
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<td>(421)</td>
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<td>Trade and Other Payables, Current</td>
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<td>Trade Payables, Current</td>
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<td>PFI leases, Current</td>
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<td>(162)</td>
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<td>PDC dividend creditor, Current</td>
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<td><strong>NET CURRENT ASSETS (LIABILITIES)</strong></td>
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<td>18,951</td>
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<td>Deferred Income, Non-Current</td>
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<td>(278)</td>
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<td>(4,000)</td>
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<td>(143)</td>
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<td>Provisions, Non-Current</td>
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<td><strong>Liabilities, Non-Current, Total</strong></td>
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<td>(5,596)</td>
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<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
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<td>Taxpayers’ Equity</td>
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<td>Public dividend capital</td>
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<td><strong>TOTAL TAXPAYERS’ AND OTHER EQUITY</strong></td>
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<td>136,830</td>
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## Appendix 7

### Capital Position

**Month 3**

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<th>Capital Position</th>
<th>Revised Capital Plan</th>
<th>Year to Date</th>
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<td><strong>Estate - Electrical Infrastructure / Energy Centre</strong></td>
<td>£'000s</td>
<td>Invoiced</td>
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<td><strong>Estate</strong></td>
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<td>£'000s</td>
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<td><strong>ICT</strong></td>
<td>1,000</td>
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<td><strong>ICT Rolling Programme</strong></td>
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<td><strong>Total ICT</strong></td>
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<td><strong>Charitable Donations</strong></td>
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<td><strong>GRAND TOTAL</strong></td>
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<td>1,501</td>
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</table>

**Month 3 Revised Capital Plan**

- **Estate - Electrical Infrastructure / Energy Centre**: £14,720
- **Estate**: £1,000
- **ICT Current Allocation - PAS / EPR**: £1,000
- **ICT Rolling Programme**: £1,000
- **Medical Equipment**: £2,307
- **Service Developments**: £0
- **Contingency**: £205
- **Charitable Donations**: £150

**Year to Date**

- **Invoiced**: £981
- **Accrued**: £10
- **Orders Committed & Raised**: £1,855
- **Approved**: £0
- **Total Committed**: £2,847
- **Uncommitted**: £11,873
Human Resources and Education Report - Quarter 1: 2017/18

Report of the Director of Human Resources and Education

Executive Summary

Strategic Aim: (The full set of Trust Aims can be found at the beginning of the Board of Directors reports)
Maintain Compliance and Performance

Strategic Objective: (The full set of Trust Objectives can be found at the beginning of Board of Directors reports)
Effective Board Governance

1. Dashboard

The Trust headcount has reduced by 16 to 5593 in quarter 1 2017/18 when compared to the baseline at the end of March 2017. The sickness absence rate for quarter 1 2016/17 (4.08%) is lower than the baseline figure as at the end of March 2017 (4.99%). It is noted that sickness absence information is provided for April and May 2017 only. Further comparison will take place once the data for June becomes available.

2. Turnover/Change in Workforce

The turnover rate for quarter 1 2017/18 is 12.07% where foundation doctors are included and 11.46% without. The turnover rate for each month has been higher when compared to the end of Quarter 4 2017/18, where the rate includes foundation doctors and also where the rate excludes foundation doctors.

There have been 182 new starters to the Trust in quarter 1 2017/18 in comparison to 217 in quarter 4 2016/17.

3. Sickness/Occupational Health

The top three reasons for sickness absence in quarter 1 2017/18 remain the same as in quarter 4 2016/17. The average regional sickness absence rate for quarter 4 2016/17 is 4.77% as compared to the Trust rate for quarter 4 2016/17 which is 4.87% (regional rates for quarter 1 2017/18 are not yet available).

4. Mandatory Training

The Trust has maintained ‘green’ compliance in a number of topics including Fire, Dementia and Blood Transfusion.

A number of topics have changed frequency due to the Regional Streamlining project that has seen the Trust align its training frequencies to other Trusts and allows staff to move from one Trust to another without duplicating mandatory training.
5. Workforce

The Regional Streamlining project continues and the pilot on the utilisation of a standard reference inter-authority transfer (IAT) between all 11 Trusts in the region has been extended.

6. Education

The Annual Review of Competence Progression (ARCP) panels have taken place with all F1 and F2 trainees having passed the assessment.

The Trust currently has 4 F1 vacancies and 8 F2 vacancies for August 2017 and these posts are currently being recruited to. There are an additional 9 posts at Core Trainee/Specialty Trainee level and 9 posts at Specialty Trainee/Registrar level.

A number of external visits and surveys have taken place during quarter 1 2016/17 including a visit by the University Medical School and Foundation School. The Foundation Training feedback was described as the most positive visit the school had attended during the reporting cycle, with exceptional feedback from the F1 and F2 trainees.

7. Staff Friends and Family Test

The Staff Friends and Family Test for Quarter 1 2017/18 reported that 74% of staff would recommend the Trust as a place to receive care or treatment and 64% of staff would recommend the Trust as a place to work.

8. Brexit – UK and EU negotiating positions on citizen’s rights

The EU Commission and UK Government have published policy position papers, which set out their respective offers to secure the rights of EU citizens and their families in the UK, post exit from the EU.

9. Shining Stars 2017

The Trust’s annual Shining Star’s event took place on 9 June 2017 with awards presented across 12 categories.

10. People Forum

A meeting of the Trust's inaugural People Forum took place on 29 June 2017, with representation from a number of clinical areas.

11. Trust App

The Employee Relations Team have been working with an external organisation to develop and implement a Trust App, which aims to act as a further communication tool to enhance staff engagement. Following a successful pilot during May and June, the App was launched to all staff from 26 June 2017.

12. Recommendation

The Board of Directors is asked to note the content of and accept this report.

Ann Burrell
Director of HR & Education
1. Dashboard

1.1 Sickness Absence

The sickness absence rate for the month of May 2017 was 4.09%, an increase of 0.01% when compared to the previous month (April 2017). It is noted that sickness absence information is provided for April and May 2017 only. Further comparison will take place once the data for June becomes available.

The sickness absence rate for quarter 1 2017/18 has shown a decrease of 0.9%, when compared to quarter 4 2016/17. The long term sickness absence rate for quarter 1 2017/18 has shown a decrease of 0.36%, when compared to quarter 4 2016/17.

The total cost of absence for quarter 1 2016/17 is £988,818, which is £767,687 lower when compared to quarter 4 2016/17 (£1,756,505) however this does not include the figures for June 2017. It is £668,902 lower when compared to quarter 1 2016/17 (£1,657,720), excluding the costs for June 2017.

There were 213 referrals to Occupational Health during quarter 1 2017/18. The top reason for referral to Occupational Health is Stress and Anxiety with 82 referrals. This was followed by Musculoskeletal with 50 referrals.

1.2 Change in Workforce

The Trust headcount as at 30 June 2017 is 16 less than as at the baseline of 31 March 2017. Turnover has increased by 0.24% for quarter 1 2017/18, when compared to the baseline of 31 March 2017.

2. Workforce

2.1 Overseas Nurse Recruitment

5 nurses arrived in the UK and were welcomed to the Trust in May 2017. Their Objective Structured Clinical Examination (OSCE) is scheduled to take place in the coming weeks.

A further 7 nurses are anticipated to arrive at the end of July 2017.

2.2 Streamlining Programme
The regional streamlining project was introduced by the North East HR Directors Network and is supported by Health Education North East (HENE) and 11 regional NHS Trusts. The aim of the programme is to reduce the duplication associated with NHS staff moving around the various NHS organisations within the region. The programme has three main work streams, which are: Recruitment; Statutory & Mandatory training, and: Occupation Health. Regional leads have been appointed for each work stream with the following updates provided.

2.2.1 Recruitment

Initially the recruitment workstream has predominately focused on standardisation of the employment reference processes across the region. The regional leads have agreed to adopt the NHS Employers Factual Reference, which will transfer new employee reference information using the Electronic Staff Record (ESR) system. From March to May 2017, an 8 week pilot took place across 6 Trusts in the region using the new referencing process alongside existing local methods to identify potential efficiencies. The results of the pilot have been varied and it has been agreed to undertake a further pilot with all 11 NHS Trusts in the region, which is expected to begin in August and run for 4 weeks, the results of which will be shared with Trust leads.

The focus of the workstream is now looking at creating a standardised approach to Disclosure and Barring Service (DBS) checks across the region, of which a number of options are being discussed at both a regional and local level.

2.2.2 Mandatory Training

The regional workstream leads have agreed to standardise 10 mandatory training topics across all 11 Trusts in the region by aligning to the Core Skills Training Framework (CSTF). Within the Trust, alignment has been made to the Core Skills Training Framework for 8 of the 10 topics, with further discussions on going with regards to alignment of Safeguarding Children Level 3 and Information Governance training. In May, the Trust’s Mandatory Training ‘Red Amber Green’ report was updated to reflect alignment to the Core Skills Training Framework, which has resulted in changes to training frequency and subsequently overall training compliance has lowered. Actions are in place to address the reduction in compliance. Additional detail is contained within section 3.7 of this report.

In addition to the alignment of the Core Skills Training Framework, all 11 Trusts in the region have agreed to utilise the Electronic Staff Record (ESR) for the recording and reporting of mandatory training information, as well as using the system for e-learning access. Work has begun, in conjunction with the regional support team, to configure the Electronic Staff Record to allow for the accurate recording and reporting of mandatory training, as well as utilising the Electronic Staff Record as the Trust’s e-learning platform. A number of key tasks have been identified and actions plans are in place to have this work complete by 31 August 2017, in line with the regional deadline.

2.2.3 Occupational Health

The regional workstream leads have agreed to create a standardised approach to the collection and sharing of Immunisation and Vaccination information for employees moving between NHS Trusts in the region. An Immunisation and Vaccination template is currently being designed for regional agreement and a process developed to share this information using a secure NHS.net email process between NHS Trusts, with a 48 hour key performance indicator identified. In the longer term, use of the Electronic Staff Record and the Occupational Health system ‘Cohort’ is currently being explored with a view to recording and transferring employee’s occupational health information, utilising processes established by a similar Streamlining project by NHS Wales.
2.3 Junior Doctor Recruitment

Work is on-going in preparation for the annual junior doctor changeover and recruitment to posts across the Trust in advance of the changeover in July/August 2017.

3. Education

3.1 Medical Education

The Annual Review of Competence Progression (ARCP) panels have taken place and all F1 trainees and F2 trainees have passed the assessment and are able to progress onto the next stage of training in August.

Despite initially having a full cohort of 42 F1 trainees for August 2017, following the publication of university exam results there are now 4 vacancies at this level. Interviews are scheduled to take place on 21 July to appoint to these posts.

Of the Trust’s 46 F2 posts, there are 8 vacancies at this level with interviews scheduled for end of July.

The Lead Employer Trust have confirmed that there are a further 9 vacancies at Core Trainee/Specialty Trainee level and 9 vacancies at Specialist Trainee Registrar level.

The University Medical School and Foundation School visited the Trust earlier this year. The Foundation Training feedback was described as the most positive visit the school had attended during the reporting cycle, with exceptional feedback from the F1 and F2 trainees. This feedback supplemented and triangulated well with the results of the GMC National Trainees Survey, Top 10 Trust League Table and Your School Your Say survey which indicated a very high level of satisfaction amongst trainees with their experience in post.

All of the trainees that the Foundation School met with agreed that they would recommend the Trust to current final year students considering their applications for Foundation Training. Trainee feedback was unanimously positive about:

- the overall culture of the organisation and trainees described the hospital as a ‘very friendly place to work’;
- excellent support from very approachable Clinical and Educational Supervisors (highlighted several times during discussions by a number of F1 and F2 trainees) in particular for Emergency Medicine which is frequently identified as a stressful rotation by trainees working in other Trusts. EAU was also highlighted as a particularly good rotation for learning;
- fantastic support from the entire Medical Education Team – both work related and pastoral support;
- Trust Induction and Shadowing which were both described as excellent and a valuable experience;
- the ability to achieve the required curriculum outcomes and protected Foundation Programme specific teaching;
- the ‘10 a day’ process where at 11.50am each day, the clinical teams would take 10 minutes to discuss and share topical issues – this was felt to be both educational and excellent in terms of team-building;
- safe and effective patient handover;
- an appropriate level of work intensity in posts, despite gaps in the rota and winter pressures and the support available from Physicians Associates;

The Trust team were highly commended for their enthusiasm and dedication to achieving the highest standards in the delivery of education and training for foundation trainees and this
was recognised and very much appreciated by, not only the Foundation School, but also by the Postgraduate Dean.

3.2 Resuscitation and Simulation

Weekly inter-professional simulations continue to be held in the Emergency Assessment Unit, with new scenarios based on Acute Coronary Syndromes.

Bi-monthly simulations continue for Paediatrics/Neonates with varying scenarios and monthly simulations continue for Obstetrics and Gynaecology, based on obstetric emergencies. Monthly Surgical and Orthopaedic Specialist Nurse Development Day simulations continue, based on Sepsis, Acute Kidney Injury (AKI) and Haemorrhage.

The Core Medical Trainees have received simulations based on Bradycardia and Anaphylaxis since March 2017.

Simulations for Foundation Year 1 Doctors are based on Acute Kidney Injury and Pulmonary Oedema, and simulations are being completed by Foundation Year 2 Doctors based on pulmonary oedema, decompensated chronic liver disease and epilepsy as part of the Foundation Programme teaching.

Simulation sessions continue for final-year medical students including: asthma; acute pulmonary oedema; pancreatitis and; acute coronary syndromes, as well as obstetric simulations.

An Acute Common Core Stem course was successfully held in March and May, with both courses evaluating positively. Introduction to Simulation course and Registrar Ready courses for Medicine and Accident and Emergency ran successfully in April, and again both courses evaluated positively.

Anaesthetics Safe Sedation course; Airway Training Day, and; TARGET courses ran and evaluated successfully in May, as did the Single Incision Laparoscopic Colorectal Surgery (SILCS) live surgery course from Theatres, observed via Scotia Medical Observation and Training System (SMOTS) camera link to the Simulation Suite.

3.3 Medical Appraisal and Revalidation

The Annual Organisation Audit (AOA) statistics for medical appraisal were submitted on 2 June 2017, with a reduction in the overall compliance rates for an NHS England appraisal. The full report will be presented to the Board at the July 2017 meeting by the Medical Director.

Actions undertaken in Quarter 1 are:

- The setting of fixed appraisal dates for all medical staff is currently underway;
- A Decision Making Group has been formed with the first meeting taking place on 6 July 2017;
- A process to ensure that only appropriate connections are made to the Trust (this will pick up the issues highlighted with zero hours contract doctors);
- Development of an escalation process for non-engagement with the appraisal process.

The AOA statistics for Alice House Hospice and the Butterwick Hospice have been submitted, with no issues highlighted (the Trust is the Designated Body for the two hospices).

There were no revalidation recommendations due in quarter 1 2016/17.
The Quality Team have provided information and updates on the medical appraisal process at the Trust Doctor Conference on 23 May 2017 and at the Anaesthetics Directorate meeting on 9 June 2017.

3.4 GMC National Training Survey

The results of the GMC Trainee and Trainer surveys were released on 4 July 2017 and overall, the indicators are more positive than those received for 2016.

3.4.1 The Trainee Survey

In the overall national ranking by Trust, for the GMC Trainee Survey, the Trust is ranked at 79, which is up 38 places from 2016 (previously ranked at 117). In the local ranking by Trust, we have maintained our position at 8 (out of 11) which is the same as 2016.

The results (100% response rate) show improvements in Anaesthetics, Core Medical Training, Radiology, Emergency Medicine, Paediatrics with general and core surgery not scoring any pink or red indicators and achieving 10 positive dark green outliers and 5 light green indicators.

There has been an improvement in the responses for: clinical supervision out of hours; reporting systems; handover; supportive environment; local teaching and; regional teaching, with workload and adequate experience showing a drop in the overall number of positive green outliers.

New areas included in the trainee survey for 2017 were teamwork, curriculum coverage and educational governance.

3.4.2 The Trainer Survey

The 2017 GMC Trainer survey also included new topics in: organisational culture; workload; overall satisfaction; resources for trainers; time for training; trainer development; curriculum coverage; supervisor training; time for trainers and; rota design. With a completion rate of 80.99%, the Trust was ranked 4th in the Deanery for completion.

Overall, the Trust received 39 positive dark green outliers, 10 light green indicators in quartile 1, but not a positive outlier. Educational governance scored 7 positive indicators, with trainer development and resources for trainers scoring 6 and 5 positive indicators respectively. There were also positive indicators for handover; supportive environment; curriculum coverage and supervisor training; support for trainers; rota design; time for trainers and; workload.

Each Speciality Training Lead will be asked to provide a quality improvement plan (QIP) to address issues in the areas reported as either red or pink for both surveys. These QIPs will be forwarded to Health Education England North East (HEENE) with progress monitored by the Quality Team.

3.5 Quality Assurance visits

The Trust received a formal Quality Assurance visit from the General Practice Vocational Training Scheme (GPVTS) on 3 May 2016; the School of Paediatrics on 12 May 2017, and; the medical and non-medical Annual Dean’s Quality Meeting (ADQM) by the Postgraduate Dean on 9 June 2017. Feedback on the day for all visits was extremely positive, with no major issues highlighted.
3.6 Faculty Development

Final adjustments are being made to the Faculty Development Red Amber Green report, which will be available on the SharePoint site for medical staff to access. Once accessible, the Red Amber Green colours for medical appraisal will mirror annual requirements (amber at month 9 and red at month 12).

3.7 Mandatory Training

The Trust has maintained ‘green’ compliance in a number of topics including Fire, Dementia and Blood Transfusion. Safe use of Insulin and Management of hypoglycaemia also maintain ‘green’ status with a compliance figure of 77% and 78% which is 37% above the target level of 40%.

A number of topics have changed frequency due to the Regional Streamlining project that has seen the Trust align its training frequencies to other Trusts and allows staff who move from one Trust to another, to be accredited for 10 core topics as discussed in the Core Skills Training Framework therefore decreasing duplication. The topics that have changed frequency are:

- Safeguarding Adults level 1 and 2 is now 3 yearly, whereas this was previously required once only, at induction
- Bullying and Harassment (Equality and Diversity) is now 3 yearly
- Infection control is now yearly for clinical patient facing staff and 3 yearly for non-patient facing staff
- Safeguarding Children level 1 is now 3 yearly
- Safeguarding Adults level 1 and 2 are both 3 yearly
- Violence and Aggression (CRT) is now 3 yearly

Additional changes will be made during the process and these will be communicated in due course.

Appraisals compliance is currently reported at 78%, against a target figure of 95%. This continues to be an area of focus and it is noted that directorates are sent their RAG reports monthly, with regular reminders issued by the education delivery team to inform directorates of those appraisals that are outstanding. This is regularly reported to the Deputy Executive team meeting to escalate areas of concern.

Additional topics added to this years’ Red Amber Green report are Waste Management and Scan4Safety which are both subject to incremental compliance targets across the year.

Members of staff at Bands 7 and above require the Performance Framework Review to be completed and they are sent separate emails 3 months prior to their incremental date, to inform them of this requirement, which when completed, maintains their compliance for appraisal.

3.8 The Knowledge and Information Service (KIS)

The KIS continues to provide clinical and management evidence to support decision-making in the Trust. The top three areas of business which are supported by KIS remain: Teaching/advising other colleagues; direct patient care; and development of guidance/guidelines or policies.

New developments for 2017/2018 include the regional implementation of a new library management service OLIB due to start in August.
4. Employee Relations

4.1 Staff Friends and Family Test

The Staff Friends and Family Test for quarter 1 2017/18 received responses from a total of 72 employees with the following results published:

- 74% of staff would recommend the Trust as a place to receive care or treatment, whereas 14% of staff would not.
- 64% of staff would recommend the Trust as a place to work, whereas 14% would not.

Response rates continue to be significantly lower, when compared to the initial introduction of the Test in April 2014. It is anticipated that the new Trust App will have a positive influence on response rates for quarter 2 2017/18.

4.2 Brexit – UK and EU negotiating positions on citizen’s rights

The EU Commission and UK Government have published policy position papers, which set out their respective offers to secure the rights of EU citizens and their families in the UK, post exit from the EU.

The EU is offering, up until the date that the UK withdraws from the EU, to provide a lifetime guarantee for all EU27 and UK citizens living in the UK or EU on all the rights they currently enjoy, including permanent residency and access to healthcare and includes current and future family members.

The UK is seeking to agree with the EU a ‘cut-off’ date before the date of withdrawal (no earlier than 29 March 2017) before which they will offer all EU27 citizens living in the UK to acquire ‘settled status’. UK settled status is not permanent residency and is subject to a period of 5 years residency in the UK. Settled status would be lost if a person is absent from the UK for more than two years.

The UK position for EU27 citizens arriving after the cut-off date, but before the date of withdrawal, is that they will be eligible to acquire a temporary residency permit which will commence on the day following the UK’s withdrawal from the UK. They may become eligible to apply for ‘settled status’ but this is not guaranteed.

The offer is predicated on reciprocal arrangements being agreed for UK citizens living in the EU.

4.3 Trust App

The Employee Relations Team have been working with an external company (Ark) to develop and implement a Trust App, which will allow employees of the Trust a unique facility to access information at any time, by downloading the programme to a mobile device.

It is recognised that many staff do not have access to a PC as part of their role and so may miss out on important communications. The app will create a central place for staff to access information and resources via a user friendly interface. It also permits the Trust to send out notifications each time a new communication is published, or to promote surveys such as the friend and family test.
The app has been free to implement, since funding is achieved through sponsor organisations wishing to offer a service or a concession to employees. The Trust is able to review and veto sponsors and offers before they are launched.

Following an initial pilot in May and June, the app is now live.

4.4 People Forum

The first meeting of the people forum took place on 29 June 2017, with representation from a number of clinical areas.

The forum is intended to enhance the Trust’s method of engagement with people from across the organisation, by providing a further opportunity of communication including the discussion and exchanging of views. The way in which the forum is structured will allow for representatives to share information within their own departments and directorates and to ultimately raise understanding across the whole Trust.

The meeting in June took the form of a ‘set the scene’ discussion to seek out the views of the representatives and establish how they would like the forum to run and what the format of the meetings would look like. The feedback from representatives was extremely positive and included a number of suggestions for consideration which are currently being explored.

4.5 Armed Forces Reservist Day 2017

The Trust held its first recognition event to publically celebrate the important contribution that our reservist staff make to our country and to the NHS.

The events were hosted by the Chief Executive as Honorary Colonel of the 201 Field Hospital and a number of reservist staff attended the events on both sites which included raising the Union Flag, followed by lunch and a short service of remembrance in the Chapel.

The Trust has used the opportunity of Reserves Day to promote the various ways in which managers can support their staff to undertake their reservist duties.

4.6 Staff Engagement

The monthly staff engagement Focus Groups continue to be well attended over the previous quarter. Discussion topics have been: Attendance Management; Reward and Recognition and Making a Difference to Patients. The sessions continue to be valuable in listening to our employee’s thoughts and suggestions in regards to particular topics each month. Suggestions and issues raised during the sessions have been fed back through the culture group, with actions agreed and taken forward as appropriate.

4.8 Shining Stars 2017

The Trust’s annual shining stars event is a showcase for recognising excellence in a number of categories across the organisation.

The event for 2017 took place on 9 June at Hardwick Hall, Sedgefield. The event is firmly embedded in the Trust’s Reward and Recognition Strategy, with this being the 6th event held.

A total of 103 nominations were received from across 12 categories, with each category then being shortlisted to 4 nominees.

In excess of 200 individuals attended the actual event, which included a meal, entertainment and an acknowledgement from the Chief Executive to formally recognise and celebrate the contributions that our employees make as part of their day to day activities.
The night was a huge success and planning is already underway for next year.

4.7 Stars of the Month

The Trust’s ‘Employee of the Month’ scheme was rebranded in April 2017 to become Stars of the Month. This change was necessary to enable recognition of the excellent examples of Teamwork which exist across the Trust, as demonstrated by the number of nominations received for Team of the Year, as part of the Shining Stars ceremony.

The extension of the scheme has been positively received by both managers and staff.

5. Recommendation

The Board of Directors is asked to note the content of and accept this report.

Ann Burrell
Director of HR & Education
July 2017
The Trust headcount at 30 June 2017 is 16 less than that at the baseline of 31 March 2017. It is 157 higher when compared to quarter 1 2016/17.

The sickness absence rates for Quarter 1 2017/18 are for the months of April and May only - further analysis will take place once the information for June 2017 is available.

The sickness absence rate for the month of May 2017 is 4.09%, an increase of 0.01% when compared to the previous month (April 2017).

The sickness absence rate for quarter 1 2017/18 has shown a decrease of 0.64%, when compared to quarter 1 2016/17.

The long term sickness absence rate for quarter 1 2017/18 (excluding June 2017) has shown a decrease of 0.43%, when compared to quarter 1 2016/17.

The cost of sickness absence showed a marginal increase during May 2017. The total cost of absence for quarter 1 2017/18 (excluding June 2017) is £388,818, which is £767,687 lower when compared to quarter 4 2016/17 (£1,756,505). It is £668,902 lower when compared to Q1 2016/17 (£1,657,720).

Turnover has increased by 0.24% for quarter 1 2017/18, when compared to the baseline of 31 March 2017. It has reduced by 0.35% when compared to quarter 1 2016/17.

The overall compliance for mandatory training is 81%, which is 1% above the target.

74% of staff would recommend the Trust as a place to receive care or treatment. 64% of staff would recommend the Trust as a place to work.
Please note that the figures shown in red in the above table indicate an increase to the previous month.

There has been an overall increase of 87.06 WTE and 156 Headcount between July 2016 and June 2017. All staff groups have seen an increase in their WTE except Medical and Dental (reduction of 30.87 WTE). This is also reflective of the headcount figures (reduced by 19).
Workforce Profile by Key Characteristics - Quarter 1 2017/18

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Headcount</th>
<th>Female</th>
<th>Male</th>
<th>White/British</th>
<th>Other</th>
<th>Part Time</th>
<th>Full Time</th>
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<tbody>
<tr>
<td>Add Prof Scientific and Technical</td>
<td>131</td>
<td>94</td>
<td>37</td>
<td>117</td>
<td>14</td>
<td>52</td>
<td>79</td>
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<tr>
<td>Additional Clinical Services</td>
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<td>992</td>
<td>125</td>
<td>1035</td>
<td>82</td>
<td>648</td>
<td>469</td>
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<tr>
<td>Administrative and Clerical</td>
<td>1113</td>
<td>931</td>
<td>182</td>
<td>1068</td>
<td>45</td>
<td>462</td>
<td>651</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>482</td>
<td>413</td>
<td>69</td>
<td>449</td>
<td>33</td>
<td>235</td>
<td>247</td>
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<tr>
<td>Estates and Ancillary</td>
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<td>383</td>
<td>224</td>
<td>583</td>
<td>24</td>
<td>379</td>
<td>228</td>
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<td>Healthcare Scientists</td>
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<td>30</td>
<td>129</td>
<td>11</td>
<td>54</td>
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<td>Medical and Dental</td>
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<td>166</td>
<td>255</td>
<td>185</td>
<td>236</td>
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<td>1383</td>
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<td>1021</td>
<td>4956</td>
<td>637</td>
<td>2593</td>
<td>3000</td>
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</table>

The headcount at the end of quarter 1 2017/18 has reduced by 16 when compared to the end of quarter 4 2016/17, from 5609 to 5593 staff.

There has been a decrease of 23 females and an increase of 7 males when comparing quarter 1 2017/18 with quarter 4 2016/17.

The number attributed to the White/British category has decreased by 23 and the Other category has increased by 7 when comparing quarter 1 2017/18 with quarter 4 2016/17.

The number of part time employees has increased by 28 and the number of full time employees has decreased by 44 when comparing quarter 1 2017/18 with quarter 4 2016/17.

At the end of quarter 1 2017/18, the largest age category is 51-55 with 16.66% of the total WTE. This is consistent with the previous quarter.
The turnover rate has increased in quarter 1 2017/18 compared to quarter 4 2016/17, from 11.83% in March 2017 to 12.07% in June 2017, where the rate includes foundation doctors; and from 11.16% in March 2017 to 11.46% in June 2017, where the rate excludes foundation doctors.

The turnover rate for each month has been higher when compared to the end of Quarter 1 2017/18, where the rate includes foundation doctors and also where the rate excludes foundation doctors.

The Medical and Dental staff group continues to show the highest turnover rate when including foundation doctors, however, the rate is significantly lower when the foundation doctors are excluded at 12.68% compared to 21.53% when they are included.

Healthcare Scientists are the next highest staff group at 15.69%, closely followed by Nursing and Midwifery (Registered) at 12.98% and Administrative and Clerical at 12.21%. This is a change to the previous quarter which saw A&C as the second highest staff group, closely followed by Healthcare Scientists and Nursing and Midwifery Registered.

The Estates and Ancillary staff group has the lowest turnover rate for quarter 1 2017/18 at 6.87%. This is a change to the previous quarter which saw the Additional Professional Scientific and Technical staff group as the lowest.
## Change in Workforce Analysis - Q1 2017/18

### New Starters

<table>
<thead>
<tr>
<th>Month</th>
<th>Headcount</th>
<th>WTE</th>
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</thead>
<tbody>
<tr>
<td>Jul-16</td>
<td>88</td>
<td>70.22</td>
</tr>
<tr>
<td>Aug-16</td>
<td>82</td>
<td>51.75</td>
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<tr>
<td>Sep-16</td>
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<td>Oct-16</td>
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<tr>
<td>Nov-16</td>
<td>57</td>
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<tr>
<td>Dec-16</td>
<td>37</td>
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<td>Q2 2016/17</td>
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<td>Mar-17</td>
<td>66</td>
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</tr>
<tr>
<td>Apr-17</td>
<td>73</td>
<td>51.62</td>
</tr>
<tr>
<td>May-17</td>
<td>63</td>
<td>46.43</td>
</tr>
<tr>
<td>Jun-17</td>
<td>46</td>
<td>32.80</td>
</tr>
<tr>
<td>Q1 2017/18</td>
<td>182</td>
<td>130.85</td>
</tr>
</tbody>
</table>

### Starters by Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Headcount</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technical</td>
<td>5</td>
<td>2.85</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>22</td>
<td>15.97</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>11</td>
<td>6.24</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>19</td>
<td>9.27</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
<td>0.00</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>18</td>
<td>10.76</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>31</td>
<td>21.59</td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>142</strong></td>
<td><strong>91.24</strong></td>
</tr>
</tbody>
</table>

### Reasons for Leaving

<table>
<thead>
<tr>
<th>Reason</th>
<th>Headcount</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexi Retirement</td>
<td>32</td>
<td>28.63</td>
</tr>
<tr>
<td>Employee Transfer</td>
<td>34</td>
<td>26.12</td>
</tr>
<tr>
<td>Voluntary Resignation - Other/Not Known</td>
<td>32</td>
<td>24.59</td>
</tr>
<tr>
<td>Retirement Age</td>
<td>25</td>
<td>17.75</td>
</tr>
<tr>
<td>Voluntary Resignation - Relocation</td>
<td>17</td>
<td>11.63</td>
</tr>
<tr>
<td>End of Fixed Term Contract</td>
<td>8</td>
<td>5.60</td>
</tr>
<tr>
<td>Voluntary Resignation - Work Life Balance</td>
<td>9</td>
<td>5.47</td>
</tr>
<tr>
<td>Voluntary Resignation - Promotion</td>
<td>5</td>
<td>4.64</td>
</tr>
<tr>
<td>Voluntary Resignation - Health</td>
<td>6</td>
<td>4.19</td>
</tr>
<tr>
<td>Retirement - Ill Health</td>
<td>4</td>
<td>2.27</td>
</tr>
<tr>
<td>Voluntary Resignation - Better Reward Package</td>
<td>4</td>
<td>2.77</td>
</tr>
<tr>
<td>Dismissal - Some Other Substantial Reason</td>
<td>2</td>
<td>1.53</td>
</tr>
<tr>
<td>Death in Service</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>Dismissal - Conduct</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>Voluntary Resignation - Child Dependents</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>Voluntary Resignation - Incompatible Working Relationships</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>Dismissal - Capability</td>
<td>1</td>
<td>0.67</td>
</tr>
<tr>
<td>Bank Staff not fulfilled minimum work requirement</td>
<td>1</td>
<td>0.00</td>
</tr>
<tr>
<td>Has Not Worked</td>
<td>1</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>185</strong></td>
<td><strong>139.80</strong></td>
</tr>
</tbody>
</table>

The number of new starters in Quarter 1 2017/18 has reduced by 35 when compared to Quarter 4 2016/17, from 217 to 182. The WTE has also reduced by 36.10 between Quarter 1 2017/18 and Quarter 4 2016/17.

Administrative and Clerical accounts for the highest number of new starters in Quarter 1 2017/18 with a headcount of 52 and 36.51 WTE. This is at a variance with Quarter 1 2016/17 which saw Additional Clinical Services as having the highest number of new starters.

Nursing & Midwifery (Registered) accounts for the highest number of leavers in Quarter 1 2017/18 with 73, however this is counter balanced by the number of starters in the quarter (45).

The highest reason for leaving during Quarter 1 2017/18 is Employee Transfer, closely followed by Flexible Retirement and Voluntary Resignation (Other/Not Known). This is a change to the previous quarter, but accounts for the fact that a number of staff TUPE transferred to Hartlepool Borough Council on 1 May 2017.
Sickness Reasons - Quarter 1 2017/18

<table>
<thead>
<tr>
<th>Absence Reason</th>
<th>WTE Days Lost</th>
<th>Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/stress/depression/other psychiatric illnesses</td>
<td>3669</td>
<td>428</td>
</tr>
<tr>
<td>Other musculoskeletal problems</td>
<td>1821</td>
<td>243</td>
</tr>
<tr>
<td>Other known causes - not elsewhere classified</td>
<td>1028</td>
<td>253</td>
</tr>
<tr>
<td>Total</td>
<td>651</td>
<td>7 924</td>
</tr>
</tbody>
</table>

The sickness absence details for Quarter 1 2017/18 are for the months of April and May only - further analysis will take place once the information for June 2017 is available.

The top three reasons for sickness absence during Quarter 1 2017/18 remain the same as in Quarter 4 2016/17.

Anxiety/stress/depression/other psychiatric illnesses is the highest reason for absence in Quarter 1 2017/18 in terms of WTE days lost and number of episodes. Anxiety/Stress is consistent with the top reason in Quarter 4 2016/17.

The Directorate that has the largest number of WTE days lost for Anxiety/Stress/Depression/Other Psychiatric illnesses during Q1 2017/18 is Out of Hospital Care, as this accounts for 603 WTE days lost. This is consistent with Q4 2016/17.

The staff group that has the largest number of WTE days lost for Anxiety/Stress/Depression/Other Psychiatric illnesses during Q1 2017/18 is Nursing and Midwifery Registered, as this accounts for 1162 WTE days lost. This is consistent with Q4 2016/17.

The Directorate that has the largest number of WTE days lost for Other Musculoskeletal Problems during Q1 2017/18 is Support Services with 340 WTE days lost. This is at a variance with Q4 2016/17, which saw Out of Hospital Care as the directorate with the largest number of days lost.

Additional Clinical Services is the staff group which has the highest number of WTE days lost (706) for Other Musculoskeletal Problems. This is consistent with Q4 2016/17.

The Directorate that has the largest number of WTE days lost for Other Known Causes during Q1 2017/18 is In Hospital Care with 246 days lost.
The sickness absence rates for Quarter 1 2017/18 are for the months of April and May only - further analysis will take place once the information for June 2017 is available.

The number of WTE days lost to sickness in Quarter 1 2017/18 currently stands at 11,617 which is a slight decrease on Quarter 4 2016/17, which was 20,852.

The Nursing and Midwifery Registered staff group incurs the greatest sickness cost in the Trust for Quarter 1 2017/18 at £356,393, which is consistent with Quarter 4 2016/17. The cost has decreased when compared to Quarter 4, by £398,377 but it is noted that this excludes the month of June.

The staff group with the lowest cost of sickness is Add Prof, Scientific and Technical with £19,310. This is closely followed by Healthcare Scientists with £23,834. This is consistent with Quarter 4 2016/17. It is, however, representative of the size of the staff groups.
Between January and March 2017 the average sickness absence rate for the NHS in England was 3.98 per cent.

The chart above shows the regional (HEE NE) sickness absence figures up to Q4 2016/17.

The average regional sickness absence rate for quarter 4 (2016/17) is 4.77%, whereas the average rate for North Tees and Hartlepool Trust is 4.87%. This is the fourth highest rate within the region.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress/Anxiety</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Post Surgery</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Bereavement</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Respiratory</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Cardiac</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Neurological</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Fracture</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Frequent STSA</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
<tr>
<td>Infections</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>213</td>
</tr>
</tbody>
</table>

There were 213 referrals to Occupational Health during the period 1 April 2017 to 30 June 2017.

The top reason for referral to Occupational Health is Stress and Anxiety with 82 referrals. This was followed by Musculoskeletal with 50 referrals.

The top two reasons of Stress and Anxiety and Musculoskeletal account for 62% of the referrals made to Occupational Health.
<table>
<thead>
<tr>
<th>Category</th>
<th>Cases commenced in Q1 2017/18</th>
<th>Cases commenced and concluded in Q1 2017/18 (with outcome)</th>
<th>Including those carried forward from Q4 2016/17</th>
<th>Total on-going cases to carry forward to Q2 2017/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Tribunal</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disciplinary</td>
<td>24</td>
<td>11 No further action* 1 Resigned 1 First Written Warning</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Capability</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Grievance</td>
<td>7</td>
<td>6 Not Upheld 1 Did not proceed</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Bullying and Harassment</td>
<td>3</td>
<td>3 No Further Action* (in 2 cases the alleged harasser resigned) 1 First Written Warning</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Disclosures of Concerns</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mediation</td>
<td>4</td>
<td>3 Resolved successfully 1 Process completed 2 Did not proceed</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Absence dismissals</td>
<td>5</td>
<td>N/a</td>
<td>N/a</td>
<td>N/a</td>
</tr>
<tr>
<td>Organisational Change</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Appeals</td>
<td>1</td>
<td>2 Appeals Upheld 2 Appeals Not Upheld</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(*No further action – usually indicates no formal action but may involve some management guidance)
Staff Friends and Family Test Quarter 1 2017/18

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Care Would recommend</th>
<th>Care Wouldn’t recommend</th>
<th>Work Would recommend</th>
<th>Work Wouldn’t recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2017</td>
<td>74%</td>
<td>14%</td>
<td>64%</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don’t know/Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2017</td>
<td>35%</td>
<td>39%</td>
<td>11%</td>
<td>6%</td>
<td>8%</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 2</th>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2017</td>
<td>35%</td>
<td>29%</td>
<td>19%</td>
<td>7%</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

A total of 72 responses were received for Quarter 1 (2017/18)

**Overall Scores for Q4 (2016/17)**

74% of staff would recommend the Trust as a place to receive care or treatment. 14% of staff would not.

64% of staff would recommend the Trust as a place to work. 14% would not.
### Training Compliance Levels - Q1 2017/18

<table>
<thead>
<tr>
<th>Topic</th>
<th>Target compliance</th>
<th>% Q1 2017/18</th>
<th>% Q2 201/18</th>
<th>% Q3 2017/18</th>
<th>% Q4 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>95</td>
<td>73**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines Management</td>
<td>90</td>
<td>97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>100</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal</td>
<td>95</td>
<td>78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Handling</td>
<td>85</td>
<td>78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Falls</td>
<td>90</td>
<td>93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation</td>
<td>80</td>
<td>78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>80</td>
<td>93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>85</td>
<td>85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (combined levels)</td>
<td>100</td>
<td>72**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (combined levels)</td>
<td>100</td>
<td>50**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Certificate</td>
<td>55*</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Management</td>
<td>10*</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>80</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>10*</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent</td>
<td>80</td>
<td>77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AWRAP</td>
<td>80</td>
<td>72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AKI</td>
<td>80</td>
<td>81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Trust compliance</td>
<td></td>
<td>81</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Additional topics have incremental increases in compliance levels on a monthly basis
** Changes to frequency have caused compliance drops for a short period of time

The Trust has maintained ‘green’ compliance in a number of topics including Fire, Dementia and Blood Transfusion. Safe use of Insulin and Management of hypoglycaemia also maintain ‘green’ status with a compliance figure of 77% and 78% which is 37% above the target level of 40%.

A number of topics have changed frequency due to the Regional Streamlining project that has seen the Trust align its training frequencies to other Trusts and allows staff who move from one Trust to another, to be accredited for 10 core topics as discussed in the Core Skills Training Framework therefore decreasing duplication. The topics that have changed frequency are:

- Safeguarding Adults level 1 and 2
- Bullying and Harassment (Equality and Diversity) is now 3 yearly
- Infection control is now yearly for clinical patient facing staff and 3 yearly for non-patient facing staff
- Safeguarding Children level 1 is now 3 yearly
- Safeguarding Adults level 1 and 2 are both 3 yearly
- Violence and Aggression (CRT) is now 3 yearly

Additional changes will be made during the process and these will be communicated in due course.

Appraisals compliance is currently reported at 78%, against a target figure of 95%. This continues to be an area of focus and it is noted that directorates are sent their RAG reports monthly, with regular reminders issued by the education delivery team to inform directorates of those appraisals that are outstanding. This is regularly reported to the Deputy Executive team meeting to escalate areas of concern.

Additional topics added to this year’s RAG report are Waste Management and Scan4Safety which are both subject to incremental compliance targets across the year.

Members of staff at Bands 7 and above require the Performance Framework Review to be completed and they are sent separate emails 3 months prior to their incremental date, to inform them of this requirement, which when completed, maintains their compliance for appraisal.
North Tees and Hartlepool NHS Foundation Trust  
Meeting of the Board of Directors  
27 July 2017  
Learning from deaths update  
Report of the Medical Director

1. Introduction and background

1.1 In March 2017 national guidance was published by the National Quality Board in relation to “Learning from Deaths”. This guidance provided information for Trusts and care providers about what was expected when reviewing deaths within care settings; and leads on from a report issued by the Care Quality Commission (CQC) in December 2016 “Learning, candour and accountability”.

1.2 The Trust has until recently been an outlier in relation to mortality statistics; the Trust has been focused on improving this position over the last 2-3 years. The Hospital Standardised Mortality Rate (HSMR) value in the latest period has decreased to 103.73; the Summary Hospital Mortality index (SHMI) is currently 110.29. The average national statistical measures are 100 for both; the current data continues to place the Trust within the “as expected” range nationally.

2. Actions required and progress to date

2.1 The guidance requires trusts to have an Executive and Non-Executive Director identified to be responsible for compliance. The Trust has identified the Medical Director, as the Executive, and the chairperson of the Patient Safety and Quality Standards Committee, as the Non-Executive Director with this responsibility.

2.2 The guidance requires all trusts to have a “Learning from deaths” policy; the Trust already has a policy related to Morality reviews; however this is being fully reviewed to ensure the requirements of the national guidance. This policy has to be approved and in place by September 2017.

2.3 The guidance provides details on the content of this policy; this includes:
   - defining the denominator of deaths, this will be all in-patient deaths and those occurring in the Accident and Emergency department;
   - which deaths MUST be reviewed as a minimum;
   - how the reviews will be completed;
   - how the results will be published.

2.4 The Trust is required to publish details of the approved policy and approach in a Public Board report by quarter 2, 2017-18; details of data in relation to avoidable deaths and learning points from the reviews undertaken by quarter 3, 2017-18. This will continue to be published in a quarterly public Board report after this.

2.5 Details of progress and learning are also to be published in the Trusts Quality Accounts in June 2018; and then released annually after this.

2.6 A dashboard template has been provided by NHS Improvement to support the application of this guidance; the Trust already has a mortality dashboard and this is currently being reviewed to ensure the appropriate data is collected.
2.7 In order to ensure the required cases are reviewed the Medical Director has identified cases to be included from the national guidance; but has also identified cases to be reviewed in addition to these. The table below identifies the cases that will be targeted for 100% review from April 2017. Many of these cases are already reviewed in relation to providing data into national reports; however the review processes are being adapted to ensure all necessary data is collected.

<table>
<thead>
<tr>
<th>Targeted reviews to 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested by families</td>
</tr>
<tr>
<td>Requested by staff</td>
</tr>
<tr>
<td>Learning difficulties</td>
</tr>
<tr>
<td>Severe Mental illness</td>
</tr>
<tr>
<td>All deaths in ITU</td>
</tr>
<tr>
<td>All maternal deaths (Obstetrics) up to 6 weeks after delivery</td>
</tr>
<tr>
<td>All Neonatal deaths</td>
</tr>
<tr>
<td>All child deaths</td>
</tr>
<tr>
<td>All Still births</td>
</tr>
<tr>
<td>All deaths in patients admitted electively</td>
</tr>
<tr>
<td>All deaths linked to Serious Incidents</td>
</tr>
<tr>
<td>All deaths linked to complaints</td>
</tr>
</tbody>
</table>

2.7 The Trust has introduced a Bereavement survey to be given to all families following a death in the hospital; this survey offers families an opportunity to provide feedback across the difficult period when a loved one dies. However it is also offering families an opportunity to request a review of the patient’s death and to advise how they want to receive feedback from this review. This survey was tested during 2016 and the opportunity for a review was accepted by 2 families; this is a relatively low number but it is hoped this can be promoted with families over 2017-18.

2.8 The Trust has 3 members of staff trained to undertake reviews for patient who were known to have a Learning Disability (LD); this is also linked to a national system that has been developed over the last 2-3 years. The Trust has recently gained access to the Learning Disability Registers across Hartlepool and Stockton; this supports effective identification of patients and allows case reviews to be undertaken as soon as possible. The Trust has recently notified a death into the national LD system and a review is planned.

2.9 The criteria relating to reviewing deaths of patients who have a “severe mental illness” diagnosis; is less clear currently. The guidance does not specify what illnesses are classed as being “severe”; the Trust has requested some clarity in relation to this from NHS Improvement. In the interim however, some diagnoses have been identified to allow cases to be more readily identified; some patients do not reveal mental illness when they are admitted to hospital for another reason. The Trust has also approached the Regional Mortality Group to agree an overarching regional approach towards these reviews; this will be guided by the regional mental health organisations until further information is available from NHS England.

2.10 The reviews of child and maternal deaths are all undertaken as part of various national review programmes to learn from deaths. The processes undertaken for the reviews already in place are being examined in order to ensure all necessary details are collated effectively. The Trust has recently introduced a web based mortality review system; the overarching review template on the system can be adapted to allow the necessary data collection.

2.11 The Trust is also working with external organisations to introduce joint mortality reviews to ensure that where a patient has died in one area, but has received care across several care
providers; their cases are reviewed by a cross system multidisciplinary team. The services involved to date include the Local Authorities, North East Ambulance Service, Care homes, GP services; Community Services and Acute health care providers. The aim of this is to examine a patient’s care across a whole pathway for joint shared learning.

3. Conclusion

3.1 The Trust has initiated the required actions in relation to the application of the national guidance.

3.2 The Trusts Policy for “Learning from deaths” is being reviewed and will be published in September 2017 with summary details to date being provided at the end of quarter 2. This will lead into the details to be published in quarter 3 in relation to mortality reviews, potentially avoidable deaths and overall learning from the analysis.

3.3 The Trusts statistical mortality rates are within the normal “expected” range nationally.

Dr D Dwarakanath
Medical Director
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27th July 2017

Executive Summary

Guardian of Safe working Hours Summary Report

Report of the Medical Director

Strategic Aim (*The full set of Trust Aims can be found at the beginning of the Board Reports*)

Maintain Compliance and Performance

**Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)**

Training

1. **Introduction**

The New Junior Doctor Contract (2016) contains within the terms and conditions of service the requirement that the Guardian of Safe Working (GOSW) prepares a quarterly report to the Board of Directors containing information relating to the safe working of doctors within the Trust.

2. **Purpose**

The purpose of this paper is to provide the Board of Directors with a summary of the work and activity undertaken during the period January – March 2017 on the working hours and practices of Junior Doctors within the Trust, providing assurances on safe working practices and highlighting areas of concerns.

3. **Background**

The new 2016 Terms and Conditions of Service for NHS Doctors and Dentists in training went live for foundation year one trainees on 7th December 2016, with all other grades due to start their transition to the new contract from August 2017.

Mr Pud Bhaskar was appointed to the role of ‘Guardian of Safe Working Hours’, which was established as part of the negotiations on the new contract to monitor compliance with the limits on working hours and rest; act as a ‘champion’ for safe working hours and be independent of the management structure.
Quarterly reports will be provided to the Patient Safety and Quality Standards Committee, with a summary report highlighting actions and issues presented to the Board of Directors.

4. Summary

The second quarterly report from the Guardian of Safe Working is appended. It provides an overview of actions to date to ensure compliance with the implementation of the contract and identifying issues raised through the exception reporting and qualitative Junior Doctor Forum.

The systems in the new junior doctor contract for monitoring safe working practices are new and will take time to embed. Three exception reports were raised during this quarter, making a total of seven since the launch of the new contract. This is a relatively low number in comparison to some other organisations and actions are being taken to improve engagement and ensure our junior doctors feel safe to highlight concerns.

Overall there have been no significant exceptions resulting in any fines and there are no major concerns, where issues have been highlighted there is on-going work to address them.

5. Recommendations

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

Dr D Dwarakanath
Medical Director
Executive Summary

In December 2016, 37 of our foundation year 1 trainees were the first group to move over to the new 2016 contract. From August 2017, it is anticipated that the number of trainees working under the new terms and conditions of service will grow as a result of the national implementation timeline and the issuing of new contracts.

The Trust continues to make good progress in preparation and there are on-going efforts to improve engagement with exception reporting, with both trainees and supervisors. However, the concept is new and will take time to embed.

A total of 7 exception reports have been received which is a relatively low number in comparison to other organisations. This may be due to good planning by the Trust or symptomatic of trainees’ uncertainty around exception reporting. It is important that any stigma relating to the process is avoided and our trainees feel safe to highlight concerns.

Not all supervisors understand their role relating to work schedules and exception reporting. Arrangements have been made to attend educational leads meetings and directorate meetings to raise awareness.

The Junior Doctor Forum is proving to be a good way of obtaining feedback from our junior medical workforce. It is hoped that they feel empowered over their working arrangements and listened to. The current issues concerning our junior doctors include; late finishes due to handovers and ward rounds, management and continuity of certain rotas, and sickness absence. Targeted work to address these concerns is on-going.

To support the Trust in ensuring safe working practices the first guardian update recommended further investment in electronic rostering, and software to manage additional duties and locum duties. Rota gaps and vacancy reporting were highlighted as areas requiring improvement.

Continued efforts to engage both supervisors and trainees in exception reporting and the personalisation of work schedules is added to these recommendations, to help create a positive open culture around highlighting concerns relating to training and working practices.

Overall there have been no significant exceptions resulting in any fines and there are no major concerns relating to safe working hours at present. Some areas where changes are needed have been highlighted and there is on-going work to facilitate this. As we enter the new contract it is clear that new systems of information gathering and workforce deployment are needed which may require further investment.

The board are asked to note this report for information and assurance.

Mr Pud Bhaskar

Guardian of Safe Working Hours

Update for quarter 4: January to March 2017
North Tees and Hartlepool NHS Foundation Trust

Responsible Officer’s update on Medical Appraisal and Revalidation

1 April 2016 – 31 March 2017

Report of the Medical Director

1. Executive Summary

This paper provides the Board with an update of the work that has been undertaken by the Trust in relation to medical appraisal and revalidation in the past 12 months along with the plans for the forthcoming 12 month period.

This year a quality assurance audit has been undertaken against NHS England criteria for medical appraisal. The results of the audit have highlighted issues to be addressed and have led to a decrease in the compliance rate.

Work continues to ensure all 2016/17 medical appraisals comply with NHS England requirements, as well as implementing the changes necessary to take the Trust forward to achieving a fit for purpose, quality assured medical appraisal and revalidation system.

2. Purpose of this Paper

Provider organisations have a statutory duty to support their Responsible Officer (RO) in discharging their duties under the Responsible Officer Regulations and it is expected that provider Boards will oversee compliance by receiving information on a regular basis as well as an end of year update report and action plan regarding issues and the way forward.

The Report of the Medical Director to the Board is a requirement of the ‘Framework of Quality Assurance for Responsible Officers and Revalidation’ (NHS England). This report will provide statistical information on medical appraisal and revalidation for the period 1 April 2016 to 31 March 2017 and a Quality Improvement Plan (QIP) of issues highlighted.

Updates on progress regarding medical appraisal and revalidation development plans will be included in the quarterly HR and Education Board Report as well as the Non Executive Directors Report.

3. Background

Medical revalidation is a legal requirement which applies to all licenced doctors listed on the GMC register in both the public and independent sectors. The purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

The RO for North Tees and Hartlepool NHS Foundation Trust is the Medical Director, who is supported in this role by a Deputy RO a Revalidation Manager and Revalidation Officer.

Revalidation recommendations are usually required every 5 years and the process by which the information is collected to make this recommendation is via an annual medical appraisal.

As we start the second five year cycle of revalidation the focus has shifted from ensuring effective processes were in place in the first cycle, to one of quality assurance in the second.
4. Governance Arrangements

Revalidation started in 2012 so this year will be the second cycle for those Doctors who registered in that year, there is a need for ROs to be able to provide assurance to patients and the public that appropriate systems and processes are in place to ensure that every licences medical practitioner connected to the Trust as their Designated Body (DB) is safe to practice.

An audit of all medical appraisal forms received by 31 March 2017 was carried out against NHS England criteria. Whereas 95% of appraisal forms were received from medical staff for the period 1 April 2016 – 31 March 2017, when they were audited against the expected criteria not all the forms met the requirements, which is why the overall Appraisal and Performance data submitted to NHS England (AOA report) has dropped to 80%.

Although this is figure is less than previous, it was not unexpected and plans are in place to address the issues raised by the audit.

Regular quarterly meetings with the GMC Employer Liaison Advisor continue to take place to share information about under-performing doctors.

5. Medical Appraisal

a. Appraisal and Revalidation submitted Performance Data 2016/17

<table>
<thead>
<tr>
<th></th>
<th>1B</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers on GMC connect (31.3.17)</td>
<td>Completed appraisal</td>
<td>Approved incomplete or missed appraisal</td>
<td>Unapproved incomplete or missed appraisal</td>
</tr>
<tr>
<td>Consultants</td>
<td>186</td>
<td>167</td>
<td>12</td>
</tr>
<tr>
<td>Staff Grade, Associate Specialists and Speciality doctors</td>
<td>35</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Temporary / short term locums</td>
<td>55</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>280</td>
<td>225</td>
<td>40</td>
</tr>
</tbody>
</table>

A comparison of the compliance levels submitted for 2015/16 with those submitted for 2016/16 is shown in Appendix A.

As a result in the drop of overall compliance, the Trust will be required to provide quarterly reports to NHS England on actual progress against expected progress.

b. Quality Assurance

As the number of completed medical appraisal forms returned to the Education Department last year was high, it was agreed that the focus should move to the quality of information submitted. It is essential that the information discussed is robust enough for a revalidation recommendation to be made.
A quality assurance audit, using the official AOA flowchart (Appendix B) as the framework for compliance was undertaken. Appendix C shows the results of the audit when completed forms were initially submitted.

The reasons for the recording of a 2 (approved missed/incomplete appraisal) or a 3 (unapproved incomplete/missed appraisal) are shown in Appendix D.

c. Appraisers

There are currently 57 medical appraisers (this figure excludes CDs) of which 27 (47%) are up-to-date with attendance at an annual update session.

A major focus for 2017/18 will be to look at the consistency in quality for the medical appraisers, and to ensure that they are supported with appropriate updates, communication and training sessions, and that recruitment and selection is transparent.

After each appraisal the doctor is asked to complete a Bristol on Line feedback questionnaire about their experience. This collated information will be forwarded to the appraiser on an annual basis, for them to reflect on.

Feedback to both the doctor and the appraiser will be provided as and when appraisal forms are received by the Revalidation Team for 2017/18.

Fifteen appraisers attended a face to face feedback session with the Revalidation Team during 2016/17.

Analysis showed that there is disparity within directorates regarding the number of appraisals the appraisers are undertaking, which will be addressed during 2017/18.

d. Access, Security and Confidentiality

The Appraisal policy (HR 64), which is currently under review, will confirm that only the RO, Deputy RO, Quality Lead and Quality Officer have access to appraisal documentation in the Trust.

e. Clinical Governance

The audit highlighted that not all doctors submitted a clinical governance form at their appraisal outlining the required clinical governance information (involvement in a serious incident or complaint). An additional question has been added onto the April 2017 medical appraisal forms asking the appraiser to find out why this information has not been supplied e.g. lack of knowledge of the process, information not provided by the directorate etc.

A MPIT (Medical Practice Information Transfer) form was introduced as part of the recruitment process for medical staff in 2015 to highlight any concern a previous RO had regarding a doctor about to start work in the Trust, as well as confirming when their last medical appraisal took place. During 2016/17 the Trust saw 44 new medical staff start work, with 13 MPIT forms being forwarded to the Revalidation Team.

6. Progress and achievements during 2016/17

6.1 Development of a shortened revalidation ready appraisal form, that focussed on discussion, reflection and learning

6.2 There are 2 version of the appraisal form for April 2017. The enhanced form is for doctors who are also either a recognised trainer and/or a medical appraiser. The basic form
is for all other doctors (and contains the section required for a revalidation ready appraisal as well as a check on the Trust mandatory training requirements.

6.3 Full quality assurance audit has been undertaken against NHS England requirements which has highlighted areas which need addressing

6.4 Development of a Full Scope of Practice form to ensure all work outside of the Trust is discussed in the medical appraisal

6.5 Development, in conjunction with the Trust Doctor Tutor, of a portfolio for trust doctors to assist them in collecting the necessary supporting information for their appraisal

6.6 Quality Team attend each Trust induction to speak to new doctors about the requirements for medical appraisal and revalidation in the Trust (as well as recognition of trainers and the educational governance process)

6.7 A process has been developed to ensure that final checks take place with HR, the relevant Clinical Director and Medical Director prior to a revalidation recommendation being made

6.8 An ‘induction’ appraisal will be required if the doctor does not have a previous PDP (as per NHS England recommendation) as it is a requirement that every doctor has an agreed PDP to discuss at their appraisal meeting.

6.9 A robust process has been developed for the recruitment, selection and quality assurance of new medical appraisers

6.10 Allocated face to face feedback with the revalidation team

6.11 A Faculty Development RAG report has been developed with the ‘colours’ aligned to medical appraisal requirements in that an appraisal due will become ‘amber’ at month 9 and ‘red’ at month 12

7. Revalidation Recommendations
Fifteen positive revalidation recommendations were made in the period 1 April 2016 to 31 March 2017, plus 1 request to defer (due to long term sick leave). One positive recommendation is on hold as the doctor is part of a GMC investigation (Appendix C).

8. Recruitment and Engagement Background Checks
An audit of recruitment and engagement background checks is attached in Appendix E.

9. Monitoring Performance
An audit of concerns about a doctor’s practice is attached in Appendix F

10. Risks and Issues highlighted and actions implemented

10.1. Decision Making Group
Recommended by NHS England to support the appraisal process by ensuring no single person is responsible for appraisal or revalidation decisions.
Action: First meeting is due to take place in June 2017, then quarterly
10.2. Escalation process for non-engagement with the appraisal process

It has been highlighted this year that there is no agreed process for those doctors who are not engaging with medical appraisal

**Action:** To be included in the revised Medical Revalidation policy (HR64) currently being reviewed

10.3. Fixed appraisal month

It is recommended by NHS England that each doctor has an agreed fixed month for their annual appraisal, which the doctor will work towards each year

**Action:** A fixed appraisal month is to be introduced during the 2017/18 appraisal year to mitigate against a doctor not being offered an appraisal whilst employed by the Trust

10.4 Supporting structure for medical appraisal and revalidation

The Quality Team have received verbal feedback from Doctors that they were unaware of who to contact regarding the medical appraisal and revalidation process

**Action:** The administrative support for medical appraisal and revalidation will be reviewed and the communication process strengthened

**Action:** Consideration needs to be given to the amount of work that needs to be undertaken to provide full support and development to these processes

10.5. Person identifiable data used in appraisal documentation

This is a risk to the doctor as it is known that previously solicitors have requested access to a doctor’s appraisal documentation in relation to a complaint.

**Action:** The focus is for the appraisers to assure the RO that they have seen the relevant information, and that no evidence should be uploaded and attached to the appraisal documentation.

10.6. Calibration of appraisals

There is no forum currently for appraisers to calibrate their decisions, the risk to the Trust is that the process may seem to be unfairly administered

**Action:** To develop a robust programme of support for medical appraisers including the opportunity to discuss cases

10.7. Drop in compliance levels in the AOA

There has been a decrease in the reported compliance for medical appraisals to NHS England via the AOA (Annual Organisational Audit) report for 2016/17. The statistics submitted for 2016/17 were in line with the expected NHS England required inputs and outputs, whereas previous year’s reported the number of appraisals undertaken.

**Action:** A robust plan has been developed to ensure that doctors and appraisers are completely up-to-date and supported in this requirement. However, the implementation will require some additional administrative input.

11. Board Reflections

Consideration needs to be given to Sir Keith Pearson’s review of medical revalidation ‘Taking revalidation forward. Improving the process of relicensing for doctors’ January 2017.

The main points of the report for Trusts are:

- More patient involvement
- Board report on the learning outcomes from revalidation and how local processes are developing

- The revalidation process should not be used to achieve local objectives that are not part of the requirement specified by the GMC

- Healthcare organisations should continue to work to drive up the quality and consistency of appraisal, learning from feedback and acknowledged good practice and ensure that time set aside for appraisal adequately reflects its importance to revalidation outcomes

- Healthcare organisations should explore ways to make it easier for doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support

- GMC to work with others to address weaknesses in information sharing in respect of doctors who move between designated bodies

- DoH in consultation with the GMC to review the RO regulations with a view to establishing a prescribed connection to a DB for all doctors who need a license to practise in the UK. They should also review the criteria for prescribed connections for locums on short term placements.

Consideration of how and when to take these recommendations forward will be discussed at the Decision Making Group.

12. Corrective Actions, Improvement Plan and Next Steps

The next 12 months

12.1 To work toward achieving the ‘gold’ standard for completion of a revalidation ready annual appraisal. This will include agreeing a ‘fixed’ appraisal month for each doctor connected to the Trust as their DB, timely communication about the process and the forms to use as well as the ability to monitor whether the appraisal paperwork has been completed and forwarded to the team within 28 days of the appraisal meeting taking place

12.2 To align Trust processes to the requirements for medical appraisal. The current default systems of an appraisal being ‘due’ 12 months from the doctor’s start date, is no longer fit for purpose, particularly for 12 month contract doctors who are due their appraisal as they leave the Trust

12.3 Discuss and agree a fixed appraisal date for each doctor attached to the Trust as their DB

12.4 To provide timely feedback to each doctor and appraiser if the appraisal forms are not appropriately completed

12.5 Introduction of quality assurance questions on the appraisal forms to find out how easy it is for the doctor to obtain the relevant clinical governance information from their directorate

12.6 To revise the current appraisal and revalidation systems for medical staff to ensure that they are fit-for-purpose and align to NHS England and GMC requirements.

12.7 To ensure that the Faculty Development RAG report is accessible to medical staff so that they can view their training requirements for their appraiser / educational / trainer roles
13. Conclusion

As we start the second cycle of revalidation it has been appropriate to undertake a review of the quality of the appraisal and revalidation systems and processes, even though this means a decrease in compliance rates, it has provided a baseline from which future improvements can be measured.

The audit has highlighted a number of issues that need addressing in order to provide a robust quality assured system of medical appraisal and revalidation.

In order to carry out the amount of work that needs to be undertaken, it is recommended that there is a full review of the administrative support for the medical revalidation and appraisal processes. Alongside this a small budget of £1,000 is required this year in order to take the patient involvement agenda forward, with promotion of the essential involvement of patients in medical appraisal and revalidation with the production of promotional material eg: posters for patient waiting areas and patient information leaflets.

14. Recommendations

The Board are asked to confirm their continued support of this activity, and to consider the resources requested in order to take the issues highlighted forward.

It is requested that if the Board accept this report, that the Chief Executive approves the attached Statement of Compliance confirming that the organisation as a Designated Body is in compliance with the regulations. This document will be shared with the higher level Responsible Officer.

Dr Deepak Dwarakanath
Medical Director / Responsible Officer
30 June 2017
### Number of doctors with prescribed connection to North Tees and Hartlepool NHS Foundation Trust who had a completed appraisal

<table>
<thead>
<tr>
<th>Category</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>167</td>
<td>152</td>
</tr>
<tr>
<td>Staff Grade, Assoc Specialist and Specialty Doctors</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>Temporary / short term locums</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Total number of doctors who had a completed appraisal**: 225 | 219

### Approved missed appraisals

<table>
<thead>
<tr>
<th>Category</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Staff Grade, Associate Specialist and Specialty Doctors</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Temporary / short term locums</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Total number of doctors who had an approved, missed appraisal**: 40 | 2

### Unapproved missed appraisals

<table>
<thead>
<tr>
<th>Category</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Staff Grade, Assoc Specialist and Specialty Doctors</td>
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<td>2</td>
</tr>
<tr>
<td>Temporary / short term locums</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Total number of doctors who had an unapproved, missed appraisal**: 15 | 2

**Total number of doctors**: 280 | 222
Quality Assurance Audit on 2016/2017 medical appraisal documents

An audit of completed medical appraisal forms was undertaken, using the official framework below in preparation for the submission of the Annual Organisational Audit (AOA) return.

Official AOA guidance flowchart

Did the doctor have an appraisal meeting between 1 April 2016 and 31 March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with a previous organisation)

Was the reason for missing the appraisal agreed by the RO in advance?

Was this in the 3 months preceding the appraisal due date AND Was the appraisal summary signed off within 28 days of the appraisal date AND Did the entire process occur between 1 April 2016 and 31 March 2017?

Yes to all 3 statements

No to any of the 3 statements

Don’t know

Yes

No

Unapproved incomplete or missed appraisal

Approved incomplete or missed appraisal

Completed Appraisal

Completed Appraisal

Completed Appraisal
Appendix C

Audit of completed appraisal forms (initially submitted)

255 were quality assured for completion, the results were:

Positives

➢ Full scope of work was described by all doctors

Needs Attention

➢ 51 doctors (20%) submitted incomplete paperwork
  ➢ 25 forms (10%) were submitted without being appropriately signed (either the declaration or appraisal outputs)
  ➢ 3 Forms were submitted without any input from the appraiser
  ➢ 14 doctors did not discuss CPD
  ➢ 9 doctors who declared they worked outside of the Trust didn’t make it clear whether private practice forms were submitted/discussed
  ➢ The majority listed Quality Improvement activity they had attended or been involved in, but the number who provided a reflection on what they had learnt was low
  ➢ There are still a number doctors who cannot access clinical governance information regarding involvement in incidents or complaints
  ➢ Ensuring all appraisals take place within the appraisal year and the paperwork is submitted within the expected timescale.
    ➢ 13 appraisals took place after 1 April 2017
    ➢ 20 doctors did not forward their paperwork in a timely manner
  ➢ 5 doctors employed on zero hours contracts & connected to the Trust as their DB were not offered an appraisal opportunity
  ➢ The current process of the next appraisal being due 12 months after the last, means that more doctors are now due an appraisal in the last 2 months of the appraisal year.
    ➢ February - 28
    ➢ March - 47
    ➢ April and beyond – 22

A current total of 97 doctors (35%) will be due their annual appraisal in the last 2 months of the appraisal year
Appendix D

Audit of all missed or incomplete appraisals

<table>
<thead>
<tr>
<th>Doctor factors (total)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity leave during the majority of the ‘appraisal due window’</td>
<td></td>
</tr>
<tr>
<td>Sickness absence during the majority of the ‘appraisal due window’</td>
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</tr>
<tr>
<td>Prolonged leave during the majority of the ‘appraisal due window’</td>
<td>2</td>
</tr>
<tr>
<td>Suspension during the majority of the ‘appraisal due window’</td>
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</tr>
<tr>
<td>New starter within 3 month of appraisal due date</td>
<td>9</td>
</tr>
<tr>
<td>New starter more than 3 months from appraisal due date</td>
<td>15</td>
</tr>
<tr>
<td>Postponed due to incomplete portfolio/insufficient supporting information</td>
<td></td>
</tr>
<tr>
<td>Appraisal outputs not signed off by doctor within 28 days</td>
<td></td>
</tr>
<tr>
<td>Lack of time of doctor</td>
<td>15</td>
</tr>
<tr>
<td>Lack of engagement of doctor</td>
<td></td>
</tr>
<tr>
<td>Other doctor factors</td>
<td>4</td>
</tr>
<tr>
<td>4 x locum F1 posts, but will go through an ARCP in June 17</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appraiser factors</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned absence of appraiser</td>
<td>1</td>
</tr>
<tr>
<td>Appraisal outputs not signed off by appraiser within 28 days</td>
<td></td>
</tr>
<tr>
<td>Lack of time of appraiser</td>
<td></td>
</tr>
<tr>
<td>Other appraiser factors (describe)</td>
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</tr>
<tr>
<td>(describe)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisational factors</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Administration or management factors</td>
<td>3</td>
</tr>
<tr>
<td>Failure of electronic information systems</td>
<td></td>
</tr>
<tr>
<td>Insufficient numbers of trained appraisers</td>
<td></td>
</tr>
<tr>
<td>Other organisational factors (describe) No MPIT received</td>
<td>2</td>
</tr>
</tbody>
</table>
## Appendix E

Number of doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors) – information obtained from ESR

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent employed doctors</td>
<td>16</td>
</tr>
<tr>
<td>Temporary employed doctors</td>
<td>33</td>
</tr>
<tr>
<td>Locums brought in to the designated body through a locum agency</td>
<td></td>
</tr>
<tr>
<td>Locums brought in to the designated body through ‘staff bank’ arrangements</td>
<td>23</td>
</tr>
<tr>
<td>Doctors on Performers list</td>
<td>0</td>
</tr>
<tr>
<td>Other (this includes independent contractors, doctors with practising privileges etc.)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
</tr>
</tbody>
</table>

**Number of doctors the Quality Team was informed about (via new starters list)**: 45

For how many of these doctors was the following information available within 1 month of the doctor’s starting date (numbers)

<table>
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<th>Category</th>
<th>Count</th>
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<tr>
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</tr>
<tr>
<td>Temporary employed doctors</td>
<td></td>
</tr>
<tr>
<td>Locums brought in to the DB through a locum agency</td>
<td></td>
</tr>
<tr>
<td>Locums brought in to the DB through ‘staff bank’ arrangements</td>
<td></td>
</tr>
<tr>
<td>Doctors on Performers List</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
</tr>
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<th>Temporary employed doctors</th>
<th>Locums brought in to the DB through a locum agency</th>
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<th>Other</th>
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<td>33</td>
<td>23</td>
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<td>Unresolved performance issues</td>
<td></td>
<td></td>
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| Total                                                                      | 72                           | 37                         | 69                                                 | 70                                                            | 33                         | 51    |
|                                                                           |                              |                            |                                                    |                                                               |                            | 49    |
### Audit of concerns about a doctor’s practice

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</thead>
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<tr>
<td>Conduct concerns (as the primary category) in the last 12 months</td>
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</tr>
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North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

27 July 2017

Executive Summary

Nursing and Midwifery Revalidation

Report of the Director of Nursing, Patient Safety and Quality

Strategic Objective (The full set of Trust Aims can be found at the beginning of the Board Reports): Putting Patients First/Patient Safety

1 Introduction

1.1 This report aims to describe progress made in relation to the revalidation process for Nurses and Midwives introduced April 2016. This process builds upon existing renewal requirements in order to demonstrate that the registrant has the continued ability to practice safely and effectively.

1.2 In order to revalidate the registrant must demonstrate they have achieved 450 practice hours, evidence of 35 hours Continuous Professional Development (CPD), completed 5 pieces of written reflective accounts and five records of feedback.

2 Preparation of Staff

2.1 To date the Head of Nursing Education and Placements and the Senior Nurse for Practice Placements have delivered Revalidation Updates bimonthly:

2.2 The NMC Revalidation newsletter is cascaded to all areas.

3 Monitoring Compliance

3.1 A Trust database is held with details of 1589 registrants, to date 908 have confirmed revalidation by the NMC, 181 are due to revalidate in the next 100 days. The remainder are due to revalidate by the end of March 2019.

3.2 The overall standard of evidence for portfolios has been very high, often exceeding requirements

4 Recommendation

The Board are asked to note the content of the report and the processes in place to ensure a robust system for support for Nursing and Midwifery Revalidation within the Trust.

Julie Lane
Director of Nursing, Patient Safety and Quality
North Tees & Hartlepool NHS Foundation Trust
North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

27 July 2017

Nursing and Midwifery Revalidation

Report of the Director of Nursing, Patient Safety and Quality

1 Introduction

1.1 From April 2016 all Registered Nurses and Midwives are required to renew their registration with the Nursing and Midwifery Council each year and are required to revalidate every three years. The revalidation process requires the registrant to demonstrate continued ability to practice safely and effectively and produce evidence of current practice.

1.2 The NMC (2015) advise that revalidation is the responsibility of the registrant and that it is the role of employers to provide support for registrants who wish to revalidate. Preparation of staff for the revalidation process commenced early 2015. The Head of Nursing Education and Placements and the Senior Nurse for Practice Placements are identified as the operational leads for revalidation within the Trust on behalf of the Director of Nursing, Patient Safety and Quality.

1.3 In order to revalidate the registrant must demonstrate that in the preceding three years they have achieved 450 practice hours within the scope of their role, evidence of 35 hours of Continuous Professional Development (CPD) completed 5 pieces of written reflective accounts and evidence of five records of feedback on their performance. They must also undertake a reflective discussion with another registrant and gain confirmation of the evidence collected.

2 Preparation of staff

2.1 Preparation of staff has continued since the last report, and continues to be included in the bimonthly Mentor Preparation Workshops. Since the last reporting period 330 registrants have received revalidation briefings. Although attendance to the bespoke briefings has reduced as registrants have become more familiar with the process, briefings are delivered and planned throughout the year. The previously developed Practice Passport which enables registrants to record Continuous Professional Development (CPD) has been reissued to each registrant.

2.2 The Revalidation newsletter produced by the NMC is cascaded to all areas on receipt.

2.3 Individual queries are dealt with as they arise and the Head of Nursing Education and Placements and the Senior Nurse for Practice Placements and have confirmed registration requirement as necessary. Due to the support provided registrants who had previously expressed an interest in retiring partly due to concern around revalidation, having received support to revalidate, have delayed retirement.
3 Monitoring compliance

3.1 A database has been established to monitor revalidation information. The database identifies the date each registrant is due to revalidate and staff are required to inform the Head of Nursing Education when confirmation of revalidation has been received.

3.2 To date there are 1589 registrants on the database and 908 are recorded as confirmed revalidation by the NMC, 181 registrants are due to revalidate in the next 100 days. Only one known case of inappropriate revalidation has occurred (recorded last year) and none are known to date.

3.3 Revalidation should lead to improved practice to the benefit of public protection. One of the main strengths of this process is to reinforce the values of the NMC Code of Conduct (2015) by integration into the evidence that registrants are required to provide. Revalidation ensures that our registered nurses and midwives undertake the prescribed hours of practice and professional development activities to maintain knowledge and skills required to maintain competencies that are required in their role. Collation of practice related feedback will help registrants to become more responsive to the needs of our patients, and reflective practice will help to identify changes or improvements required.

3.4 The majority of registrants have expressed positive experiences in the revalidation process and development of a professional portfolio: the overall standard of evidence for portfolios has been very high, often exceeding requirements.

3.5 To further support staff a Revalidation Policy has been developed and ratified since the last reporting period.

4 Recommendation

The Board are asked to note the content of the report and the processes in place to ensure a robust system for support for Nursing and Midwifery Revalidation within the organisation.

Julie Lane
Director of Nursing, Patient Safety and Quality
North Tees & Hartlepool NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
Meeting of the Board of Directors
27 July 2017
Seven Day Working: Progress Report
Report of the Chief Operating Officer/Deputy Chief Executive

Strategic Aim and Objective (the full set of Trust Aims can be found at the beginning of the Board of Directors Reports)

Maintain Compliance and Performance
Putting Patients First

1. Introduction

1.1 Considerable evidence has emerged in recent years linking poorer outcomes for patients admitted to hospital as an emergency and the reduced level of service provision at the weekend.

1.2 The delivery of seven day working has escalated on the political and patient safety agenda mandating that four of the ten clinical standards must be implemented by 2020. This priority has been reinforced in the ‘Single Oversight Framework (September 2016), and also within the ‘Delivering the Forward View NHS planning guidance 2016/17-2020/21’ and the ‘NHS Operational Planning and Contracting Guidance 2017-2019’.

1.3 In March 2016 a National Survey was conducted to benchmark compliance against the four priority standards. Although the analysis report has not been validated and the data should be treated with caution, it gives a good indication of the Trusts performance. The survey was repeated in September 2016 and March 2017 and will be replicated again in September 2017.

2. Summary

2.1 The results of the March 2017 survey have not yet been published so this report will provide the Board of Directors with an overview of the results of the September 2016 national benchmarking survey for the priority clinical standards, progress to date in the other six standards and next steps in the project.

2.2 National benchmarking information and comparisons to previous survey results are provided for the four priority clinical standards:

- First consultant review
- Access to diagnostics
- Access to consultant directed interventions
- On-going review

2.3 Progress against the other six clinical standards is detailed:

- Patient experience
- Multi-disciplinary team review
- Shift handover
• Access to mental health
• Transfer to community, primary and social care
• Quality improvement

2.4 Next steps in the project are detailed for each clinical standard to progress towards full compliance.

3. **Summary and Recommendations**

3.1 All ten standards are being addressed by the Seven Day Working Group, supported by a Clinical Change Lead in Transformation, and significant work is on-going to address gaps in services. Progress has been made in the implementation of the standards however it is recognised that a significant amount of work is still to be undertaken, to support measurement, audit and delivery in practice.

3.2 Focus has concentrated on the four priority standards, 2, 5, 6 and 8, as directed by NHS Improvement.

3.3 The Trust has taken part in three national benchmarking surveys and will continue to contribute to future surveys.

3.4 The Board of Directors is asked to note the contents of the report and to acknowledge the work being undertaken to progress and meet the ten clinical standards for seven day working and take assurance that the Trust is on track to deliver the four mandated clinical standards by 2020.

Julie Gillon       Deepak Dwarakanath
Chief Operating Officer / Deputy Chief Executive    Medical Director
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Seven Day Working: Progress Report

Report of the Chief Operating Officer/Deputy Chief Executive Introduction

1 Introduction

1.1 Everyone Counts: Planning for Patients 2013/14 signalled that the NHS will move towards routine services being available seven days a week – a development which is essential to delivering a much more patient-focused service and one which offers the opportunity to improve clinical outcomes.

1.2 Considerable evidence has emerged in recent years linking poorer outcomes for patients admitted to hospital as an emergency and the reduced level of service provision at the weekend. A ‘NHS Services, Seven Days a Week Forum’ was established in February 2013, chaired by Sir Bruce Keogh, and developed a set of clinical standards, in December 2013. The Trust has an established Seven Day Working Group, co-chaired by the Clinical Director of Emergency Care and the Associate Director of Operations (Anaesthetic and Emergency Care Services), supported by a Clinical Change Lead in Transformation, with a membership of senior managers and clinicians, to deliver the clinical standards.

1.3 Standards 2, 5, 6 and 8 were suggested to have the most impact on reducing weekend mortality and, in February 2016, the supporting information for standards 2, 5 and 8 was revised.

1.4 In March 2016 a National Survey was conducted to benchmark compliance against the four priority standards. Although the analysis report has not been validated and the data should be treated with caution, it gives a good indication of the Trust’s performance. The survey was repeated in September 2016 and March 2017 and will be replicated again in September 2017.

1.5 The delivery of seven day working has escalated on the political and patient safety agenda. In May 2016 NHS Improvement informed NHS Trust and Foundation Trust Chief Executives and Medical Directors that, backed by the Academy of Medical Royal Colleges (AoMRC), the implementation of clinical standards 2, 5, 6 and 8 had been prioritised as a ‘must do’ for all hospitals by 2020. This priority has been reinforced in the ‘Single Oversight Framework (September 2016), and also within the ‘Delivering the Forward View NHS planning guidance 2016/17-2020/21’ and the ‘NHS Operational Planning and Contracting Guidance 2017-2019’.

1.6 The results of the March 2017 survey have not yet been published so this report will provide the Board of Directors with an overview of the results of the September 2016 national benchmarking survey for the priority clinical standards, progress to date in the other six standards and next steps in the project.

2 National Mandate

2.1 The Executive Medical Director of NHS Improvement wrote to NHS Trust and Foundation Trust Chief Executives and Medical Directors to set out the expectations around implementing seven day services, in particular in light of on-going planning...
work and their roles in the development of Sustainability and Transformation Plans (STPs).

2.2 She informed them that the clinical standards are supported by the AoMRC and that four have been prioritised as a ‘must do’ for all hospitals by 2020 to ensure:
- Patients wait no longer than 14 hours to initial consultant review
- Patients get access to diagnostic tests with a 24 hour turnaround time. For urgent requests, this drops to 12 hours and for critical patients, one hour
- Patients get access to specialist, consultant-directed interventions
- Patients with high-dependency care needs receive twice-daily specialist consultant review and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

2.3 The remaining six standards, which include standards relating to patient experience, shift handovers, transfers out of hospital care and quality improvement, will support improving quality of care every day of the week.

2.4 The Single Oversight Framework includes the delivery of the four priority standards within the theme ‘Quality of care (safe, effective, caring, responsive)’.

2.5 To help create the safest, highest quality health and care service and reduce avoidable deaths, one of the overall 2020 goals of ‘Delivering the Forward View NHS planning guidance 2016/17-2020/21’ is to roll out seven-day services in hospitals to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week.

2.6 The NHS Operational Planning and Contracting Guidance 2017-2019 includes seven day services in its ‘must dos’ for urgent and emergency care stating that by November 2017 the four priority standards must be met for all urgent network specialist services (vascular surgery, stroke, major trauma, STEMI heart attack and children’s critical care).

3 Priority Standards

3.1 Standards 2, 5, 6 and 8 are suggested to have the most impact on reducing weekend mortality:

3.2 In September 2016 the Trust participated in a national survey to review progress against the four priority clinical standards. 145 sets of case notes of emergency admissions, for one week, were reviewed by clinicians and the survey proforma completed and submitted for analysis and benchmarking. The survey was repeated in May 2017 and the Trust awaits publication of the benchmarked report.

3.3 Standard 2 – First Consultant Review

3.3.1 All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.

3.3.2 Since the implementation of TrakCare, data retrieval has been a significant challenge. A questionnaire has been developed and is being refined to deliver the required information. Indications show that the compliance to completing the fields correctly in TrakCare is low for all but emergency care.

3.3.3 The Trust was within the upper quartile for being seen within 14 hours of arrival to hospital, a significant improvement on the previous survey results. This was above the national and regional percentage, as illustrated in chart 1.
3.3.4 The Trust was within the upper quartile for being seen within 14 hours of admission to hospital, a significant improvement on the previous survey results. This was above the national and regional percentage, as illustrated in chart 2.

Chart 2 – Percentage of patients seen and assessed by a suitable consultant within 14 hours of admission to hospital.

3.3.5 Next Steps

3.3.5.1 The TrakCare performance report is generated weekly and circulated to General Managers (GM) and Clinical Directors (CD) to inform discussions and changes in practice and a dashboard is being developed.

3.3.5.2 Education is being provided for consultants on accurately entering the required information on TrakCare.
3.4 Standard 5 – Diagnostics

3.4.1 Hospital inpatients must have scheduled seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography (ECG), endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

3.4.2 The national survey explored consultant perception of availability of diagnostics at weekends. It consisted of a small sample of consultants admitting emergency patients, regardless of speciality and type of diagnostics they would require.

3.4.3 Although not all diagnostics are provided on site there are formal arrangements for access to all services 7 days a week.

3.4.4 Local data informs that, in January and February 2017, 56.3% of scans were reported within 1 hour and 94.3% within 12 hours. In the first week of May, scans referred from A&E, EAU and Ambulatory Care, this had increased to 62.5% within 1 hour, 96.2% within 12 hours and 99.3% within 24 hours. It must be noted that there have been issues regarding the ‘critical’ referrals so included in the figures are scans that were vetted and deemed as ‘non critical’.

3.4.5 Next Steps

3.4.5.1 The critical access has now been activated electronically however requests are vetted to avoid inappropriate use.

3.4.5.2 A more detailed analysis will be performed on the ‘model ward’, in line with Lord Carter’s ‘model hospital’

3.5 Standard 6 – Consultant Directed Interventions

3.5.1 Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as:
- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery

3.5.2 All patients have 24 hour access, 7 days a week for consultant directed interventions with the exception of interventional radiology, which is being reviewed within the Better Health Programme/Sustainability and Transformation Plan (BHP/STP) negotiations. Services not available on site are accessed by alternative providers by formal, protocol led agreements.

3.6 Standard 8 – On-going Review

3.6.1 A All patients on the Acute Medical Unit (AMU/EAU), Acute Surgical Unit (ASU/SDU) and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate)

B Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant delivered ward round at least ONCE
EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

3.6.3 The Trust is within the upper quartile for the percentage of patients in high dependency areas seen and reviewed by a consultant twice daily at 100% 7 days a week, as illustrated in chart 6. This is a significant improvement from March 2016 where compliance was at 92% on a weekday and 90% on a weekend.

3.6.4 The percentage of patients reviewed as part of a consultant delivered ward round at least once every 24 hours following a transfer from an acute area of the hospital to a general ward is within the upper quartile on weekdays and weekends at 98% and 97% respectively (chart 7). This is a significant improvement on March 2016 performance where compliance was 90% on weekdays and 92% on weekends.

Chart 3 – Percentage of patients in high dependency areas seen and reviewed by a consultant twice daily.

Chart 4 – Percentage of patients reviewed as part of a consultant delivered ward round at least once every 24 hours following a transfer from an acute area of the hospital to a general ward.

4 The Other Six Standards

4.1 By 2020 the Trust must have made progress on clinical standards 1, 3, 4, 7, 9 and 10

4.2 Standard 1 – Patient Experience

4.2.1 Patients, and where appropriate, families and carers must be actively involved in shared decision making and, supported by clear information from health and social
care professionals, to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

4.2.3 It is suggested that real time feedback is collected and week day and weekend admissions data is compared. The Trusts Family and Friends Test (FFT) has been adapted to segregate weekday admissions from Saturday and Sunday. Chart 5 indicates a slight difference in satisfaction in April 2017 showing a more positive experience at weekends.

4.2.4 Although the FFT is not an absolute reflection of the standard, a previous audit has shown good compliance to involvement of patients, families and carers in decision making, supported by information, to make informed choices.

Chart 5 – Weekend/weekday admission FFT at April 2017

![Weekday/Weekend % positive & % negative scores April 2017](chart)

4.2.4 Next Steps

4.2.4.1 Links between national data and local data is currently being explored, i.e. Staff, Patient Experience Quality Standards (SPEQS), local quality measures for the Trust and other performance measures that involve the patient experience to understand the correlation and interventions required to improve the overall outcomes.

4.2.4.2 Local audits are to be performed to identify compliance to patient, family and carer involvement.

4.3 Standard 3 – Multi-disciplinary Team (MDT) review

4.3.1 All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

4.3.2 To provide a full MDT (consisting of a minimum of nursing, medicine, pharmacy, physiotherapy and, for medical patients, occupational therapy, unless deemed unnecessary by the responsible consultant) within 14 hours of admission is a challenge for the Trust. To provide a consistent team including therapists and pharmacy support would require significant investment however changes in practice have provided partial compliance.
4.3.3 Daily huddles continue to take place in all inpatient areas which include nursing, medical and therapy staff, and a social worker. Compliance at weekends is improving and the introduction of a second daily weekday huddle, later in the day, to focus on discharges, has been introduced. This process enables the teams to assess each patient, confirm the estimated discharge date and develop an integrated management plan.

4.3.4 Physiotherapy provision is available and provided on a formal on call basis. Nurses are able to provide basic therapy as prescribed in the treatment plans.

4.3.5 On admission to hospital, transfer to another ward or department and on discharge, an up-to-date and accurate medication list needs to be obtained and compared to the most recently available information and any discrepancies, changes, deletions and additions must be documented. Although a basic medicines reconciliation is performed by a nurse on admission and more detailed by the clerking doctor or nurse practitioner, NICE guidance recommends that pharmacists should be involved in the process as soon as possible after admission. To provide complete medicines reconciliation within 24 hours of admission would require additional pharmaceutical support on a weekend.

4.3.6 Pharmacy have developed a project plan for medicines reconciliation however, to provide a seven day service, investment would be required.

4.3.7 Next Steps

4.3.7.1 A deep dive will be undertaken in the ‘model ward’ project, in line with Lord Carter’s ‘model hospital’, supported by audit and compliance indicators.

4.3.7.2 Formal consultation on seven day physiotherapy support is underway to progress to delivery.

4.4 Standard 4 – Shift handovers

4.4.1 Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant incoming and outgoing shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

4.4.2 A handover policy has been developed, utilising the SBAR tool, and is awaiting ratification. A video has been produced to support training.

4.4.3 Next steps

4.4.3.1 A training programme will commence on ratification of the policy.

4.4.2.1 Deep dives into specialty areas will be performed, on a roll out basis, to ensure compliance.

4.5 Standard 7 – Mental Health

4.5.1 Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:
   • Within 1 hour for emergency* care needs
   • Within 14 hours for urgent** care needs

* An acute disturbance of mental state and/or behaviours which poses a significant, imminent risk to the patient or others.
4.5.2 The psychiatric liaison team, CRISIS and CAMHS team are available 24 hours a day, 7 days a week.

4.5.3 An electronic solution has been developed in TrakCare and the psychiatric liaison team have been given access to record the time of their intervention.

4.5.4 A frail elderly liaison service is also available, linking to community services.

4.5.5 **Next Steps**

4.5.5.1 A report is being developed to provide the compliance information.

4.6 **Standard 9 – Transfer to community, primary and social care**

4.6.1 *Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken.*

4.6.2 All core services provided by the Trust are available seven days a week. Each pathway will be reviewed to support change in provision including stroke, respiratory, cardiac, frail elderly etc.

4.6.3 **Next Steps**

4.6.3.1 The A&E Delivery Board is directing the system wide approach to the delivery of services which will include the introduction of seven day services where appropriate.

4.7 **Standard 10 – Quality improvement**

4.7.1 *All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.*

4.7.2 All clinicians are involved in monitoring patient experience, patient safety and clinical effectiveness through service line management.

4.7.3 Heatmaps are being developed to identify where support and guidance may be required.

4.7.4 **Next Steps**

4.7.4.1 Staff surveys and appraisal and training compliance are being included in monitoring the delivery of quality improvement.

5 **Summary**

5.1 All ten standards are being addressed by the Seven Day Working Group, supported by a Clinical Change Lead in Transformation, and significant work is on-going to address gaps in services. Progress has been made in the implementation of the standards however it is recognised that a significant amount of work is still to be undertaken, to support measurement, audit and delivery in practice.
5.2 Focus has concentrated on the four priority standards, 2, 5, 6 and 8, as directed by NHS Improvement.

5.3 The Trust has taken part in three national benchmarking surveys and will continue to contribute to future surveys.

6 Recommendation

6.1 The Board of Directors is asked to note the contents of the report and to acknowledge the work being undertaken to progress and meet the ten clinical standards for seven day working and take assurance that the Trust is on track (evidence by benchmarking data) to deliver the four mandated clinical standards by 2020. (Urgent and Emergency Care 2017).

Julie Gillon
Chief Operating Officer / Deputy Chief Executive

Deepak Dwarakanath
Medical Director

July 2017
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Executive Summary

North Tees and Hartlepool NHS FT Charitable Funds Accounts 2016/17

Report of the Director of Finance

Strategic Aim (The full set of Trust Aims can be found at the beginning of the Board Reports)

Maintain Compliance and Performance

Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)

Finance

1. Introduction

1.1 The purpose of this report is to present the Trust’s audited Charitable Funds Accounts for the year ending 31 March 2017.

1.2 On 13 July 2017 the Charitable Funds Committee recommended that the Board of Directors approve the Charitable Funds Accounts.

2. Key Issues

2.1 The final accounts detail the full financial performance in 2016/17 and the main points to note are highlighted below:

- The net assets of the Charity have increased by £112k to £1,558k during the year;
- Income and expenditure have both increased from 2015/16 level, income £270k to £280k and expenditure £344k to £378k with the Charity reporting a deficit of £(98k). However, due to an unrealised gain on investment of £210k resulting from an increase in market value the net movement in year was £112k.
- The Charity supported training to the value of £75k, representing a notable contribution to Trust staff development. This is a 29% increase on the previous year;
- The investment valuation method used under FRS 102 is to revalue assets to the bid price.

2.2 The Charity continues to support individual purchases of medical equipment to benefit patient care and these are detailed on page 6 of the accounts.
3. **Recommendation**

3.1 The Board of Directors are asked to approve the Charitable Funds Accounts for 2016/17.

Caroline Trevena  
Director of Finance
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

North Tees and Hartlepool NHS FT Charitable Funds Accounts 2016/17

Report of the Director of Finance

1. Introduction/Background

1.1 The purpose of this report is to present the Trust’s audited Charitable Funds Accounts for the year ending 31 March 2017.

1.2 The 2016/17 Charitable Funds Accounts and Annual Report have been prepared in line with Charitable Commission guidance and comply with the Charities Act 2011 and Regulation 8 of the Charities (Accounts and Reports) Regulations 2008. They are also in accordance with the United Kingdom Accounting Standards, comprising FRS 102 “The Financial Reporting Standard applicable in the UK and the Republic of Ireland”. The Accounts and Trustees report have been externally audited by PricewaterhouseCoopers LLP (PWC).

1.3 For this financial year the Charitable Funds Accounts have been subject to a full independent audit.

1.4 On 13 July 2017 the Charitable Funds Committee recommended that the Board of Directors approve the Charitable Funds Accounts.

2. Main content of report

2.1 The Final Accounts detail the full financial performance in 2016/17 and the main points to note are highlighted below.

2.2 The investment valuation method under FRS 102 is to revalue assets to the bid price.

2.3 The net assets of the charity have increased by £112k to £1,558k during the year. This comprised of an in year loss of £(98k) and an unrealised gain on investment due to the increase in market value of £210k, resulting in a net movement of £112k.

2.4 Although the difficult economic climate has previously resulted in the incoming resources for the Charity having a downward trend, in 2016/17 the total income received increased slightly from £270k in 2015/16 to £280k.

2.5 The Charity made significant individual purchases of medical equipment in 2016/17 and these are highlighted below:
Expenditure £000

Verathon Bladder Scanner 7
Infant Optiflow System x 3 5
Medwarm Neonatal Phototherapy x 4 8
Echocom Neo Sim 23
Cardiology Monitors 22
Portable Dictation Devices 8
Day Surgery Trolley 8
Other smaller medical equipment 40

121

The major refurbishments during the year are shown below:

AC Version 7 upgrade 8
Omnicell Cabinet/Restock Interface 11
Other smaller refurbishment costs, office equipment, computer hardware, books, printing and stationery 15

34

3. Conclusion/Summary

3.1 The financial performance of the Charity in 2016/17 is documented in the audited Accounts and Annual Report.

3.2 Following Board of Directors approval the Chairman and Chief Executive, agents for the Corporate Trustee, will sign the Letter of Representation and Annual Accounts. The auditors will then provide a signed audit opinion to incorporate into the accounts prior to them being submitted to the Charity Commission. This is in advance of the deadline of 31 January 2018.

4. Recommendation

4.1 The Board of Directors are requested to approve the Charitable Funds Accounts for 2016/17.

Caroline Trevena
Director of Finance
Trust name: North Tees and Hartlepool NHS Foundation Trust General Charitable Fund

Annual Report and Accounts for the year ended 31 March 2017

Charity Registration Number 1057682

The annual accounts were approved by the Board of Directors

and signed on its behalf by:

Paul Garvin, Chairman

Alan Foster, Trustee
Annual Report and Accounts for North Tees and Hartlepool NHS Foundation Trust

Trustees Report

The North Tees and Hartlepool NHS Foundation Trust General Charitable Fund, registered Charity Number 1057682, was entered on the Central Register of Charities on 1st May 1996. The Charity was established to administer charitable funds received from donations and bequests.

Charitable funds received by the Charity are accepted and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Acts 1990 and these funds are held on trust by the corporate body.

The Charitable Funds are registered with the Charity Commission (Charity Number 1057682) in accordance with the Charities Act 2011.

The Charity has a Corporate Trustee, the North Tees and Hartlepool NHS Foundation Trust, with the members of the Board of Directors responsible for its governance as per the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

Members of the Board of Directors are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

The members of the Board who served as agents for the Corporate Trustee during the financial year were as follows:

Paul Garvin Chairman
Alan Foster Chief Executive
David Emerton Medical Director
Julie Gillon Chief Operating Officer / Deputy Chief Executive
Lynne Hodgson Director of Finance, ICT and Support Services (to 31st May 2016)
Ann Burrell Director of Human Resources and Education
Cath Siddle Director of Nursing, Patient Safety and Quality (to 20th May 2016)
Brian Dinsdale Vice Chairman and Non-executive Director
Stephen Hall Non-executive Director
Rita Taylor Non-executive Director
Jonathan Erskine Non-executive Director
Kevin Robinson Non-executive Director
Julie Lane Director of Nursing, Patient Safety and Quality
Caroline Trevena Director of Finance
Peter Mitchell Director of Estates and Facilities (from 1st July 2016)
Anandapuram Deepak Dwarakanath Medical Director (from 1st April 2016)
Graham Evans Chief Information Technology Officer (from 4th July 2016)

The Executive Directors and Non-executive Directors of the Foundation Trust Board are the Trustee of the Charity. The Executive Directors are appointed by the Non-executive Directors and the Governors appoint the Non-executive Directors.
Trustees Annual Report (continued)
This Annual Report has been prepared by the Corporate Trustee.

Acting for the Corporate Trustee, North Tees and Hartlepool NHS Foundation Trust General Charitable Fund Board has, under the Trust's Scheme of Delegation, appointed the Director of Finance to be the officer responsible for implementing suitable procedures, to ensure that the relevant legislation and directives are implemented and that the expenditure from Charitable Funds is appropriate for the purpose.

How to contact us

Principal Office
The principal office for the Charity is:

The Director of Finance
North Tees and Hartlepool NHS Foundation Trust
University Hospital of North Tees
Hardwick Road
Stockton on Tees TS19 8PE

For fundraising queries please contact:

The Finance Department
North Tees and Hartlepool NHS Foundation Trust
University Hospital of North Tees
Hardwick Road
Stockton on Tees TS19 8PE

Sharon Pounder 01642 624274

The professional advisers of the Corporate Trustee are:

Bankers Investment Manager
Lloyds Bank CCLA
27 High Street for Charities
Stockton on Tees Senator House
TS18 1SG 85 Queen Victoria Street
Internal Auditors External Independent Auditors
Audit North PricewaterhouseCoopers LLP
Helmsley House Chartered Accountants and Statutory Auditors
University Hospital of North Tees Central Square South
Stockton on Tees Orchard Street
TS19 8PE Newcastle upon Tyne

Legal Advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle Upon Tyne
NE1 3DX
Trustees Annual Report (continued)

The aim of the Charity is to improve patient care for the local population served by the Foundation Trust; Provide additional resources to fund over and above that normally funded by the NHS Foundation Trust; Purchase equipment, improve facilities in which patients are treated & fund staff training to enhance modern techniques in their specialty.

Structure, Governance and Management

The Deeds of the Charity outlining its structure are held by the Director of Finance. The Charity was formed by direction of the Charity Commission by virtue of the provisions of Section 96 of the Charities Act 2011. In 1999, two charities, the North Tees Health NHS Trust Charitable Fund and the Hartlepool and East Durham NHS Trust Charitable Fund, merged to form the North Tees and Hartlepool NHS Foundation Trust General Charitable Fund.

A Charitable Funds Committee was established in 2009. The membership comprises the Chairman, Chief Executive, Director of Finance and two Non-executive Directors. The Committee meets twice a year.

The recruitment process for appointing the members of the board who serve as agents for the Corporate Trustee follows Trust procedures.

The Charity's unrestricted fund was established using the model declaration of trust and all funds held as at the date of registration were either part of this unrestricted fund or registered as separate restricted funds under the main Charity.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds, the Corporate Trustee respects the wishes of the donor to benefit patient care and improve the health and welfare of patients and staff.

The Charitable Funds available for spending are allocated to specialities within the NHS Foundation Trust’s management structure according to the donor’s wishes. Each fund is managed by a member(s) of staff (the Fund Manager) and overseen by the General Manager of the Speciality.

Where funds have been received which have specific restrictions set by the donor a restricted fund has been established. At 31 March 2017 there were 76 (2016: 87) such funds.

The Charity has one unrestricted fund, the General Purposes Fund.

The Corporate Trustee of the North Tees and Hartlepool NHS Foundation Trust General Charitable Fund delegates responsibility for the operational running of the Charitable Funds to the Director of Finance who is required to:

- Maintain such accounts and records, as necessary, to record and protect all funds in trust;
- Control, manage and monitor the use of the fund’s resources;
- Provide support and advice for all of its income raising activities;
- Ensure that best practice is followed in the conduct of its affairs fulfilling all of its legal responsibilities;
- Ensure that the approved investment policy is adhered to and that performance is continually reviewed; and
- Keep the Board of Directors fully informed on the performance, activity and risks of the Charity
Annual Report and Accounts for North Tees and Hartlepool NHS Foundation Trust
General Charitable Fund

Trustees Annual Report (continued)

The training needs of the members of the Board who serve as agents for the Corporate Trustee are assessed on an ongoing basis and all training complies with the policies of the Foundation Trust.

The accounting records and day to day administration of the funds are dealt with by the Finance Department of the North Tees and Hartlepool NHS Foundation Trust, located at the University Hospital of North Tees, Hardwick, Stockton on Tees.

The Charity's fund has NHS Foundation Trust wide objectives as follows:

- The Corporate Trustee shall hold the Trust Fund upon trust to apply the income, and at its, or its agents discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.
- The Charity will continue to further improve the provision of high quality patient care throughout the Trust focusing on areas not covered or fully supported by central NHS Foundation Trust funds.
- The future plans for the Charity are dependent on the future direction of the NHS and the strategic plan of the Trust. This is focussed on a new Energy Centre and the delivery of the clinical services strategy.

Risk Management

The major risks to which the Charity is exposed have been identified and systems put in place to mitigate them.

The major external risk to which the Charity is exposed is a sudden fall in the value of the investment portfolio. However, the Corporate Trustee invests over the longer term to ensure that the greatest returns are achieved. History has shown that over any 10 year period in the last century investment in a wide range of equity based investments will add greater value when compared to a fixed interest based portfolio.

The Corporate Trustee has appointed professional fund managers, CCLA for Charities, to manage the Charity Investments. There are procedures in place to review the investment policy and monitor its performance.

To mitigate exposure to risk in this area the Charity's Investment Managers, CCLA for Charities, have adopted an investment policy that spreads the risk over a wide range of investments.

The Charity is audited by the North Tees and Hartlepool NHS Foundation Trust's internal auditors, Audit North who review and test systems, and the Trust's external independent auditors, PricewaterhouseCoopers LLP, who independently audit the Charity's Annual Accounts and Report.
Trustees Annual Report (continued)

Annual Review

During the year Charitable Funds continued to support a wide range of charitable and health related activities benefiting both patients and staff. In general they are used to provide goods and services to improve patient care and staff welfare that the NHS Foundation Trust is unable to provide.

Ward funds receive many donations from grateful patients and their families and this enables wards to improve the environment in which patients are treated. These donations enable all types of staff to attend courses and conferences which are not able to be funded by the NHS Foundation Trust, and will update them on new ideas and modern techniques in their speciality. Many donations are specifically given to thank the staff on the wards and these are used for charitable activities that will benefit staff.

The NHS Foundation Trust’s General Purposes Fund receives donations that can be used for any charitable purpose relating to the NHS. The Chief Executive of the North Tees and Hartlepool NHS Foundation Trust has the authority to approve and support applications for funding from areas within the NHS Foundation Trust which do not have sufficient funds themselves.

Grant Making Policy

The Corporate Trustee Grant Making Policy aims to support the Charity by enhancing patient care and staff welfare.

Firstly the General Purposes Fund is constituted of gifts received by the Charity where no particular preference as to its expenditure has been expressed by donors.

Secondly, Restricted Funds reflect the wishes of the donor. These are managed by fund holders who are authorised to spend the money within their designated area. These funds can be spent at any time.

Grants are made to both institutions and individuals. Details of the main types of grants are shown on page 6.

The net assets of the Charity as at 31 March 2017 are £1,558,000 (2016: £1,446,000) an increase over the year of £112,000 (2016: decrease of £138,000), comprised of an in year operating loss of £98,000 (2016: £74,000) and by an unrealised gain of £210,000 (2016: £64,000 loss), resulting from an increase in the market value of investments.
Trustees Annual Report (continued)

Income

The Charity relies on donations, legacies and investment income as the main source of income. Total incoming resources were £280,000 (2015/16: £270,000) an increase from the previous year.

There has been a small number of fund raising activities undertaken by the Corporate Trustee during 2016/17. Total fundraising income £2,000 (2015/16: £nil).

Expenditure (Grants Made)

During the year direct charitable expenditure was £342,000 (2015/16: £310,000). A full breakdown of expenditure by category is shown in note 7 of the accounts.

Major individual purchases of medical equipment made during the year are set out below

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditure £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verathon Bladder Scanner</td>
<td>7</td>
</tr>
<tr>
<td>Infant Optiflow System x 3</td>
<td>5</td>
</tr>
<tr>
<td>Medwarm Neonatal Phototherapy x4</td>
<td>8</td>
</tr>
<tr>
<td>Echocom Neo Sim</td>
<td>23</td>
</tr>
<tr>
<td>Cardiology Monitors</td>
<td>22</td>
</tr>
<tr>
<td>Portable dictation devices</td>
<td>8</td>
</tr>
<tr>
<td>Day Surgery Trolley</td>
<td>8</td>
</tr>
<tr>
<td>Other smaller medical equipment</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

The Charity has contributed £34,000 (2015/16: £77,000) to refurbishments in North Tees and Hartlepool NHS Foundation Trust.

The major refurbishments during the year are shown below

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditure £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC Version 7 upgrade</td>
<td>8</td>
</tr>
<tr>
<td>Omnicell Cabinet/Restock Interface</td>
<td>11</td>
</tr>
<tr>
<td>Other smaller refurbishment costs, office equipment, computer hardware, books, printing &amp; stationery</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

The Charity has spent £75,000 (2015/16: £58,000) on staff training, welfare and development which represents a significant contribution to staff development and provision of high quality health care within the Foundation Trust.

Plans For The Future

The NHS is an ever changing environment and the future direction of the Charity will be shaped by these changes. The priorities for spending charitable funds is determined primarily by the fund holders who are managers in the service. Delegating the responsibility of expending charitable funds to this level ensures that those able to make the decisions are best placed to know the exact needs of the service.
Trustees Annual Report (continued)

Corporate Trustee Statement
The Corporate Trustee confirms that it has referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities and setting grant making policy for the year. It is the opinion of the Corporate Trustee that it has carried out these objects by:

- Patients’ Welfare - Purchase of small pieces of equipment and enhancement of services and facilities over and above that normally provided by the NHS;
- Staff Welfare - Enhancement of staff facilities and by providing education over and above that which would normally be provided by the NHS;
- Capital Equipment - Purchase of equipment in addition to, or an enhancement of, that which would be normally provided by the NHS.

Thank You
The Corporate Trustee would like to express its thanks to all who have made charitable donations to the Charity. The support and assistance of the public, patients, local businesses and community associations is much appreciated and helps in providing the best possible service to the benefit of everyone who is cared for in our hospitals.

Reserves Policy
Reserves are that part of the Charity's unrestricted funds which are freely available to spend on any of the Charity's purposes, the value as at 31 March 2017 was £130,000. This definition excludes restricted income funds and endowment funds.

The Corporate Trustee requests that the cash balance at any one time should not fall below £100,000 although the cash held at the bank may be less the Charity has the facility to withdraw funds as and when required from CCLA for Charities, to enable the charity's aims to be protected in the event of expenditure exceeding income in a given year. By providing a buffer the Corporate Trustee has the ability to reduce discretionary grants and implement plans to increase fundraising without impacting disproportionately in the short term. The reserve policy is reviewed annually, taking into account historic results and future expectations of income levels and inflation.

Investments
The Corporate Trustee invests the charitable funds in line with its investment policy with a view to obtaining a return higher than through cash deposits. The investment policy is reviewed on an ongoing basis by the Corporate Trustee.

The portfolio was managed by CCLA for Charities and comprised investments in a Global Charity Multi-Asset Fund and Cash.

There is no investment in companies involved in tobacco products. The performance of the investments is monitored by the Finance Department of the North Tees and Hartlepool NHS Foundation Trust and reported to the Director of Finance.

Summary Of Investments at 31 March 2017
Funds managed by CCLA For Charities are as follows:

<table>
<thead>
<tr>
<th>Equities</th>
<th>£000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>COIF Charities Investment Fund</td>
<td>1,568</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>1,568</td>
<td>100</td>
</tr>
</tbody>
</table>

The market value of the portfolio of investments as at 31 March 2017 showed an increase in value of £210,000 (compared to a decrease of: £64,000 31 March 2016). This is disclosed as an unrealised gain in the Statement of Financial Activities.

Apportionment of Investment Income
Dividend income from investments has been apportioned on a pro rata basis to funds with an average balance exceeding £2,500 (2016: £2,500) as at 31 March 2017.
Statement of trustees’ responsibilities

The trustees are responsible for preparing the Trustees’ Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgments and estimates that are reasonable and prudent;
- state whether applicable accounting standards, comprising FRS 102, have been followed, subject material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charitable company will continue in business.

The trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and financial information included on the charity’s website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Signed on behalf of the Corporate Trustee:

Chairman……………………………………… Date…………………………………. 2017

Chief Executive………………………………… Date…………………………………. 2017
Independent auditors’ report to the trustees of North Tees and Hartlepool NHS Foundation Trust General Charitable Fund

Report on the financial statements

Our opinion

In our opinion, North Tees and Hartlepool NHS Foundation Trust General Charitable Fund’s financial statements (the financial statements”):

- give a true and fair view of the state of the charity’s affairs as at 31 March 2017 and of its incoming resources and application of resources and cash flows, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of section 144 of the Charities Act 2011 and Regulation 8 of The Charities (Accounts and Reports) Regulations 2008).

What we have audited

The financial statements, included within the Annual Report and Accounts (the “Annual Report”), comprise:

- the balance sheet as at 31 March 2017;
- the statement of financial activities for the year then ended;
- the statement of cash flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in the preparation of the financial statements is United Kingdom Accounting Standards, comprising FRS 102 “The Financial Reporting Standard applicable in the UK and Republic of Ireland”, and applicable law (United Kingdom Generally Accepted Accounting Practice).

In applying the financial reporting framework, the trustees have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

Other matters on which we are required to report by exception

Sufficiency of accounting records and information and explanations received

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- we have not received all the information and explanations we require for our audit; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns.

We have no exceptions to report arising from this responsibility.

Other information in the Annual Report

Under the Charities Act 2011 we are required to report to you if, in our opinion the information given in the Trustees’ Annual Report is inconsistent in any material respect with the financial statements. We have no exceptions to report arising from this responsibility.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the trustees

As explained more fully in the Statement of Trustees’ Responsibilities set out on page 8, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) (“ISAs (UK & Ireland)”). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.
Annual Report and Accounts for North Tees and Hartlepool NHS Foundation Trust
General Charitable Fund

This report, including the opinions, has been prepared for and only for the charity’s trustees as a body in accordance with section 144 of the Charities Act 2011 and regulations made under section 154 of that Act (Regulation 27 of The Charities (Accounts and Reports) Regulations 2008) and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

What an audit of financial statements involves

We conducted our audit in accordance with ISAs (UK & Ireland). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

• whether the accounting policies are appropriate to the charity’s circumstances and have been consistently applied and adequately disclosed;
• the reasonableness of significant accounting estimates made by the trustees; and
• the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the trustees’ judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Newcastle upon Tyne

2017

PricewaterhouseCoopers LLP is eligible to act, and has been appointed, as auditor under section 144(2) of the Charities Act 2011.
Statement of Financial Activities for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>Unrestricted Funds £000</th>
<th>Restricted Funds £000</th>
<th>Total Funds 2016/17 £000</th>
<th>Total Funds 2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17</td>
<td>2015/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incoming resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incoming resources from generated funds:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Voluntary income:</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donations</td>
<td>4</td>
<td>143</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>Income from activities from other public services</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Legacies</td>
<td>19</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Sub-total voluntary income</td>
<td>23</td>
<td>156</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>Investment Income</td>
<td>11.3</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Incoming resources from charitable activities</td>
<td>4</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Other incoming resources</td>
<td>5</td>
<td>10</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Total incoming resources</td>
<td>38</td>
<td>242</td>
<td>280</td>
</tr>
<tr>
<td></td>
<td>Resources expended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Charitable activities:</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Research Posts and Clinical Care</td>
<td>28</td>
<td>46</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Purchase of Equipment</td>
<td>-</td>
<td>121</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Refurbishment costs</td>
<td>2</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Staff Education and Welfare</td>
<td>16</td>
<td>59</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Patient Welfare</td>
<td>4</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Governance Costs</td>
<td>6</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Total resources expended</td>
<td>53</td>
<td>325</td>
<td>378</td>
</tr>
<tr>
<td></td>
<td>Net outgoing resources before transfers</td>
<td>(15)</td>
<td>(83)</td>
<td>(98)</td>
</tr>
<tr>
<td></td>
<td>Transfers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Movement between restricted and unrestricted funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Net outgoing resources before other recognised gains and losses</td>
<td>(15)</td>
<td>(83)</td>
<td>(98)</td>
</tr>
<tr>
<td></td>
<td>Other recognised gains and losses</td>
<td>11.1</td>
<td>19</td>
<td>191</td>
</tr>
<tr>
<td></td>
<td>Gain / (loss) on investment assets</td>
<td>15</td>
<td>4</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td>Net movement in funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fund balances brought forward at 1 April</td>
<td>126</td>
<td>1,320</td>
<td>1,446</td>
</tr>
<tr>
<td></td>
<td>Fund balances carried forward at 31 March</td>
<td>130</td>
<td>1,428</td>
<td>1,558</td>
</tr>
</tbody>
</table>

All gains and losses recognised in the year are included in the above statement.
All amounts relate to continuing operations.
The notes at pages 14 to 22 form part of these financial statements.
### Balance Sheet as at 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>Unrestricted Funds £000</th>
<th>Restricted Funds £000</th>
<th>Total at 31 March 2017 £000</th>
<th>Total at 31 March 2016 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>11</td>
<td>130</td>
<td>1,438</td>
<td>1,568</td>
</tr>
<tr>
<td>Total fixed assets</td>
<td></td>
<td>130</td>
<td>1,438</td>
<td>1,568</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>12</td>
<td>-</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td></td>
<td>-</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td>-</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors: Amounts falling due within one year</td>
<td>13</td>
<td>-</td>
<td>102</td>
<td>102</td>
</tr>
<tr>
<td><strong>Net current (liabilities)/assets</strong></td>
<td></td>
<td>-</td>
<td>(10)</td>
<td>(10)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>130</td>
<td>1,428</td>
<td>1,558</td>
<td>1,446</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>130</td>
<td>1,428</td>
<td>1,558</td>
<td>1,446</td>
</tr>
</tbody>
</table>

The funds of the charity

| Restricted income funds | - | 1,428 | 1,428 | 1,320 |
| Unrestricted income funds | 130 | - | 130 | 126 |

**Total Charity Funds**

| 16 | 130 | 1,428 | 1,558 | 1,446 |

The notes on pages 14 to 22 form part of the financial statements.

The financial statements on pages 11 to 22 were approved by the Corporate Trustee and signed on its behalf by:

Signed: ................................................................. Alan Foster (Chief Executive)

Date:
### Statement of Cash Flows for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016/17 £000</th>
<th>2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash used in operating activities</td>
<td>15</td>
<td>(79)</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends and interest from investments</td>
<td>11</td>
<td>54</td>
</tr>
<tr>
<td>Proceeds from sale of investments</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td><strong>Net cash provided by investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>155</td>
</tr>
<tr>
<td><strong>Change in cash and cash equivalents in the reporting period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(25)</td>
<td>27</td>
</tr>
<tr>
<td>Increase in cash and cash equivalents in the year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(25)</td>
<td>27</td>
</tr>
<tr>
<td>Cash and cash equivalents at the beginning of reporting period</td>
<td>100</td>
<td>73</td>
</tr>
<tr>
<td><strong>Total cash and cash equivalents at the end of the year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75</td>
<td>100</td>
</tr>
</tbody>
</table>
Notes to the Financial Statements

1 Accounting Policies

(a) Basis Of Preparation

The financial statements have been prepared on a going concern basis and under the historic cost convention, with the exception of investments which are included at bid price. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) and the Charities Act 2011.

The charity meets the definition of a public benefit entity under FRS 102. Assets and liabilities are initially recognised at historical cost or transaction value unless otherwise stated in the relevant accounting policy note(s).

(b) Funds Structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Unrestricted income funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the charitable objectives. Funds which are not legally restricted but which the Corporate Trustee has chosen to earmark for set purposes are designated funds. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. No endowment funds are currently held by the charity.

The major funds held in each of these categories are disclosed in note 16.

(c) Incoming Resources

All incoming resources are recognised and included in full in the Statement of Financial Activities as soon as the following factors are met:

- entitlement - arises when a particular resource is receivable or the Charity's right becomes legally enforceable;
- certainty - when there is reasonable certainty that the incoming resource will be received; and
- measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the Charity or the amount actually realised.
Annual Report and Accounts for North Tees and Hartlepool NHS Foundation Trust
General Charitable Fund

1 Accounting Policies (continued)

(d) Incoming Resources From Legacies

Legacies are accounted for as incoming resources at the earliest of either receipt or where the receipt of the legacy is probable: this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

(e) Resources Expended

Expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Grants are only made to related or third party NHS bodies and non-NHS bodies in furtherance of the charitable objectives of the funds. A liability for such grants is recognised when approval has been given by the Fund Manager of the relevant Charitable Fund. The North Tees and Hartlepool NHS Foundation Trust General Charitable Fund has delegated authority to the Fund Managers.

(f) Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(g) Governance Costs

Costs of governance arrangements are included which relate to the general running of the Charity as opposed to the direct management functions inherent in generating funds, service delivery and programme or project work. These activities provide the governance infrastructure which allows the Charity to operate and to generate the information required for public accountability. They include the strategic planning processes that contribute to the future development of the Charity and comprise of administration, independent auditors’ fee, internal audit costs and all support costs (see note 6). These costs were charged pro rata against funds which had a balance of £2,500 and above as at 31 March 2016.

(h) Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the objectives of the Charity. These costs comprise direct costs and an apportionment of the management, administrative and audit costs.

(i) Fixed Asset Investments

Investments are stated at the closing market value which is the ‘bid price’ at the balance sheet date. The Statement of Financial Activities includes any net gains and losses.

(j) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(k) Cash and Cash equivalents

Cash at the bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highlight liquid investments, usually in 90 day notice interest bearing savings accounts.
1 Accounting Policies (continued)

(l) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

(m) Recognised Gains and Losses

All realised and unrealised gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

(n) Going Concern

The Charity activities, together with the factors likely to affect its future development, performance and position are set out on pages 1-7.

The Charity has significant financial resources and due to its long standing policy of only funding one-off in-year applications to the fund, has no future commitments to discharge.

The return on investments has decreased over the previous year, with donations and legacies also falling. However, the expenditure of the Charity is discretionary and the Corporate Trustee will ensure expenditure is affordable to maintain financial sustainability.

After making enquiries, the Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the Annual Report and Accounts.

(o) Taxation Liability

As a registered charity, the North Tees and Hartlepool NHS Foundation Trust General Charitable Fund is potentially exempt from the taxation of income and gains falling within S505 of the Income and Corporation Taxes Act 1988 and S256 Taxations and Chargeable Gains Act 1992.

No tax charge has arisen in the year
2. Related Party Transactions

The North Tees and Hartlepool NHS Foundation Trust is the sole beneficiary of the Charity. The Charity has provided funding to the NHS Foundation Trust for approved expenditure made on behalf of the Charity. This funding amounted to £342,000 (2015/16: £310,000) and is shown on the face of the Statement of Financial Activities. During the year none of the members of the NHS Foundation Trust Board or Senior NHS staff or parties related to them were beneficiaries of the Charity or have undertaken any material transactions with the Charity.

Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments or expenses in the year (or in the prior year). The Corporate Trustee has purchased Trustee indemnity insurance for 2016/17.

Details of related party transactions with individuals 2016/17

<table>
<thead>
<tr>
<th>Payments to related party</th>
<th>Receipts from related parties</th>
<th>Amounts owed to related parties</th>
<th>Amounts due from related parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Declaration of Interest

2016/17 – – – –

3. Voluntary Income

<table>
<thead>
<tr>
<th>Unrestricted Funds</th>
<th>Restricted Funds</th>
<th>Total 2016/17</th>
<th>Total 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Donations

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>143</td>
</tr>
<tr>
<td>147</td>
<td>135</td>
</tr>
</tbody>
</table>

Income from activities from other public services

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Legacies

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>30</td>
<td>34</td>
</tr>
</tbody>
</table>

Total

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>156</td>
</tr>
<tr>
<td>179</td>
<td>170</td>
</tr>
</tbody>
</table>

4. Incoming Resources From Charitable Activities

The income was primarily from the provision of training courses in furtherance of the Charity's objectives.

<table>
<thead>
<tr>
<th>Unrestricted Funds</th>
<th>Restricted Funds</th>
<th>Total 2016/17</th>
<th>Total 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Income from the provision of education and training

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>–</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

Total

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>–</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

5. Other Incoming Resources

<table>
<thead>
<tr>
<th>Unrestricted Funds</th>
<th>Restricted Funds</th>
<th>Total 2016/17</th>
<th>Total 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Other Income

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>26</td>
</tr>
<tr>
<td>36</td>
<td>28</td>
</tr>
</tbody>
</table>

Total

<table>
<thead>
<tr>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>26</td>
</tr>
<tr>
<td>36</td>
<td>28</td>
</tr>
</tbody>
</table>

This income is received from staff Christmas function ticket sales, sponsorship of various meetings and conferences held by the Trust, payment for clinical trials performed by the North Tees and Hartlepool NHS Foundation Trust and the provision and facilitation of training for outside parties.

The North Tees and Hartlepool NHS Foundation Trust has been notified of a restricted legacy for the Cancer Fund which has not been reflected in the 2016/17 Statement of Financial Activities as the timing and exact amount of funds remains uncertain.
6. Governance Costs

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal audit</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>External audit</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Governance</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Financial administration</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>36</td>
<td>34</td>
</tr>
</tbody>
</table>


7. Charitable activities

The Charity pursued its charitable activities by making grants, shown below by category.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of Equipment</td>
<td>121</td>
<td>90</td>
</tr>
<tr>
<td>Research Posts and Clinical Care</td>
<td>74</td>
<td>33</td>
</tr>
<tr>
<td>Refurbishment Costs</td>
<td>34</td>
<td>77</td>
</tr>
<tr>
<td>Staff Education and Welfare</td>
<td>75</td>
<td>58</td>
</tr>
<tr>
<td>Patients Welfare</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>342</td>
<td>310</td>
</tr>
</tbody>
</table>

8. Analysis of Grants

All grants are made to the Charity for the year 1 April 2016 to 31 March 2017. The Corporate Trustee operates a Scheme of Delegation, through which all grant funded activity is managed by fund holders responsible for the day to day activities in accordance with the directions set out by the Corporate Trustee in the Standing Financial Instructions and Standing Orders. The total cost of making grants is disclosed in the activity analysis on the face of the Statement of Financial Activities. The grants received by the beneficiaries for each category of charitable activity is disclosed in note 7 of the financial statements.
Annual Report and Accounts for North Tees and Hartlepool NHS Foundation Trust
General Charitable Fund

9. Staff Costs

There are no staff directly employed by the Charity in 2016/17 (2015/16: none)
The Charity's Corporate Trustee agents give their time freely and receive no remuneration for the work that they undertake acting for the Corporate Trustee.

10. Audit Remuneration

The auditors' remuneration of £4,650 (2015/16: £3,900) related solely to the audit and a charge of £750 for additional work being undertaken for the FRS102 compliance (2015/16: £nil).

11. Investments

The investment is valued at bid price 2016/17.

11.1 Movement in fixed asset investment

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Market value brought forward</td>
<td>1,358</td>
<td>1,522</td>
</tr>
<tr>
<td>Monies owed by CCLA for Charities</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Add cash deposits</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Short term dividends</td>
<td>(14)</td>
<td>(15)</td>
</tr>
<tr>
<td>Less disposals at carrying value</td>
<td>-</td>
<td>(100)</td>
</tr>
<tr>
<td>Net gain / (loss) on revaluation</td>
<td>210</td>
<td>(64)</td>
</tr>
<tr>
<td>Market value at 31 March</td>
<td><strong>1,568</strong></td>
<td>1,358</td>
</tr>
</tbody>
</table>

11.2 Market value at 31 March

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Held in UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COIF Charities Investment Fund</td>
<td>1,568</td>
<td>1,358</td>
</tr>
<tr>
<td>Total</td>
<td><strong>1,568</strong></td>
<td>1,358</td>
</tr>
</tbody>
</table>

The COIF Charities Investment Fund includes the following investments:

<table>
<thead>
<tr>
<th>Asset allocation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Equities</td>
<td>26.3%</td>
<td></td>
</tr>
<tr>
<td>Overseas Equities</td>
<td>50.4%</td>
<td></td>
</tr>
<tr>
<td>Private Equity &amp; Other</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>Infrastructure &amp; Operating Assets</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>Property</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Contractual &amp; Other Income</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Fixed Interest</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>2.9%</td>
<td></td>
</tr>
</tbody>
</table>
11.3 Total gross income from investments and cash on deposit

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Held in UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>54</td>
<td>55</td>
</tr>
</tbody>
</table>

The Corporate Trustee believes that the carrying value of the investments is supported by their underlying net assets.

12. Debtors

<table>
<thead>
<tr>
<th>Debtors under one year</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dividend Income</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Prepayments</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>21</td>
</tr>
</tbody>
</table>

13. Creditors: amounts falling due within one year

<table>
<thead>
<tr>
<th>Creditors under one year</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Accruals</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Deferred Income</td>
<td>6</td>
<td>–</td>
</tr>
<tr>
<td>Amounts owed to North Tees and Hartlepool NHS Foundation Trust</td>
<td>81</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>102</td>
<td>33</td>
</tr>
</tbody>
</table>

There is no security for non-trading amounts owed to the Foundation Trust.
14. Ultimate parent undertaking and controlling party

The Charity is a wholly owned subsidiary of North Tees and Hartlepool NHS Foundation Trust, a company registered in England. North Tees and Hartlepool NHS Foundation Trust is also the ultimate parent company.

The parent undertaking of the smallest group which includes the Charity, and for which consolidated financial statements are prepared, is North Tees and Hartlepool NHS Foundation Trust.

Copies of the financial statements for this group can be obtained from:

North Tees and Hartlepool NHS Foundation Trust
University Hospital North Tees
Hardwick Road
Stockton on Tees
TS19 8PE

North Tees and Hartlepool NHS Foundation Trust is a public benefit corporation established under the National Health Service Act 2006. NHS Improvement, the Independent Regulator for NHS Foundation Trusts, has the power to control the Trust within the meaning of IAS27 ‘Consolidated and Separate Financial Statements.’ NHS Improvement does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS FT Consolidated Accounts are included within the Whole of Government Accounts and this is the largest group with which the results of North Tees and Hartlepool NHS Foundation Trust General Charitable Fund is consolidated into. NHS Improvement is accountable to the Secretary of State for Health and therefore the Trust’s ultimate parent is HM Government.

15. Reconciliation of net movement in funds to net cash flow from operating activities

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Net movement in funds</td>
<td>112</td>
<td>(138)</td>
</tr>
<tr>
<td>Gains/(losses) on investments</td>
<td>(210)</td>
<td>64</td>
</tr>
<tr>
<td>Deduct interest/dividends income shown in investing activities</td>
<td>(54)</td>
<td>(55)</td>
</tr>
<tr>
<td>Decrease in debtors</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Increase/(decrease) in creditors</td>
<td>69</td>
<td>(25)</td>
</tr>
<tr>
<td><strong>Net cash used in operating activities</strong></td>
<td><strong>(79)</strong></td>
<td><strong>(128)</strong></td>
</tr>
</tbody>
</table>
### 16. Analysis of Charitable Funds

#### General Charitable Fund

<table>
<thead>
<tr>
<th>Name</th>
<th>Description of the nature and purpose of the fund</th>
<th>£000 at 1 April 2016</th>
<th>£000 Resources Expended</th>
<th>£000 at 31 March 2017</th>
<th>£000 Resources Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fund Balances</strong></td>
<td><strong>Incoming</strong></td>
<td><strong>Resources</strong></td>
<td><strong>Fund Balances</strong></td>
<td><strong>Incoming</strong></td>
<td><strong>Resources</strong></td>
</tr>
<tr>
<td>1 Diabetes Fund</td>
<td>To support patient care for individuals diagnosed with Diabetes/ training</td>
<td>28</td>
<td>8</td>
<td>(21)</td>
<td>15</td>
</tr>
<tr>
<td>2 Memorial Fund (Surgery)</td>
<td>To support patient care within the Directorate of Surgery</td>
<td>39</td>
<td>15</td>
<td>(9)</td>
<td>45</td>
</tr>
<tr>
<td>3 Breast Surgery Fund</td>
<td>To support patient care within breast service including equipment &amp; training</td>
<td>34</td>
<td>14</td>
<td>(1)</td>
<td>47</td>
</tr>
<tr>
<td>4 Spinal Fund</td>
<td>To support patient care for individuals requiring treatment within the Spinal Department</td>
<td>40</td>
<td>8</td>
<td>(1)</td>
<td>47</td>
</tr>
<tr>
<td>5 Haematology Fund</td>
<td>To support patient care for individuals with blood disorders</td>
<td>163</td>
<td>43</td>
<td>(21)</td>
<td>185</td>
</tr>
<tr>
<td>6 Urology Research Fund</td>
<td>To support patient care for individuals diagnosed with Urology/Kidney related illness</td>
<td>27</td>
<td>6</td>
<td>(1)</td>
<td>32</td>
</tr>
<tr>
<td>7 Mims Fund</td>
<td>Fund to be expended in training staff</td>
<td>34</td>
<td>9</td>
<td>(11)</td>
<td>32</td>
</tr>
<tr>
<td>8 Chemotherapy Fund</td>
<td>To support patient care for individuals requiring treatment within Chemotherapy Fund UHNT</td>
<td>63</td>
<td>64</td>
<td>(25)</td>
<td>102</td>
</tr>
<tr>
<td>9 M Legacy Fund</td>
<td>To support the purchase of equipment for the benefit of cancer patients</td>
<td>82</td>
<td>34</td>
<td>(41)</td>
<td>75</td>
</tr>
<tr>
<td>10 Elderly Care Fund</td>
<td>To support patient care for individuals requiring treatment within Elderly care</td>
<td>42</td>
<td>8</td>
<td>(4)</td>
<td>46</td>
</tr>
<tr>
<td>11 Cardiology Fund</td>
<td>To support patient care for individuals requiring treatment within the Cardiac unit</td>
<td>143</td>
<td>27</td>
<td>(18)</td>
<td>152</td>
</tr>
<tr>
<td>12 Neo-Natal</td>
<td>To support patient care for individuals requiring treatment within the neo-natal unit</td>
<td>48</td>
<td>22</td>
<td>(16)</td>
<td>54</td>
</tr>
<tr>
<td>13 Stroke Fund</td>
<td>To support stroke patients welfare and staff training</td>
<td>56</td>
<td>13</td>
<td>(5)</td>
<td>64</td>
</tr>
<tr>
<td>14 Palliative Care</td>
<td>To support palliative care patients including equipment and staff training</td>
<td>40</td>
<td>28</td>
<td>(28)</td>
<td>40</td>
</tr>
<tr>
<td>15 Music V Cancer</td>
<td>Raise awareness of bowel cancer and other bowel conditions</td>
<td>27</td>
<td>38</td>
<td>(4)</td>
<td>61</td>
</tr>
<tr>
<td>16 Gut Fund</td>
<td>Gastro Intestinal research and related training</td>
<td>22</td>
<td>5</td>
<td>(4)</td>
<td>23</td>
</tr>
<tr>
<td>17 Medical Directorate Fund</td>
<td>Training, secondment opportunities, ward equipment &amp; furniture to improve the environment for patient and staff</td>
<td>70</td>
<td>14</td>
<td>(4)</td>
<td>80</td>
</tr>
<tr>
<td>18 Pharmacy Fund</td>
<td>Pharmacy staff welfare &amp; training development</td>
<td>25</td>
<td>7</td>
<td>(14)</td>
<td>18</td>
</tr>
<tr>
<td><strong>Funds increased to above £25,000 as at 31 March 2017</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>To support Colorectal patient services, staff Education &amp; Training</td>
<td>20</td>
<td>11</td>
<td>(5)</td>
<td>26</td>
</tr>
<tr>
<td>19 Development Fund</td>
<td>To support Lung Cancer &amp; Respiratory patients research</td>
<td>22</td>
<td>14</td>
<td>(7)</td>
<td>29</td>
</tr>
<tr>
<td>20 Respiratory Fund</td>
<td>Support running of Life Support course</td>
<td>19</td>
<td>17</td>
<td>(10)</td>
<td>26</td>
</tr>
<tr>
<td>21 Neonatal Life Support</td>
<td>Breast Cancer nurse training / Welfare &amp; hardship fund for patients</td>
<td>16</td>
<td>22</td>
<td>(7)</td>
<td>31</td>
</tr>
<tr>
<td>22 Breast Care Nursing Fund</td>
<td>Support patient care for individuals diagnosed with Diabetes/ training</td>
<td>(28)</td>
<td>(8)</td>
<td>21</td>
<td>(15)</td>
</tr>
<tr>
<td><strong>Removed funds decreased to below £25,000 as at 31 March 2017</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Fund</td>
<td>Pharmacy staff welfare &amp; training development</td>
<td>(25)</td>
<td>(7)</td>
<td>14</td>
<td>(18)</td>
</tr>
<tr>
<td>Pharmacy Fund</td>
<td>Gastro Intestinal research and related training</td>
<td>(22)</td>
<td>(5)</td>
<td>4</td>
<td>(23)</td>
</tr>
<tr>
<td>Funds at 31 March 2017</td>
<td></td>
<td>985</td>
<td>407</td>
<td>(218)</td>
<td>1,174</td>
</tr>
<tr>
<td><strong>Other Funds balances less than £25,000 as at 31st March 2017</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>335</td>
<td>26</td>
<td>(107)</td>
<td>254</td>
</tr>
<tr>
<td><strong>Total Restricted Funds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,320</td>
<td>433</td>
<td>(325)</td>
<td>1,425</td>
</tr>
<tr>
<td><strong>Total Unrestricted Funds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>126</td>
<td>57</td>
<td>(53)</td>
<td>130</td>
</tr>
<tr>
<td><strong>Total Fund balances at 31 March 2017</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,446</td>
<td>490</td>
<td>(378)</td>
<td>1,558</td>
</tr>
</tbody>
</table>
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Executive Summary

Estates and Facilities Management Annual Report 2016/17

Report of the Director of Estates & Facilities Management

Strategic Aim
*(The full set of Trust Aims can be found at the beginning of the Board Reports)*

- Manage our relationships

Strategic Objective
*(The full set of Trust Objectives can be found at the beginning of the Board Reports)*

- Maintain Compliance and Performance

1. Introduction

1.1 The key functions of the Estates and Facilities directorate are to optimise the operational effectiveness of the services that it provides whilst ensuring compliance with key legislation. That the services are responsive to the changing requirements of the Trust, providing assurances to the Board of Directors that services are delivered in a safe and secure environment, through utilising best practices and ensuring the safety of staff, patients and visitors. That the services provided are of an appropriate quality and delivered in an efficient and effective manner.

1.2 The Trust will, for the foreseeable future, continue to operate from the two main hospital sites at Hartlepool and Stockton and from the community hospital at Peterlee. The strategy for the management of the Trust’s estate in the short-term is to deliver the £25m capital investment programme to upgrade the primary engineering infrastructure at UHNT. Thus, extending the useable life of the hospital whilst ensuring the operational safety, effectiveness, reliability and capacity of the hospital’s critical engineering services aligned to the requirements of the Trust’s business objectives and potential expansion requirements.

1.3 The efficiency of the Estates & Facilities services are annually benchmarked against the Lord Carter developed ‘Model Hospital’ metrics; these continue to indicate that services are delivered in the lowest cost quartile with quality indicators rated as ‘Good’. The annual compliance assessment using the Department of Health’s Premises Assurance Model indicates an estate that is compliant in managing the risks associated.

2. Key Issues & Planned Actions

2.1 The planned actions in the short-term are to continue to provide a safe, effective, well maintained estate and a patient-focussed service whilst endeavouring to deliver continuous improvement. Staff training, development, recognition and opportunities to progress are paramount to delivering high quality support services. Key performance indicators of the services are measured and compare favourably in assessing operational efficiency, effectiveness and patient satisfaction. Operational costs for estates and facilities services are within the lowest 20% range nationally. Assessment of the safety of the estate is by an
annual assessment using the Department of Health’s Premises Assurance model which was validated by independent audit.

2.2 The directorate was successful in securing £25m of capital funding to replace the primary engineering infrastructure at UHNT. During 2016/17 the scheme has progressed well, phase 1 of the programme is now complete. This has provided an increased electrical intake capacity to the site which is distributed through a new 11,000 volt primary intake substation and three new substations, with modifications and expansion of the remaining substations, and renewed the 11,000 volt cabling systems across the hospital estate.

2.3 Phase 2 of the project has commenced, this will provide a new energy centre; this will include the provision of 100% stand-by emergency generation capacity, a reduction in carbon emissions through renewable energy sources and improving the safety, efficiency and resilience of the utility services. The scheme will substantially reduce the significant backlog maintenance requirements in the light of the new life expectancy of the hospitals, ensuring that the estates services remain consistent with the concept of first class facilities.

2.4 During the later months of 2016/17 the directorate commenced an options appraisal process to consider a range of alternative business models through which Estates and Facilities and other support services could be delivered, the opportunity exists to significantly reduce Trust expenditure and to invest in enhancing the quality of services to deliver improved patient experience.

2.5 The medium-term estates strategy, working with clinical colleagues and in discussions with neighbouring Trusts is to develop additional clinical accommodation on the UHNT site consistent with the Trusts clinical strategy and the ambitions of the Better Healthcare Programme and Sustainability and Transformation Plans. This estates master plan will form a key contributor to the Outline Business Case to be submitted to the Department of Health for major capital funding.

2.6 The long-term estates strategy continues to be to rationalise the existing estate to centralising into core buildings and the disposal of surplus estate or to attract business developments which utilise the existing surplus estate. Reducing backlog maintenance requirements and maximising the utilisation of the estate for clinical activities. At all times ensuring the estate is maintained in a safe condition while achieving performance standards and patient expectations.

3 Recommendations

3.1 The Board is requested to receive this report.

Peter Mitchell
Director of Estates & Facilities Management
1. Introduction/Background

1.1 The key functions of the Estates and Facilities directorate is to optimise the operational effectiveness of the services it provides whilst ensuring compliance with key legislation and ensuring the services adapts to the changing needs of the Trust, thereby providing assurances to the Board of Directors that services are delivered in a safe environment, utilising safe practices are employed, ensuring the safety of staff, patients and visitors. To ensure all the services are delivered in accordance with best value principles, are of appropriate quality, efficient and on time. The service supports key corporate services but is also a front line provider of other key services. Underpinning these services are the requirements of meeting the five CQC domains of Safe, Effective, Caring, Responsive and Well-Led.

1.2 The Trust will, for the foreseeable future, continue to operate from the two main hospital sites and Peterlee Community hospital. The strategy for the management of the Trust’s estate in the short-term will be to deliver the major capital investment programme to upgrade the engineering infrastructure at UHNT. This shall ensure the operational safety, effectiveness, and reliability of the hospital’s engineering services and will be aligned to the requirement of the Trust’s business objectives. Energy efficiency measures will be improved, carbon emissions reduced and approximately 10% of electrical consumption will be via renewable, on-site energy sources. The critical engineering infrastructure will be expanded and future-proofed, ensuring additional capacity is available to allow any future expansion requirements of the hospital estate. Also, to substantially reduce the significant backlog maintenance requirements in the light of the new life expectancy of the hospital, ensuring that the estates services remain consistent with the concept of first class facilities. Construction work commenced on the electrical infrastructure phase in August 2016 with practical completion at the end of March 2017. Construction work on the second phase of the infrastructure programme will commence in August 2017 building the new energy centre and will take 12 months to complete.

1.3 An estates master plan has been developed to support the medium term ambitions of the Trust articulated through the Clinical Services strategy and the emerging Better Healthcare Programme influences. The detailed estates master plan work will be a key contributor to the Outline Business Case to be submitted to the Department of Health for capital funding.

1.4 The long-term estates strategy continues to be to rationalise the existing estate to centralise into core buildings and the disposal of surplus estate and to seek inward investment to utilise the existing estate, increasing the proportion of the estate used for clinical activity to above 65% and reducing unused space to below 2.5%. The estates challenges of the short, medium and long term strategies will be enacted whilst at all times maintaining the current...
estate in a safe condition while achieving high performance standards and patient satisfaction outcomes.

2. Main content of report

2.1 Strategically to achieve the Trust’s business objectives the following objectives were prioritised and implemented during 2016/17:

- Delivery of the estates-led business case to secure the largest capital investment in the Trust's history of £25M from the Department of Health to support the major engineering infrastructure scheme.
- Delivered estates solutions to support the Clinical Services Strategy / Better Healthcare Programme / Sustainability and Transformation Plans and development of the Outline Business Case submission.
- Delivered estates developments to accommodate the Urgent Care Centres at UHNT and UHH and a new paediatric OPD.
- Maintain the existing facilities to a level consistent with legislative compliance, operational efficiency, effectiveness, and safety of staff, patients and visitors.
- Undertake a full and formal assessment of all of Estates and Facilities services using the Premises Assurance Model advocated by the Department of Health, generally outcomes were good and systems were externally audited to ensure robust and comprehensive assessments were undertaken.
- Maintain and improve upon the existing high standards of hygiene and environment, striving to deliver further improvements to manage and reduce levels of HCAI.
- Continue to invest in reducing the energy consumption, carbon emissions and environmental impact of the estate.
- Benchmarking of key performance indicators evidences occupancy costs within the lowest 20% of small / medium Trusts nationally.
- The directorate concluded 2016/17 with an operational budget surplus in excess of £950,000 having met its SIEP target with approximately 50% recurring contributions.

3. Conclusion/Summary

3.1 The Estates and Facilities directorate has continued to provide a safe, patient-centred, efficient and effective estate, with a record of achievement and a culture that strives for and delivers continuous improvement. Benchmarking undertaken nationally on behalf of Lord Carter against all other small/medium size Trusts provides assurance that our Estate and Facilities operating costs are within the lowest 20% compared to peer organisations. The directorate concluded the 2016/17 operating period with a budget surplus, delivered its SIEP target, reducing managerial staffing levels, reducing operating costs and increasing income generation. Quality standards are evidenced as good through patient-led inspections of the clinical environment (PLACE) and SPEQS inspections. An independent review of the Premises Assurance model provides confidence in the standards of compliance delivered. The directorate is well placed to continue to meet and achieve the challenges ahead. A detailed summary of key issues and achievements is contained within Appendix 1.

4. Recommendation

4.1 The Board is requested to receive this report.

Peter Mitchell
Director of Estates & Facilities Management
Appendix 1  Key Issues and Achievements

1. Premises Assurance Model summary report

The strategic aim of the Premises Assurance Report is to:

- Allow the Trust to demonstrate to our patients, commissioners and regulators that robust systems are in place to assure that our premises and associated services are safe.
- Provide a consistent basis to measure compliance against legislation and guidance across the whole NHS.
- Allow the Trust to compare how efficiently they are using their premises.
- Prioritise investment decisions to raise standards in the most advantageous way.

This report seeks to provide assurance to the Board of Directors, Commissioners, Regulators the public and other interested stakeholders about the Trust's performance and on-going work to address estates and facilities, safety and quality matters and compare estates and facilities efficiency with peer NHS providers.

Every NHS organisation has a unique combination of patient needs, priorities, requirements and resources, including its Estates & Facilities (E&F) services. Therefore, there cannot be a single overall approach to the provision of its E&F that produces optimal result for all NHS organisations. However, all NHS patients, visitors and staff have the right to receive an appropriate level of service. The NHS is committed to provide services in line with the NHS Constitution “right to be cared for in a clean, safe, secure and suitable environment”. The NHS Premises Assurance Model (PAM) is a tool that allows NHS organisations to better understand the efficiency, effectiveness and level of safety with which they manage their estates and how that links to patient experience.

The NHS PAM Self-Assessment Questions are grouped into five Domains, which are broken down into individual self-assessment questions and further sub-questions known as prompt questions.

The model is completed by scoring the prompt questions under each self assessment questionnaires. The six domains are:

- Safety (Hard and Soft)
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance

The NHS PAM has been produced for the financial year 2016/17 and includes a self-assessment to better understand the efficiency, effectiveness and level of safety with which the Trust manages their estate and how that links to patient experience. It also includes the 20017/18 action plan.

Areas in which the Trust Obtained a Rating of Outstanding

Out of 46 self-assessment criteria (333 prompt questions) the Trust obtained a partial outstanding rating in 16 of the self-assessment criteria, as follows:-
- Organisational Governance 1 - Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed.
- Safety Hard 4 – Health & Safety at Work.
- Safety Hard 5 – Asbestos.
- Safety Hard 6 – Medical Gas Systems.
- Safety Hard 7 – Natural Gas and Specialist Piped Systems.
- Safety Hard 9 – Electrical Systems.
- Safety Hard 14 – Fire Safety.
- Safety Hard 15 – Medical Devices and Equipment.
- Safety Soft 5 – Laundry and Linen Services.
- Safety Soft 9 – Portering Services.
- Efficiency 4 – Financial Controls.

The majority of further development relate to the production of local procedures.

Capital cost for reaching compliance with the PAM is estimated to be £478,000, and this is attributable to individual areas and included within the five year capital backlog programme.

2. **Conditional Appraisal of Trust property – aging estate**

In 2015 the Trust carried out a detailed Six Facet survey at the University Hospital of North Tees (UHNT), as defined within HTM 00 08 (Estates code) to determine the condition of the site.

The six facets surveyed were:
- Physical Condition.
- Functional Suitability.
- Space Utilisation.
- Quality.
- Fire and Health and Safety requirements.
- Environmental management.

The final report highlighted that the major engineering services were at or beyond their design life and were in need of replacement. However, the structural elements of the buildings were sound and had an estimated life of a further 20-30 years. The report also highlighted the estimated cost to bring the site back to a good condition. The cost was broken down by block and by building, electrical and mechanical services. The costs were also RAG rated to categorise the risk rating. Funding was secured from the Department of Health in October 2015 to invest £25m to replace the major engineering infrastructure. The infrastructure replacement projects commenced in September 2016 and the new HV electrical substations are complete. Works have commenced on the second project to build a new Energy Centre, which will be completed by August 2018 with the de-commissioning of the old boiler house by November 2018. This work will eradicate a significant portion of the primary infrastructure backlog but the secondary engineering services will still form a large portion of the high and significant risk backlog on the University Hospital of North Tees site,
which will need to be carefully managed, with targeted backlog funding for the foreseeable future to avoid unplanned breakdowns and disruption to patient services.

3. Corporate Health, Safety, Security & Car Parking/Non-Clinical Risk Services

Key Issues and Achievements:

- Successful implementation of an organisational change in the department creating new structure and allowed £20,000 SIEP to be declared.
- All H&S/Non Clinical Risk policies reviewed, revised and re-communicated, clearly demonstrating the risk management and monitoring processes.
- Premises Assurance –. Audits were undertaken with all required services to obtain assurances through self-assessment questions which support quality and safety compliance. This enables the Trust to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe.
- Development and monitoring of safer sharps compliance reports (monthly for individual Directorates and Quarterly for presentation to Medical Devices Committee).
- Continued development and delivery of the following specific training courses:
  - Fire Warden Training
  - Fire Team Leader Training
  - Conflict Resolution
- Trust training compliance figures as at 31st March 2017:
  - Fire Safety – 88%
  - Conflict Resolution Training – 92%
  - Spinal Awareness 99%
  - Manual Handling Patients 78%
  - Manual Handling Objects 91%
- Observational health and safety inspections covering general health and safety, and fire (141).
- Waste Pre-Acceptance audits required under Duty of Care (47).
- Bulk waste storage areas inspection (3) and statutory audits required to carry out waste pre-acceptance audits.
- Risk Assessment compliance audit x 166 audits and the production of Trust wide annual report and continued review and further improvements to the risk register in collaboration with Patient Safety and all Directorates. This involved reviewing, closing and making necessary changes / amendments within risks to allow the sharing of risk assessments within Directorates where applicable and enable the risk to comply with policy and statutory guidance.
- Anetic Aid QA3 trolley audit supporting Clinical Engineering / Estates and Quality and Performance undertaken across all three hospital sites.
- The department has been involved in supporting claims investigation and analysis and this has resulted in more timely and accurate evidence collation for claims and a reduction in the number of employee liability claims coming through. (2015/2016 = 34, 2016/2017 = 18). A number of these claims are now also being successfully defended resulting in a reduction in liability costs.
- Continued networking and sharing of information by attending the Local Security Management Specialist Network held by NHS Protect and the production of the Security Annual Report and Work plan which was forwarded to NHS Protect as required under
statutory regulations and condition of the national contract. LSMS/NHS Protect work has resulted in the following:
  o Completion of the organisational Crime Profile which has been issued to Commissioners.
  o Completion of the NHS Protect Security Management Standards for Providers 2016/2017 which was submitted to NHS Protect.
  o All NHS Protect national security alerts and local alerts were disseminated where necessary to provide staff with important information regarding potential violent patients and members of the public.
  • Appointment of an Fire Safety Advisor in November 2016 to give internal assurance on the fire safety performance of the Trust including working with Estates and Design and Development around:
    o Compartmentation
    o Fire hazard rooms
    o Fire dampers
    o Fire Plans
  • Review of the response, roles and responsibilities of the violent incident response team as well as reviewing the policy and procedures, resulting in Business Case.
  • Continued to develop close links with the police and proactively seek to undertake partnership working and information exchange in relation to potentially violent patients.
  • Increasing the use of acknowledgement of responsibility letters (ARA’s) to violent or abusive patients and visitors, which included behaviour ranging from physical assaults, verbal and racial abuse to threats and disruption.
  • Increased the visible presence of security into the A&E department providing body worn cameras and appropriate PPE for security officers.
  • Recycling volume up by 3% equates to 64 tonne.
  • Paper waste representing 73% of recycled volume (275 tonne).
  • Cost savings generated through new clinical waste contracts enabled £30,000 to be declared as recurrent SIEP.

4. Fire Safety

The responsible person (the employer of persons working at the premises, a person who has control of the premise or the owner of the premises) is required to undertake a suitable and sufficient assessment of fire risk. Responsibility for compliance rests with the responsible person. The duties of the responsible person are also imposed on every person other than the responsible person who has to any extent control of the premises. The person in charge of a ward at any given time is subject to the same responsibilities under the Fire Safety Order as the responsible person in respect of the ward, in so far as the elements they control.

The fire risk assessment for all Trust premises is carried out across four levels termed PK1, PK2, PK3 and PK4, the PK4 being applicable to refurbishment or new build projects. At each of these levels appropriate staff undertakes, an assessment of their area of responsibility, the assessments are collated to form an overall assessment of risk on an annual basis.

An action plan is produced for each area to address any issues identified and is the responsibility of the person in control of that area.

From April 2017 to date all in-patient areas have been assessed using the PK3 (Health and Safety Department) and action plans produced some areas have completed PK1’s, those
who do not have been advised of the need and Estates PK2 risk assessments are complete for each of the three Trust sites.

The Fire Brigade visited the University Hospital of North Tees on the 22nd February 2017 and the University Hospital of Hartlepool on 17th May 2017 and the outcomes at both sites were considered broadly compliant with some areas requiring attention.

- Breaches in the compartmentation and lack of fire stopping.
- Number of changes to the use of rooms – hazard rooms / compartmentation.
- Fire survey.
- Fire Evacuation Training.
- Fire Evacuation Strategy.
- Wedging Open of Doors.
- Ill-fitting Doors.
- Lack of intumescent strips and cold smoke seals.
- Lint filters in laundry requiring empty/cleaning.
- Change of detector heads to either optical or ionising smoke detectors.
- The testing and maintenance of fire systems are adequately managed. However, although improvements are being made to the control of penetrations and their subsequent repairs to compartmentation, a log or reference document is not available.

It was commented that it was apparent at both sites, whilst inspecting different departments and wards that a great deal of change has occurred over recent years, a number of rooms have either change their purpose over these years or have not previously been identified as Hazard Rooms as described within HTM 05-02. It was recommended that an audit should be undertaken to identify all such rooms and the provisions described within HTM 05-02 should be provided, such as 30mins fire resistance, FD30s doors and the provision of automatic fire detection (AFD). This recommendation was already in hand and included on the Trust Fire Safety action plan.

The representative of Cleveland Fire Brigade, is at present is comfortable with the results of recent fire safety audits which were undertaken at UHNT and UHH respectively and is confident that no further actions are required by either the Trust or Cleveland Fire Brigade at this time. Further discussion is taking place on requirements regarding the urgent request to review the fire safety of all the Trusts in-patient accommodation buildings and as such the Brigade representative and the Trust Fire Safety Adviser is confident that no further actions are required by either the Trust or Cleveland Fire Brigade at this time and particularly as a result of this advice, and confirmation from the Estates that all fire safety systems within the Trust are operating correctly and in the knowledge that the Trust has no external cladding materials of any concern.

In the recent annual report received from the Authorising Fire Engineer (external consultant to the Trust) in May the following was noted:-

- From the evidence assessed it is clear that there is a willingness and desire to provide appropriate fire safety provisions across the Trust. With ageing assets it is a challenge to provide appropriate modern, safe facilities, however, the Trust is using best endeavours to achieve this.
- Strategically there is an effective management structure in place and responsibilities have been assigned appropriately. Where possible the Trust is striving to achieve standards as
set out within HTM guides and where this is not possible it aims to achieve a suitable risk assessed compromises.

- The recent appointment of a qualified fire safety advisor has provided an increased level of fire safety expertise and has also provided impetus to assessing current fire safety provisions.
- Estates and Facilities have produced an action plan to address fire safety issues. This is a positive move and will greatly assist the overall management of fire risks.
- From the information assessed it is clear that the Trust is making progress, has a suitable management structure and a planned approach going forward that will be effective in management of fire risks.
- The production of an annual and long term fire safety plan will greatly assist in highlighting achievement and demonstrating progress against objectives in future years.
- The intention to invest in the replacement of the automatic fire detection system at North Tees due to supplier maintenance withdrawal due to age of the system is appropriate.
- The intention to strengthen fire evacuation strategies through the upgrading of passenger lifts to the standards of a ‘fire evacuation lift’ is considered most appropriate.

5. Occupational Health & Wellbeing Service

Key issues and achievements:

A healthier workforce means less avoidable days off sick, reduced levels of presenteeism and a more efficient workforce resulting in better patient care. The importance of promoting and improving staff health and wellbeing is increasing year on year. The Health and Wellbeing team within Occupational Health & Wellbeing Service was established only 12 months ago and has already made significant improvements in the range and accessibility of activities, advice, guidance and training available for staff and managers. Staff engagement and input was sought via a health and wellbeing survey to listen to what staff wanted to see with regards to health and wellbeing activities. This enabled the introduction of a range of new physical and mental health support activities including everything from running/walking clubs to relaxation classes to reading and singing group.

The introduction of the ‘Wellbeing Wednesday’ two weekly communication of local activities and national campaigns has resulted in significantly increased levels of staff participation and interest. This continued focus on health and wellbeing and increased engagement has resulted in achieving the best uptake in in staff having their ‘flu jab and the highest level of staff participation in activities and campaigns.

The team understand the financial challenges the Trust face and have started running fund raising events and seeking sponsors to support activities for staff.

Initiatives are receiving excellent feedback from staff and managers, such as providing fruit baskets to wards during the national ‘Blue Monday’ campaign and the perfect week, to thank staff for their continued hard work over the exceptionally busy winter months.

Feedback from individual staff and managers who have accessed the Workplace Mental Health Advisor have all been very positive and the introduction of the employee and managers stress workshops and mindfulness sessions are enabling greater accessibility for staff to excellent advice and guidance.
Accessibility to physiotherapy and the availability and quality of moving and handling training has also improved evidenced by feedback comments such as:

“Just wanted to thank you again for today’s training session. I have been with the Trust since 1991, and have been to quite a few Manual Handling sessions over the years. Today’s session was the most informative, the most inclusive and the most enjoyable that I have been too. Well done.”

The team are ensuring the Trust is at the forefront of staff health and wellbeing provision which is looked upon with envy from neighbouring Trusts. They have ensured we are well on track to achieve the Health and Wellbeing CQUIN targets for 2016/17.

The Trust has received external recognition for the work the team have done achieving the Better Health at Work Award for their “on-going commitment and outstanding practice in the workplace for health and wellbeing” and as a result were awarded ambassador status as well as gaining the continuing excellence award for the 3rd year running.

6. Lord Carter Model Hospital Metrics, Estates & Facilities

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<th>Cost Efficiency</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
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<th>Info</th>
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7. **Capital Programme and Design and Development Service**

The 2016/17 capital programme progressed very well with 98% of the allocation being invoiced or accrued as goods received by the end of the financial year. The full allocation was £11.219m, of which the £8.139m was directly managed by the directorate. This comprised of allocations for the replacement of medical equipment of £2.990m, UHNT infrastructure upgrade £4.649m, backlog maintenance £0.5m. A further £2.731m of commitment was incurred above allocation which addressed schemes which emerged during the year including the Integrated Urgent Care Centres on both hospitals including associated enabling moves, notably paediatric OPD, theatre 5 & 6 refurbishments and the acquisition of Hardwick Health Centre and its subsequent redevelopment to form an additional income generating car park.
Specific schemes undertaken in the year include:

- The UHNT site has now acquired an increase to its electrical supply intake capacity from 1.8 Megawatts to 2.5 Megawatts from Northern Powergrid through the development of a new primary high voltage intake substation.
- Construction, commissioning and energising of new electrical sub-stations for the UHNT site was completed.
- Completion of the design and procurement phases for the new energy centre at UHNT; evaluations of tenders were completed and contract awarded to NG Bailey.
- Development of the Urgent Care Centre at UHH incorporating a new radiology capacity within the centre.
- Development of the Urgent Care Centre at UHNT involving the enabling schemes:-
  - Upgrading of Jervaulx House to create additional office accommodation.
  - Upgrading of North Wing Floor 3 office accommodation to relocate staff from the Women and Children’s services.
  - Construction of a new purpose designed, high quality Paediatric OPD.
- UHNT Theatre 5 – replacement Ultra-Clean Ventilation system.
- UHNT Theatre 6 - replacement Ultra-Clean Ventilation system. Also new operating light, medical gas pendants, surgeons’ panel, LED lighting, flooring and decoration and new isolated power supply and uninterruptable power supply equipment installed.
- Acquisition (99 year lease) of Hardwick Health Centre site, demolition of existing buildings and construction of 150 space new car park.
- Synexus Ltd Clinical Trials Suite – significant input and collaboration between the Trust and Synexus in planning the design of the new unit and advising and overseeing the construction phase. Largely completed in 2016/17 but scheduled for opening in June 2017.
- Completed the review and updating of all of the Trust’s fire plans.
- UHH surplus land- initiated discussion amongst the Trust, the Thirteen Group, Hartlepool and Stockton CCG, Hartlepool Borough Council and to form a collaboration to develop the surplus land.
- Supported the development of the Sustainability and Transformational Plans estates options working in collaboration with colleagues in neighbouring Trusts.
- Capital audit undertaken by Audit One, demonstrating significant compliance.

8. Clinical Engineering Service and the Medical Equipment Replacement Programme

The Clinical Engineering department oversees the maintenance, safety and reliability of all medical equipment within the Trust; currently there are 16,067 assets on the medical equipment asset register. During 16-17, preventative maintenance was undertaken on 9000 items of equipment and unscheduled maintenance on 4000 items achieving 96% completion on our high and medium risk PPM’s. The service oversees 291 maintenance contracts with a value of £1.55M. In addition new items of equipment are commissioned and equipment at end of life is decommissioned. As well as overseeing the maintenance, safety and reliability of all medical equipment within the Trust the department has advised and supported clinical directorates through bringing forward business cases to replace medical equipment through the capital allocation process.

A key achievement for 2016/2017 was the replacement of all our Carefusion infusion devices at no capital cost to the Trust, the replacement program consisted of 427 volumetric pumps
and 200 Syringe drivers with a recurring saving to the Trust of £370K on consumables and £60K on spare parts.

During 2016-17 the department supported the replacement medical equipment:
- **Radiology.** A new X-ray machine was purchased and installed for the lung health department to replace the existing machine which has come to the end of its life. Two new portable X-ray machines were purchased. Two new Image Intensifiers for use within theatres producing a much clearer image than the two aging machines they replaced.
- **Community Dental.** A refit for the Eston Dental Clinic has been carried out, the work included replacement of the dental cart and chair.
- **Endoscopy.** A new state of the art endoscopy stack system has been bought replacing a current video trolley no longer supported by the manufacturer. Along with the Stack System there were 5 endoscopes that also are no longer supported by the manufacturer that were replaced.
- **Urology Services.** Replacement urodynamic machine.
- **Outpatients.** A replacement colposcopy scope was purchased and installed in OPD.
- **Pathology Services.** Replacement microtomes and blood fridge
- **Cardiology.** Two new Cardio Echo machines used to scan the heart for anomalies have been purchased; the new machines provide a much improved clarity to the images produced.

The department has successfully worked with clinical directorates to develop agreed medical equipment annual replacement programme for 2017/18, this has streamlined the approval process and allowed approvals to be based on an agreed protocol against all requests.

9. **Estates Services**

The Estates Strategy continues to be delivered through the work of the Estates Department, space utilisation improvements which have seen local authority and educational services, Community Services, and Urgent Care Centres all occupy space at both hospitals. North East Ambulance Service is currently occupying space within the estates department at UHNT and has expressed interest in further expanding their presence. The utilisation of the estate for clinical activity has a Lord Carter metric of 65% or greater and has this year exceeded this value.

Concentrated efforts working with the Design and Development department have delivered some challenging projects including new theatre ventilation systems within occupied areas and the on-going electrical infrastructure works, which has seen extensive electrical work with minimum impact to the Trust.

Improvements to the Patient Environment have continued to be delivered via the ward decant programme, allowing greater maintenance activities such as the installation of new energy efficient lighting (LED) and full ward re-decoration utilising dementia friendly colour schemes, enhancing the healing environment. This initiative was trialled within the Holdforth Unit, following very positive feedback this has now set the standard for all such ward refurbishments during decant. The improvements to the ward environment are further supported by the dedicated ward ‘Handyman’ scheme to provide a same day service to most maintenance repair requests.

The Estates Service’s continues to provide a safe, compliant and cost effective service which compares favourably when benchmarked against peer organisation for occupancy costs. Performance has been enhanced through the introduction of hand-held personal computer
devices (PDA) across the whole of its workforce, using technology solutions to reduce the reliance upon paper-based systems; in excess of 1000 individual job tasks are produced and processed each week. The department’s medium term strategy is to become completely paperless for planned preventative and reactive tasks by 2018. To introduce reconciliation of work tasks via the PDA’s as estates staff log on and off to each work task, this will record productivity levels and via analysis will provide information to further drive productivity. There is an ambition via the Scan4Safety project to barcode all estates assets, utilising the PDA’s to recognise the barcodes thus recording asset attendance and full service history electronically.

10. Carbon Reduction and Sustainability

The NHS Sustainable Development Unit (SDU) has reported that the wider NHS community in England was responsible for more than 30 million tonnes of CO$_2$ in 2010. In recognition of the urgency of climate change, the UK Government introduced the Climate Change Act 2008 and committed itself to take action and cut UK carbon emissions by 10% by 2015 (based on 2007 reference levels), 34% by 2020 and 80% by 2050.

The Trust commenced its participation in the NHS Carbon Management Programme in May 2010 with the purpose of reducing carbon emissions, making energy savings and reducing costs, thereby demonstrating the organisation’s commitment to ‘good corporate citizenship’.

The initial period of the programme has now been completed, whereby the Trust set itself and achieved an ambitious target for reducing CO$_2$ emissions by 17% over the 5 year programme and by 20% (or 3000 TonnesCO$_2$) against the Government benchmark year of 2007/08. As a direct result of this programme recurring financial savings have been made annually, representing cost and tax avoidance of some £1million pa.
The effects of site rationalisation and service transformation are apparent on each site, but the overall reductions are clear; indeed the range of carbon management initiatives introduced has placed the Trust within the lowest 20% for energy consumption against its peers as seen in Lord Carter metrics for CO₂ and utility costs/m².

Moving forward, the investment in major infrastructure will allow the Trust to make further savings through specifying new equipment and technologies and by implementing known energy saving measures. In particular is included the installation of 250KW of solar photatic panels. As such a new target for further carbon reduction has been set at 2-3% per year over the next 5 years.

11. Catering Service

Key issues and achievements:

- Introduction of new Ward Beverage Trolleys to improve the range of beverage services available for patients.
- Successfully achieved Trust CQUIN requirements for 2016/2017 Health & Wellbeing 1B Healthy food for staff, visitors and patients.
- Introduced a range of chilled drinks available for patients throughout the day delivered by ward hostesses as an alternative to a hot drink or a jug for the patients’ bedside which supports patients’ hydration particularly during periods of warmer weather.
- Introduced a pilot scheme to extend the ward hostess service on wards 28 and 29, this has proven extremely successful with both patients and ward staff in terms of improved quality of service and reduced involvement of ward staff. The directorate seeks to further roll-out the successful pilot whilst exploring means to maintain a cost neutral solution across the directorate.
12. Portering Service

Key issues and achievements:

- The Portering services were delighted to be recognised as the Team of the Year in 2015/16, and recognition of Andy Howard, Portering Services Supervisor who was awarded Employee of the Month Award in April of 2017 has further helped to reinforce the service profile across the organisation.

  The service operates at costs below the Lord Carter benchmarking comparison against peer organisations.

- Portering & Transport services have supported winter pressures and capacity surges by increasing resources and introducing the following:
  - Additional A&E Porter working at peak times between 15:00 and 23:00 which continues to be provided.
  - Introduction of a “man in a van” to deliver prescriptions to patients homes speeding up the discharge process.
  - Additional Porters recruited specifically for winter pressures working predominantly through the emergency care pathway areas.
  - Increased staffing levels within Radiology to meet 7 day clinical service requirements.

13. Linen Service

Key issues and achievements:

Linen Services continue to provide a seam-less service to the Trust across all sites with the contract delivered by Berendsen performing to expectations. The tender process was commenced during October with Berendsen again successful with a 5 year contract award and in return the Trust receiving a discounted price to provide a cost per piece below peer median comparisons.

Changes to the issuing of uniforms and laundering policy commenced in 2015 and continues cost avoidance on purchasing and cleaning with a reduction of circa 100,000 items now being processed since the commencement of the project.

Improvements in the facilities in the staff changing areas have been on-going throughout the year along with audits of lockers. This has enabled tighter controls on the use of lockers and as a consequence increased availability for employees.

14. Domestic Services and Deep clean/Ward Hygienist Team

Key issues and achievements:

The departments have continued to provide excellent, high quality, routine and responsive cleaning services to the Trust across North Tees, Hartlepool and the Peterlee sites. During 2016-17 almost all of the cleaning provided in the community including the One Life was transferred to NHS property services with only Eaglescliffe Health Centre remaining in-house.

Excellent standards have continued to improve year on year, this has been reflected by the cleaning standards monitoring measured monthly, and in line with the National Standards of
cleanliness. This is validated by favorable and positive feedback from our patients in the national in-patient survey results. This has been especially encouraging while operating under continuing significant pressures on the system in relation to patient throughput.

The ward decant programme 2016/17 was completed which underpins and supports the ongoing work of domestic services and estates. All medical wards were decanted from the main ward block as was each ward from west wing, this allowed the deep cleaning and bio decontamination element to be carried out; cleaning of ventilation systems, deep cleaning, light fitting cleaning and maintenance or replacement in some cases, all equipment, furniture and fittings were deep cleaned. In addition the opportunity to ensure we are managing and maintaining the estate; re-decoration, minor repairs highlighted prior to the ward moving and any necessary, improvements required which can’t be undertaken within an occupied ward.

15. CSSD Service

Key issues and achievements:

- The department was successful in maintaining its ISO13485:2016 & MDD93/42EEC accreditation within both Sterile Services and the SSD Endoscopy Unit, this was achieved following an intensive 3 day external audit review.
- The department has exceeded its agreed turnaround timescales of 24 hours down to less than 12 hours where required through working closely with Theatres and other service users to continually improve the service.
- Expansion of endoscopy reprocessing services in response to the demands of the regional bowel screening service.
- Extending the current traceability system to include flexible endoscope processing at North Tees and Hartlepool decontamination units.
- Exploring the potential to provide an endoscopy reprocessing service to the Nuffield hospital.

16. Commercial Service

Key issues & achievements:

- Finalise Communications team new Anthem magazine contract saving Trust £20K per annum with potential of additional Advertising income.
- Secure £60K income from TV filming productions Rough Cut TV at Hartlepool Hospital for BBC Comedy series and Vera (ITV series).
- Finalise Business case and approval for TV Screen solution for Trust across 60 TV screens improving Communication Strategy for patients, visitors & staff with Income potential from advertising and sponsorship.
- Income of £20K achieved by Advertisers across the Trust in various platforms such as Internet, Posters, leaflets, Lift doors and many more.
- Facilitation, management and promotion of internal staff Salary Sacrifice schemes for Home Electronics and Bikes providing Tax and pension contribution savings to staff and Trust of £40k per annum.
- Drafting of full Business plan for Private Anatomical Pathology training business to be provided by Trust as well as Business proposals for income generation for Audiology private service, Podiatry private service, Radiology income generator and A&E prescription Out of Hours income.
• Retail provision and management of daily stall holders across both hospital sites generating income for the Trust of £22K.
• Successful product development of proto-type self-releasing Tourniquet with full market evaluation, product trials & testing, Patent registration to production step.
• Marketing support provided to Catering re-brand, Optimus Health branding, Occ Health Campaigns, Maternity Service promotion, Panacea product marketing, Team Durham Physio Service Marketing, APTitude Ltd Branding and many more.
• Received £18,500 income from AHSN for meeting annual Innovation targets through submission of performance reports and innovation business plan & strategy.
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

July 2017

Executive Summary

Research & Development

1. Strategic Aim
   Putting Patients First

2. Strategic Objective
   Maintain Compliance and Performance

3. Key Issues and planned actions

   **Financial sustainability:** Further reductions in funding from the NIHR via the regional research network are likely, we need to be able to mitigate against this by increased grant and commercial income.
   Action: promotion and support of increased external grant applications and commercially sponsored research activity via business case for Trust funding of Band 7 Research Co-Ordinator 1.0WTE post to provide support for submission of such grants.

   **Maintenance of skilled workforce:**
   Action: Business case for trust to underwrite further research delivery posts with permanent contracts to ensure skilled staff aren’t lost to other trusts/departments due to concerns around temporary contracts. Consideration of potential joint medial appointments with Synexus Clinical Research Facility to improve recruitment and retention of medical staff into the Trust.

   **Recruitment constraints:**
   Action: Directorates to ensure research is embedded and as many relevant people as possible are offered access to GCP training to maximize the Trust’s ability recruit outside of core weekday hours when R&D staff are present. Support for specialist nurses to contribute to research recruitment where applicable

4. Recommendations
   a. Support of business cases for increased Band 7 research co-ordinator role to support Chief Investigator grant applications and underwriting of R&D temporary posts with permanent contracts
   b. Explore possibility of joint appointments with Synexus Clinical Research Facility

Author Name: Dr Deepak Dwarakanath
Title: Medical Director
Date: 30/06/2017
1. Introduction/Background

We exceeded our NIHR annual recruitment target of 818 patients by recruiting 846 patients in a challenging year. Implementation of the new regulatory process run by the Health Research Authority impacted on the approval of studies at the beginning of the year, these delays reduced our recruitment window quite significantly in some instances.

We remain a trust that largely recruits to clinical trials that have been developed and sponsored elsewhere. Through the R&D Incentive fund, we try to support clinicians though the provision of a clinical PA session to develop applications for submission for external funding. The new R&D Co-ordinator is now responsible for mentoring and liaison with novice researchers to guide them through the grant submission process and progress these individuals through to successful grant applications. We are also in discussions with neighbouring Trusts to establish a joint “Chief Investigator mentoring programme” all of which should support the development of more Trust Chief Investigators.

The Three new R&D committees have been running for a year now and have been hugely successful in ensuring we have Trust wide engagement with research. We regularly have over 25 Trust staff attending the bi-monthly Trust Research Awareness and Governance (TRAG) meetings.

The Trust Research Advisory committee (TRAC) has ratified the new R&D strategy. Our new strategic aims are:

- To ensure engagement from all staff groups and areas in research to ensure all patients have an opportunity to participate in research
- To maintain current levels of non-commercial research activity and increase where possible
- To increase our participation in commercially sponsored trials
- To ensure recruitment for commercial and non-commercial research is delivered to NIHR time and target metrics and monitor this performance
- To develop strategic partnerships across the STP footprint to maximise opportunities for a collaborative and strategic approach to research delivery
- To develop Trust sponsored Chief Investigator led studies and a robust research delivery infrastructure
- To ensure the Patient Research Ambassador role actively engages with patients and raises the profile of research with them.
Recruitment Activity

1.1. Official annual NIHR Portfolio recruitment figures

Although we exceeded our target for the year by 28 patients, we have seen a slight decrease in the total recruitment compared with the previous year. Nationally there has been a decrease in the overall numbers of patients being recruited as there are fewer large observational studies with higher recruitment potential. 44% of the studies we participated in were interventional or commercial. This is a reduction on the proportion of such trials last year (77%). Recruitment largely operates on a 9-5 basis – we need to include more non-R&D staff on delegation logs to increase recruitment opportunities out of hours.

Research Activity is now evident in almost all directorates. For the Out of Hospital Directorate we have initiated a one year Community Research Forum outlined later in the document to raise the profile of research and increase participation in studies.

Fig 2

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</tr>
<tr>
<td>Surgery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HiSLAC PROJECT</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>Community</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Trust-wide OOH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>818</td>
<td>846</td>
</tr>
</tbody>
</table>

Target recruitment = 818
Actual recruitment = 846
Performance review

Performance in Initiating and Delivering Research (PID)

Our contract with the NIHR CRN:NENC places increasing emphasis on reporting of data for the NIHR/Department of Health “Performance in Initiation and Delivery of Research” (PID). The Trust is monitored in relation to

- our ability to approve studies and recruit the first patient into a study within 70 days of receiving a valid application pack.
- Recruiting to time and target for commercial studies

Data is submitted quarterly to the Department of Health along with explanations of why targets haven’t been met and any mitigating factors. Data below shows our quarterly Trust performance against the PID metrics for 2016/17 with national comparator data shown where available.

**Fig 3 % Trials meeting 70 day benchmark**

*Note no trials eligible in Q3*

**Fig 4 % commercial trials recruiting to time and target**

To further raise the profile and directorate responsibility to report on research performance, we have introduced a requirement for each Directorate to annually present data on their research performance as “guest directorate” at the Trust Research Awareness and Governance committee (TRAG).
3. Areas of growth

Using a combination of commercial income and a small amount of NIHR income we have created new posts to enable us to increase activity within

- Anaesthetics & Critical Care
- Surgery
- Orthopaedics
- Cardiology

Job descriptions for all specialist nurses in the Trust now include a responsibility to promote or participate in research. To assist with this, the R&D Manager and Co-ordinator will run a series of workshops for all specialist nurses in 2017/18 as an introduction to research. It’s hoped that ultimately this will lead to us being able to include specialist nurses on the delegation logs of studies which will maximise our potential to recruit to studies, particularly outside of normal working hours.

4. Commercial activity

Our collaboration with the external Clinical Research Facility Synexus has culminated in the successful conversion of the ground floor Middlefield Centre into an 8 room Clinical Research Facility which will be operational from July 2017. There are opportunities to develop joint posts with Synexus that will be attractive to prospective medical grade applicants that will provide an opportunity to work in the research facility whilst also contributing to NHS clinical work.

The NIHR have prioritised participation in commercially sponsored studies for all NHS trusts. We continue to increase our participation in these studies. We now have 16 commercially sponsored studies active within the Trust in this year (12 last year) within Respiratory Medicine, Paediatrics, Neonates and Cardiology, Gastroenterology and Orthopaedics all active in commercial research.

Our respiratory and cardiology research teams continue to enhance their reputations as “preferred sites” for commercially sponsored research studies. The Cardiology research team was recently visited by the global representatives from a commercial company to learn lessons from their very successful recruitment strategies for the RELAX-2 study.

5. Research led by North Tees & Hartlepool staff

We have three Trust Chief Investigators in the Trust who have gained external funding to run their own studies (Prof Samir Gupta, Prof Matt Rutter, Mel McEvoy). We are actively supporting an additional 10 potential Chief Investigators at varying stages of their research study development including Caroline Fernandes-James (Respiratory physiotherapist), Iain Loughran (Physiotherapist), Pud Bhaskar (Breast surgeon), Samir Gupta (Neonatologist) and Matt Rutter (GI consultant), Richard Jeavons (Orthopaedic surgeon) and Alan Middleton (Orthopaedic surgeon)

6. Staffing/Finance

Maintaining the skilled research nurse / AHP workforce is paramount to ensure continuity of research delivery support. We currently have 6 permanent cross-specialty research nurses in post (NIHR funded but posts are underwritten by the trust), we aim to submit a business case to secure additional permanent posts within the Trust so that we can provide greater job security and retain the skills of the staff to ensure they do not have to return to their substantive clinical positions at the end of secondment periods.
In addition we need to increase the support we offer to potential Chief Investigators in the Trust and plan to increase the level of WTE for this function through submission of a business case.

Our income from non CRN sources increases year on year.

**Fig 5 Non CRN External income**

All additional income received is used to fund additional research delivery posts as well as funding clinical PA sessions. We received a cut in the clinical PA allocation from the NIHR NENC for 2016/17 and again for 2017/18 so our commercial income will be increasingly relied upon to fund PA sessions to delivery research.

We receive £20K in Research Capacity Funding from the Department of Health annually for recruiting over 500 patients into trials. This part-funds our Research Coordinator post. In addition Prof Rutter’s RfPB bid will provide additional RCF funding which we will use to fund a research fellow to help develop the next grant application.

External grant income and commercial income are the only way we can mitigate against further cuts in the NIHR NENC budget we receive so it is imperative that we increase our financial sustainability from these external income sources.

7. Training

**Community Research Forum**

To assist with participation in NIHR portfolio research and develop Chief Investigator led studies from the Nursing and Allied Health Professionals (AHPs) within the OOH directorate, we have committed to a 12 month programme of more intensive research support to the directorate. This comprises presentations, workshops and 1:1 mentoring with experts from within the R&D department and from the Research Design Service (RDS) from Durham University. This has already resulted in a successful application to the R&D Incentive fund for a physiotherapist to develop a CI led study and grant application.

We currently have 133 members of staff with valid Good Clinical Practice (GCP) training and will be delivering more GCP training within the Trust rather than at external locations.

8. Patient Involvement and feedback

We conducted a survey of research participants to assess their satisfaction with their involvement in research and understand whether there was anything that we could have improved upon. The main results show 94% of respondents felt the purpose of the research was explained properly, 98% felt they had enough time to consider before taking part, 96% would recommend taking part in research to others. Qualitative comments indicated they felt valued and appreciated being able to contribute to the evidence base.

We have successfully appointed a volunteer to be a Patient Research Ambassador (PRA) for a 12 month period. Their role will be to raise the profile of research with patients and carers and ensure we have active involvement of patients in all aspects of our research activity.
9. Risks

Financial risk
The main risks to the Trust from its research activity relate to financial sustainability of the current research activity/nursing resource. The NIHR funding to the Trust has decreased in real terms over three successive years because there haven’t been any increments to the overall regional budget yet all Trusts are more research active. Our clinical PA allocation from the NIHR for 2017/18 has been reduced as expected and this is an indication of the future funding difficulties we will face - we must plan for Trust support and funding of research PAs to ensure enthusiastic and dedicated clinicians who participate in research have sufficient job planned time to do so. Where these can be funded or supplemented by commercial income we have sought to do so but not all areas are able to generate commercial income. We need to ensure there is growth in our commercial income and grant income to mitigate against any NIHR cuts and adopt a trust-wide approach to supporting research activity from this income rather than viewing it as specialty specific income. The TRAC committee will work on a model for financial management of this.

Risk to patients and staff
Adherence to Trust SOPs, national guidance and European Clinical Trials Regulations is monitored by a mixture of regular risk based monitoring by both the R&D Department and by external monitors for commercial studies. Risks are minimised by ensuring all staff are suitably trained for their role in the research study and only signed off on delegation logs for their delegated duties once the Principal Investigator is satisfied they are suitably trained. Risks will always be present but through our monitoring, auditing and training programmes we are satisfied that all risks are mitigated as far as possible. A thorough review of the risk register for research will be undertaken and reviewed on a monthly basis.

10. Accolades / Achievements
Certificates of Excellence were awarded to R&D for from Teesside University for their student nurse placements in the department. Deborah Wilson and Liz Baker were awarded their Masters in Clinical Research from Teesside university with Liz Baker achieving the prize for student of the year for the course, their course fees were funded by the Trust R&D Incentive fund. We achieved an 85% response rate to expressions of interest for commercial studies. Our surgical and Respiratory teams received “performance flow through payments” from NCRN NENC for successfully recruiting to time and target for some of their commercial studies.

11. Conclusion/Summary
The R&D department have exceeded their NIHR recruitment target despite a challenging year. In order to maintain NIHR funding in subsequent years we need to ensure clinical PA time is supported to deliver studies, the skills of research delivery staff are maintained within the team and not lost due to fears around fixed term contracts and that we continue to support the development of Chief investigator led studies and grant applications.

The Synexus Clinical Research Facility presents a unique opportunity for the Trust to broaden the scope of studies offered to patients, increase commercial income and raise the profile of the Trust as one that supports cutting edge clinical research.

Author Name Jan Greenaway
Title R&D Manager
Date 27/06/2017
Executive Summary

Actual and Potential Organ Donors
2016/2017

Report of Kevin Robinson, Non-Executive Director
And Dr A D Dwarakanath, Medical Director

Strategic Aim

Maintain Compliance and Performance

Strategic Objective

Maintain Compliance and Performance

1. Introduction

1.1 NHS Blood and Transplant set key targets for the UK in relation to Organ Donation. The Trust's performance is measured against these key targets.

1.2 The Specialist Nurse – Organ Donation (SNOD) audits the deaths that occur in both the Emergency Department and the Critical Care to monitor performance.

1.3 The information in this report has been taken from the report provided by NHS Blood and Transplant to the Trust. Attached is the Detailed Full Report.

2. Key Issues & Planned Actions

2.1 Donor Outcomes: A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated, obtained from the UK Transplant Registry.

Donors, patients transplanted and organs per donor, 1 April 2016 – 31 March 2017 (1 April 2015 – 31 March 2016 for comparison)

<table>
<thead>
<tr>
<th></th>
<th>Number of donors</th>
<th>Number of patients transplanted</th>
<th>Average number of organs per donor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>Deceased donors</td>
<td>4 (4)</td>
<td>11 (8)</td>
<td>3.5 (3.0)</td>
</tr>
</tbody>
</table>
2.2 **Key Rates on Potential for Organ Donation:** - A summary of the key rates on the potential for organ donation, obtained from the Potential Donor Audit (PDA)

**Key numbers, rates and comparison with national targets,**
1 April 2016 – 31 March 2017 (1 April 2015 – 31 March 2016 for comparison)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients meeting referral criteria (1)</strong></td>
<td>6</td>
<td>1775</td>
<td>5</td>
<td>1747</td>
<td>21</td>
<td>6204</td>
</tr>
<tr>
<td>Referred to SNOD Referral Rate %</td>
<td>6</td>
<td>100%</td>
<td>5</td>
<td>100%</td>
<td>18</td>
<td>88%</td>
</tr>
<tr>
<td>Neurological Death tested Testing rate %</td>
<td>6</td>
<td>100%</td>
<td>4</td>
<td>80%</td>
<td>1684</td>
<td>96%</td>
</tr>
<tr>
<td>Eligible donors (2)</td>
<td>6</td>
<td>1329</td>
<td>3</td>
<td>1296</td>
<td>19</td>
<td>43%</td>
</tr>
<tr>
<td>Family approached Approach rate %</td>
<td>5</td>
<td>83%</td>
<td>3</td>
<td>75%</td>
<td>1296</td>
<td>92%</td>
</tr>
<tr>
<td>Family approached and SNOD involved % of approaches where SNOD involved</td>
<td>5</td>
<td>1236</td>
<td>3</td>
<td>1180</td>
<td>19</td>
<td>43%</td>
</tr>
<tr>
<td>Consent given Consent rate %</td>
<td>4</td>
<td>80%</td>
<td>3</td>
<td>100%</td>
<td>91%</td>
<td>891</td>
</tr>
<tr>
<td>Actual donors from each pathway % of consented donors that became actual donors</td>
<td>4</td>
<td>7819</td>
<td>2</td>
<td>786</td>
<td>0</td>
<td>565</td>
</tr>
</tbody>
</table>

(1) DBD – A patient with suspected neurological death
DCD – A patient in whom imminent death is anticipated, i.e. a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

(2) DBD – Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD – Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

3. **Recommendations**

The SNOD will continue to monitor performance and feedback on a regular basis (namely the Critical Care, Emergency Department and the Organ Donation Committee). The Trust compares favourably against the national figures in many of the key performance areas and caution should be applied when interpreting percentages based on small numbers.

NHS Blood and Transplant has chosen to remove most of the National Targets; the focus now is to address missed opportunities. The biggest concern for last year was the DCD consent rate. Although a SNOD was involved in all formal approaches to families, the reason that all 3 families gave for refusing donation was timing. The SNOD will now also audit the timing of the referrals to SNOD and feed back to the unit involved to promote early referrals.

DCD approach rate will always be low due to the local team screening patients for their potential to donate organs for transplant; as long as all patients are referred families will be approached appropriately.

We cannot be complacent, maintaining our excellent SNOD involvement and DBD consent rates will continue to be a challenge, this relies the continued excellent support from both the hospitals health care professionals and the Northern Specialist Nurses Organ Donation Team.
In order to address any missed opportunities, the SNOD and CLOD will case review and feedback to the clinical area, when an opportunity is missed. This may include missed referrals, approaching a family without the SNOD, family refusal to donate and not maximising the potential to donate by failing to manage a potential donor appropriately. Please find attached a letter from NHS Blood and Transplant, regarding addressing missed opportunities.

Please note: - The number potential DCD patients in this executive summary differs from the Detailed Full Report, due to the late submission of a missed referral for a potential donor in Accident and Emergency.

4. Kevin Robinson, Non-Executive Director
   Dr A D Dwarakanath, Medical Director
   2017
Dear Colleagues,

Thank you for making 2016/17 another record year for organ donation and transplantation. There were 1413 deceased donors last year, up from 1364 the year before, and this meant that 3712 patients were able to receive a transplant. This is 5% more than in 2015/16 and it is all down to the generosity of donors and their families and the dedication of everyone in the donation and transplantation communities. Overall, we have now seen a 75% increase in deceased donors compared with the baseline year of the Taskforce and a 56% increase in deceased donor transplants. This is an immense achievement; thank you.

As you know, our ambition is to be world class and the progress made last year proves that this is realistic. Family refusal remains a big challenge and it is encouraging that, in the last quarter, we achieved an overall consent/authorisation rate of 65%, 72% for DBD and 61% for DCD.

Yet there is still more to do and we won’t become world class by just increasing the consent/authorisation rate. We must take every opportunity to save lives through transplantation.

Our theme for next year is one of Missed Opportunities and this applies to the whole of the donation and transplantation pathway.

For those involved in organ donation, please work with us to make sure that:
- no referral is missed;
- every organ donation discussion with a family involves a Specialist Nurse;
- as many organs are retrieved and transplanted as possible by ensuring physiological optimisation of DBD donors and minimising warm ischaemic injury in DCD donors.

These objectives should be core elements of your Organ Donation Committee meetings – understanding and learning from every single occasion in which a patient was not referred, when a Specialist Nurse was not involved and when donor optimisation was less than it could have been. A recent visit to James Cook University Hospital highlighted areas of good practice (see attached report). We suspect that many other units can also demonstrate similar success and if this is the case, please let us know.
Opportunities for transplantation are also missed when organs are being offered. Our organ utilisation strategy supports transplant clinicians to safely utilise higher-risk organs for patients who understand the balance of risk in remaining on the waiting list. We would encourage transplant centres to discuss and reflect on possible missed opportunities after turning down an organ.

Together let’s miss no opportunity to make donation and transplantation happen. With 4 to 5 deceased donors every day we can save or improve the lives of more than 4000 people this year.

Yours faithfully,

E. Sally Johnson
Director of Organ Donation and Transplantation
NHS Blood and Transplant

Prof John Forsythe
Associate Medical Director, Organ Donation and Transplantation
NHS Blood and Transplant

Dr Paul Murphy
Clinical Lead for Organ Donation, Organ Donation and Transplantation
NHS Blood and Transplant
Learning from visit to James Cook University Hospital 16/3/17

- Trust is a trauma centre (with helipad) and neurosurgery centre.

- Organ Donation journey started about 15 years ago with the appointment of a donor liaison nurse.

- Organ Donation Committee is chaired by one of their Medical Directors and reports directly to the Trust Board. Board receives a report on progress annually, sometimes with Clinical Lead – Organ Donation (CLOD) in attendance. Since 2008 all CEOs have taken a personal interest in OD: new CEO was told on induction that this was one of the things she should keep as a priority. She was aware of the OD performance reports and reviewed them.

- CLOD is a nephrologist. IC consultants have a strong preference for separating the CLOD role so there is neither a real nor a perceived conflict of interest. Nephrologist is a senior, established consultant whose views carry weight and who is prepared to have difficult conversations about missed opportunities.

- As a Level 1 Trust, there is a Specialist Nurse – Organ Donation (SNOD) team of three. All were previously nurses on the ICU. Clearly a positive team who work well together.

- Strong culture that organ donation is a positive act. Organ Donation memorial tree in courtyard, OD notice boards in corridor with considerable patient, family and staff traffic. OD notice boards also on ICU corridor. Potential donors admitted to ICU and if full, will find space elsewhere to ventilate.

- Culture is reinforced by strong SNOD & CLOD leadership, eg:
  - Messaging that the consent process starts when the patient is admitted. Staff understand that quality of care received before death contributes to consent.
  - SNOD attitude: *respectful but not timid*. Able to tell many stories about challenging paternal/maternal attitudes and how this takes away the choice to donate from families.
  - Message to ignore contraindications and *refer everybody*. Tell the SNODs about anyone with ‘blown pupils’ as early as possible.
  - CLOD very clear that 100% referral is expected.
  - Recent neonatal donation clearly a positive experience.
  - Visiting SNODs and retrieval teams notice that they are welcomed by ICU staff.

- Training is regular and at different levels:
  - Familiarisation training for those with peripheral involvement
  - More detailed training for ICU staff. One of the IC consultants takes a lead on training juniors in BSD testing. All consultants provide advice to colleagues in other local hospitals who may only do BSD occasionally.
o CLOD aiming to get all IC senior doctors on the breaking bad news course.

- Culture and Training supported by excellent **processes** and supporting materials:
  - Bright yellow folder on ICU containing all documentation needed to support OD.
  - Brain stem death testing leaflet for families (currently being reviewed using PDSA cycles)
  - Use Map of Medicine to guide ICU through process, especially the section on stabilising donors for testing. Ask nurses to follow this overnight so donors can be tested first thing in the morning.
  - Organ donation built into general trust policies on care of the dying rather than separate.

- Imaginative use of donor reimbursement monies includes:
  - Putting medical gases into a room on ICU to create an extra space to enable donation happen when there are no beds.
  - Redecorating family room and family overnight room to improve the environment. ICU staff all know that this has been done from donor reimbursement money to benefit all ICU patients’ families

---

E. Sally Johnson
March 2017
Detailed Full Report
Actual and Potential Organ Donors
1 April 2016 - 31 March 2017

North Tees and Hartlepool NHS Foundation Trust
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   2.1 Key rates
   2.2 Key numbers and rates

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   3.1 Overview of lost opportunities
   3.2 Neurological death testing
   3.3 Referral to SN-OD
   3.4 Contraindications
   3.5 Family approach
   3.6 Proportion of approaches involving a SN-OD
   3.7 Consent
   3.8 Reasons why solid organ donation did not occur

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   4.1 Key numbers and rates by unit where the patient died

Appendices
A.1 Bar charts of key rates
A.2 National rates by unit type
A.3 National rates by Trust/Board level
A.4 Definitions
A.5 Data description
A.6 Table and figure description

Further Information
- Appendix A.4 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA on 1 April 2013.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD)

Source
NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued May 2017 based on data reported at 8 May 2017.
1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated, obtained from the UK Transplant Registry

1.1 Donor outcomes

Between 1 April 2016 and 31 March 2017, North Tees and Hartlepool NHS Foundation Trust had 4 deceased solid organ donors, resulting in 11 patients receiving a transplant. 14 organs were donated but one was not transplanted. Additional information is shown in Tables 1.1.1 and 1.1.2, along with comparison data for 2015/16. Figure 1.1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

Table 1.1.1 Donors, patients transplanted and organs per donor, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

<table>
<thead>
<tr>
<th>Donor type</th>
<th>Number of donors</th>
<th>Number of patients transplanted</th>
<th>Average number of organs donated per donor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>DBD</td>
<td>4 (2)</td>
<td>11 (4)</td>
<td>3.5 (3.0)</td>
</tr>
<tr>
<td>DCD</td>
<td>0 (2)</td>
<td>0 (4)</td>
<td>- (3.0)</td>
</tr>
<tr>
<td>DBD and DCD</td>
<td>4 (4)</td>
<td>11 (8)</td>
<td>3.5 (3.0)</td>
</tr>
</tbody>
</table>

Table 1.1.2 Organs transplanted by type, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

<table>
<thead>
<tr>
<th>Donor type</th>
<th>Kidney</th>
<th>Pancreas</th>
<th>Liver</th>
<th>Heart</th>
<th>Lung</th>
<th>Small bowel</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBD</td>
<td>6 (2)</td>
<td>1 (0)</td>
<td>3 (2)</td>
<td>1 (0)</td>
<td>2 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>DCD</td>
<td>0 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>DBD and DCD</td>
<td>6 (6)</td>
<td>1 (0)</td>
<td>3 (2)</td>
<td>1 (0)</td>
<td>2 (0)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Figure 1.1.1 Number of donors and patients transplanted each year

Data in this section have been obtained from the UK Transplant Registry. Section 2 onwards reports on data obtained from the national Potential Donor Audit (PDA).
2. Key Rates on Potential for Organ Donation

A summary of the key rates on the potential for organ donation, obtained from the national Potential Donor Audit (PDA)

2.1 Key rates

Two radar charts are displayed in Figure 2.1.1 showing specific percentage measures of potential donation activity in 2016/17 for North Tees and Hartlepool NHS Foundation Trust compared with national data for the UK, and compared with 2015/16 activity. This information is displayed in an alternative format as bar charts in Appendix A.1. The funnel plots in Section 3 can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential. The colour of the rate label indicates the Trust performance as shown in the appropriate funnel plot using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Figure 2.1.2 shows the trends in percentage measures of potential donation activity from 1 April 2013.

Figure 2.1.1 Key rates on the potential for organ donation, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

![Radar chart for DBD showing Testing (100%), Consent (80%), SN-OD involved (100%), Approach (83%)]

![Radar chart for DCD showing Referral (90%), Approach (20%), SN-OD involved (100%), Consent (0%)]

Figure 2.1.2 Key rates on the potential for organ donation, 1 April 2013 - 31 March 2017

![Bar charts for DBD showing Testing, Referral, Approach, SN-OD involvement, Consent for different years]

![Bar charts for DCD showing Referral, Approach, SN-OD involvement, Consent for different years]
2.2 Key numbers and rates

The percentages shown in Figure 2.1.1 are also shown in Table 2.2.1 along with the number of patients at each stage. A national comparison and a time period comparison are again provided. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. See Appendix A.6 for ranges used. Note that caution should be applied when interpreting percentages based on small numbers.

<table>
<thead>
<tr>
<th>Table 2.2.1 Key numbers, rates and comparison with national targets, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DBD</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Patients meeting organ donation referral criteria¹</td>
</tr>
<tr>
<td>Referred to SN-OD</td>
</tr>
<tr>
<td>Referral rate %</td>
</tr>
<tr>
<td>Neurological death tested</td>
</tr>
<tr>
<td>Testing rate %</td>
</tr>
<tr>
<td>Eligible donors²</td>
</tr>
<tr>
<td>Family approached</td>
</tr>
<tr>
<td>Approach rate %</td>
</tr>
<tr>
<td>Family approached and SN-OD involved</td>
</tr>
<tr>
<td>% of approaches where SN-OD involved</td>
</tr>
<tr>
<td>Consent ascertained</td>
</tr>
<tr>
<td>Consent rate %</td>
</tr>
<tr>
<td>Expected consents based on ethnic mix</td>
</tr>
<tr>
<td>Expected consent rate based on ethnic mix %</td>
</tr>
<tr>
<td>Actual donors from each pathway</td>
</tr>
<tr>
<td>% of consented donors that became actual donors</td>
</tr>
</tbody>
</table>

¹ DBD - A patient with suspected neurological death
² DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation
3. Stages Where Opportunities were Lost

Stages at which potential donors lost the opportunity to become actual donors

3.1 Overview of lost opportunities

Of the 6 potential DBD donors with suspected neurological death, 4 proceeded to donation and 2 did not proceed. None of the 15 eligible DCD donors proceeded to donation.

Figure 3.1.1 gives an overview of the various stages where opportunities were lost. There are four charts showing DBD and DCD stages separately for North Tees and Hartlepool NHS Foundation Trust and the UK, all of which contain a comparison with 2015/16. The number of potential donors is shown on the vertical axis for each chart and at each ‘step’ the proportion of potential donors lost at that stage is displayed. Caution should be applied when interpreting percentages based on small numbers. Further information is available for individual hospitals and units in Tables 4.1.1 and 4.1.2 in Section 4.

Figure 3.1.1 Stages at which potential donors lost the opportunity to become actual donors, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)
3.2 Neurological death testing

A funnel plot of neurological death testing rates is displayed in Figure 3.2.1. The goal is to ensure that neurological death tests are performed wherever possible. For information about how to interpret the funnel plots, please see Appendix A.6.

**Figure 3.2.1 Funnel plot of neurological death testing rates, 1 April 2016 - 31 March 2017**

Table 3.2.1 shows the reasons why neurological death tests were not performed, if applicable, for your Trust. Patients for whom the reason for not performing neurological tests is given as 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', or 'neonates - less than 2 months post term' are now excluded from the calculation of the neurological death testing rate and Table 3.2.1.

<table>
<thead>
<tr>
<th>Table 3.2.1 Reasons given for neurological death tests not being performed, 1 April 2016 - 31 March 2017</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients were tested or there were no patients with suspected neurological death</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>If 'other', please contact your local SN-OD for more information, if required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.3 Referral to Specialist Nurse - Organ Donation (SN-OD)

Funnel plots of DBD and DCD referral rates are displayed in Figure 3.3.1. Every patient who meets the referral criteria should be identified and referred to the SN-OD, as per NICE CG135¹ and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors².

Figure 3.3.1 Funnel plots of referral rates, 1 April 2016 - 31 March 2017

Table 3.3.1 shows the reasons why patients were not referred to a SN-OD, if applicable, for your Trust.

<table>
<thead>
<tr>
<th></th>
<th>DBD</th>
<th>%</th>
<th>DCD</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not identified as a potential donor/organ donation not considered</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

If 'other' or 'medical contraindications', please contact your local SN-OD for more information, if required. Please note that patients may appear in this table more than once if they met the referral criteria for both DBD and DCD donation.
Early referral to the SN-OD is important to enable the opportunity for donation to be maximised. Early referral triggers should be in place to ensure all donors are identified to the SN-OD to allow the family the option of organ donation. For patients who were referred, Table 3.3.2 shows the timing of the first contact with the SN-OD by the clinical staff. All patients meeting the referral criteria should be referred as early as possible to enable attendance of the SN-OD to assess suitability for donation and ensure that a planned approach for consent to the family is made in line with NICE CG135¹ and NHSBT Best Practice Guidance on approaching the families of potential organ donors³.

<table>
<thead>
<tr>
<th>DBD</th>
<th>N</th>
<th>%</th>
<th>DCD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before sedation stopped</td>
<td>1</td>
<td>16.7</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Absence of one or more cranial nerve reflexes and GCS of 4 or less not explained by sedation</td>
<td>1</td>
<td>16.7</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>No sedation or after sedation stopped, decision made to carry out BSD tests, before 1st set of tests</td>
<td>3</td>
<td>50.0</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>After 1st set and before 2nd set of BSD tests</td>
<td>-</td>
<td>0.0</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>After neurological death confirmation</td>
<td>-</td>
<td>0.0</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Clinical decision to withdraw life-sustaining treatment has been made, before treatment withdrawn</td>
<td>1</td>
<td>16.7</td>
<td>17</td>
<td>94.4</td>
<td></td>
</tr>
<tr>
<td>After treatment withdrawn</td>
<td>-</td>
<td>0.0</td>
<td>1</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td>-</td>
<td>0.0</td>
<td>-</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>100.0</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

NB, 0 patients with suspected neurological death also went on to meet the referral criteria for DCD donation, and are therefore included twice.

¹ NICE, 2011. **NICE Clinical Guidelines - CG135** [online]. Available at: [https://www.nice.org.uk/guidance/cg135] [accessed 8 May 2017]


3.4 Contraindications

Table 3.4.1 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

<table>
<thead>
<tr>
<th>Table 3.4.1 Primary absolute medical contraindications to solid organ donation, 1 April 2016 - 31 March 2017</th>
<th>DBD</th>
<th>DCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any cancer with evidence of spread outside affected organ (including lymph nodes) within 3 years</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Active haematological malignancy (myeloma, lymphoma, leukaemia)</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>
3.5 Family approach

Funnel plots of DBD and DCD family approach rates are displayed in Figure 3.5.1. All families of eligible donors should be formally approached to discuss organ donation.

**Figure 3.5.1 Funnel plots of approach rates, 1 April 2016 - 31 March 2017**

---

Table 3.5.1 shows the reasons why patients were not formally approached to discuss organ donation, if applicable, for your Trust.

**Table 3.5.1 Reasons given why family not formally approached, 1 April 2016 - 31 March 2017**

<table>
<thead>
<tr>
<th>Reason</th>
<th>DBD</th>
<th>%</th>
<th>DCD</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coroner / Procurator Fiscal refused permission</td>
<td>1</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1</td>
<td>100.0</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

If 'other', please contact your local SN-OD for more information, if required.
3.6 Proportion of approaches involving a SN-OD

In the UK, in 2016/17, when a SN-OD was not involved in the approach to the family to discuss organ donation, DBD and DCD consent rates were 39% and 25%, respectively, compared with DBD and DCD consent rates of 71% and 66%, respectively, when a SN-OD was involved. NICE CG135¹ and NHSBT Best Practice Guidance on approaching the families of potential organ donors³ reinforces that every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SN-OD and should be clearly planned taking into account the known wishes of the patient. The Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Funnel plots of DBD and DCD SN-OD involvement rates are displayed in Figure 3.6.1. A SN-OD should be actively involved in the formal approach to the family and an approach plan made and followed.

Figure 3.6.1 Funnel plots of SN-OD involvement rates, 1 April 2016 - 31 March 2017
3.7 Consent

Funnel plots of DBD and DCD consent rates are displayed in Figure 3.7.1. The 2016/17 national targets of 72% and 68% for DBD and DCD, respectively, are also shown, for information.

**Figure 3.7.1 Funnel plot of consent rates, 1 April 2016 - 31 March 2017**

Table 3.7.1 shows the reasons why families did not support donation, if applicable, for your Trust.

| Table 3.7.1 Reasons given why family did not support donation, 1 April 2016 - 31 March 2017 |
|-----------------------------------|---------|---------|
|                                   | DBD     | DCD     |
| Family were not sure whether the patient would have agreed to donation | 1       | 100.0   |
| Family felt the length of time for donation process was too long   | -       | -       |
| **Total**                                                                 | 1       | 100.0   |

If 'other', please contact your local SN-OD for more information, if required.
3.8 Reasons why solid organ donation did not occur

Table 3.8.1 shows the reasons why solid organ donation did not occur, if applicable, for your Trust.

Table 3.8.1 Reasons why solid organ donation did not occur, 1 April 2016 - 31 March 2017

<table>
<thead>
<tr>
<th>DBD</th>
<th>DCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
</tbody>
</table>

All consented patients donated or there were no consented patients

If 'other', please contact your local SN-OD for more information, if required.
4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where the patient died

4.1 Key numbers and rates by unit where the patient died

Tables 4.1.1 and 4.1.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Caution should be applied when interpreting percentages based on small numbers. For each of the units tabulated in Tables 4.1.1 and 4.1.2, the national key rates from the PDA are displayed in Appendix A.2 to aid comparison with equivalent units. For example, neurosurgical ICUs can be compared against the average rates achieved nationally for neurosurgical ICUs.

| Table 4.1.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison) |
|---|---|---|---|---|---|---|---|---|---|
| Unit where patient died | Patients where neurological death was suspected | Patients where neurological death was suspected that were referred to SN-OD | Neurological death testing rate (%) | Patients confirmed dead by neurological testing | Eligible DBD donors (Death confirmed by neurological tests and no absolute contraindications) | Eligible DBD donors whose family were approached | DBD approach rate (%) | Consent ascertained | DBD consent rate (%) | Actual DBD and DCD donors from eligible DBD donors | DBD SN-OD involvement rate (%) |
| Stockton-On-Tees, University Hospital Of North Tees |
| A&E | 0 | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | 0 |
| Gen. ICU/HDU | 6 | 6 | 100 | 6 | 100 | 6 | 6 | 5 | 83 | 4 | 80 | 4 | 100 |
| Stockton-On-Tees, University Hospital Of North Tees |
| 1 April 2016 to 31 March 2017 |
| A&E | 0 | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | 0 |
| Gen. ICU/HDU | 5 | 4 | 80 | 5 | 100 | 4 | 4 | 3 | 75 | 3 | 100 | 2 | 100 |
Table 4.1.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

<table>
<thead>
<tr>
<th>Unit where patient died</th>
<th>Patients for whom imminent death was anticipated</th>
<th>Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contraindications)</th>
<th>Patients for whom treatment was withdrawn</th>
<th>Eligible DCD donors whose family were approached</th>
<th>DCD approach rate (%)</th>
<th>Consent ascertained</th>
<th>DCD consent rate (%)</th>
<th>Actual DCD donors from eligible DCD donors</th>
<th>DCD SN-OD involvement rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unit where patient died</td>
<td>DCD referral rate (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stockton-On-Tees, University Hospital Of North Tees</td>
<td>1 April 2016 to 31 March 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Gen. ICU/HDU</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stockton-On-Tees, University Hospital Of North Tees</td>
<td>1 April 2015 to 31 March 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Gen. ICU/HDU</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tables 4.1.1 and 4.1.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total, for North Tees and Hartlepool NHS Foundation Trust in 2016/17 there was one such patient.

It is acknowledged that the PDA does not capture all activity. In total there were 5 patients referred in 2016/17 who are not included in Section 2 onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.
Appendices

Appendix A.1 Bar charts of key rates

Figure A.1.1 shows the same information as the radar charts in Section 2 but in an alternative format. The bars show the latest rates for your Trust. Purple lines have been superimposed to provide a comparison with the UK and turquoise dashed lines show the rates achieved by your Trust in the equivalent period last year. The funnel plots in Section 3 can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential. The colour of the rate label indicates the Trust performance as shown in the appropriate funnel plot using the gold, silver, bronze, amber, and red (GoSBAR) scheme.

Figure A.1.1 DBD and DCD key rates

![DBD and DCD key rates chart]

- **DBD**
  - Rate (%)
  - ND testing: 100, Referral: 100, Approach: 83, SN-OD inv.: 100, Consent: 80

- **DCD**
  - Rate (%)
  - Referral: 90, Approach: 20, SN-OD inv.: 100, Consent: 0

- **Legend**
  - Trust, 2016/17
  - UK, 2016/17
  - Trust, 2015/16
Appendix A.2 National rates by unit type

For each of the units tabulated in Tables 4.1.1 and 4.1.2, the national key rates from the PDA are displayed in Tables A.2.1 and A.2.2 to aid comparison with equivalent units.

### Table A.2.1 National DBD key numbers and rates by unit where the patient died, 1 April 2016 - 31 March 2017

<table>
<thead>
<tr>
<th>Unit where the patient died</th>
<th>Patients where neurological death was suspected</th>
<th>Patients that were tested</th>
<th>Neurological death testing rate (%)</th>
<th>Patients where neurological death was suspected that were referred to SN-OD</th>
<th>DBD referral rate (%)</th>
<th>Patients confirmed dead by neurological testing</th>
<th>Eligible DBD donors (Death confirmed by neurological tests and no absolute contraindications)</th>
<th>Eligible donors whose family were approached</th>
<th>DBD approach rate (%)</th>
<th>Consent ascertainment</th>
<th>DBD consent rate (%)</th>
<th>Actual DBD and DCD donors from eligible donors</th>
<th>DBD SN-OD involvement rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General ICU¹</td>
<td>1076</td>
<td>937</td>
<td>87</td>
<td>1064</td>
<td>99</td>
<td>925</td>
<td>884</td>
<td>821</td>
<td>93</td>
<td>581</td>
<td>71</td>
<td>511</td>
<td>93</td>
</tr>
<tr>
<td>Neurosurgical ICU</td>
<td>294</td>
<td>268</td>
<td>91</td>
<td>291</td>
<td>99</td>
<td>263</td>
<td>257</td>
<td>242</td>
<td>94</td>
<td>151</td>
<td>62</td>
<td>144</td>
<td>95</td>
</tr>
<tr>
<td>General/Neuro ICU</td>
<td>220</td>
<td>186</td>
<td>85</td>
<td>215</td>
<td>98</td>
<td>185</td>
<td>176</td>
<td>162</td>
<td>92</td>
<td>121</td>
<td>75</td>
<td>107</td>
<td>93</td>
</tr>
<tr>
<td>Cardiothoracic ICU</td>
<td>33</td>
<td>28</td>
<td>85</td>
<td>29</td>
<td>88</td>
<td>27</td>
<td>26</td>
<td>21</td>
<td>81</td>
<td>14</td>
<td>67</td>
<td>11</td>
<td>95</td>
</tr>
<tr>
<td>Paediatric ICU²</td>
<td>82</td>
<td>56</td>
<td>68</td>
<td>72</td>
<td>88</td>
<td>56</td>
<td>55</td>
<td>43</td>
<td>78</td>
<td>23</td>
<td>53</td>
<td>20</td>
<td>74</td>
</tr>
<tr>
<td>Specialist ICU³</td>
<td>48</td>
<td>43</td>
<td>90</td>
<td>47</td>
<td>98</td>
<td>42</td>
<td>42</td>
<td>39</td>
<td>93</td>
<td>26</td>
<td>67</td>
<td>25</td>
<td>97</td>
</tr>
<tr>
<td>Accident and emergency</td>
<td>21</td>
<td>3</td>
<td>14</td>
<td>10</td>
<td>48</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>33</td>
<td>1</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

¹ includes General ICU, HDU, General ICU/HDU/Coronary Care Unit, General ICU/HDU.

² includes Paediatric ICU, Neonatal ICU.

³ includes Specialist ICU, Multiple Injuries Unit.

Further national comparisons can be made by viewing the PDA section of the Organ Donation and Transplantation Activity Report and the PDA Annual Report, both of which are available on the ODT website. See links on Page 2.
Appendix A.3 National rates by Trust/Board level

North Tees and Hartlepool NHS Foundation Trust has been categorised as a level 3 Trust/Board. Tables A.3.1 and A.3.2 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid comparison with equivalent Trusts/Boards. Note that caution should be applied when interpreting percentages based on small numbers.

Table A.3.1 National DBD key numbers and rates by Trust/Board level, 1 April 2016 - 31 March 2017

<table>
<thead>
<tr>
<th>Trust/Board Level</th>
<th>Patients where neurological death was suspected</th>
<th>Neurological death testing rate (%)</th>
<th>Patients where neurological death was suspected that were referred to SN-OD</th>
<th>DBD referral rate (%)</th>
<th>Patients confirmed dead by neurological testing</th>
<th>Eligible DBD donors (Death confirmed by neurological tests and no absolute contra-indications)</th>
<th>Eligible DBD donors whose family were approached</th>
<th>DBD approach rate (%)</th>
<th>Consent ascertained</th>
<th>DBD consent rate (%)</th>
<th>Actual DBD and DCD donors from eligible DBD donors</th>
<th>DBD SN-OD involvement rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Trust</td>
<td>6</td>
<td>100</td>
<td>6</td>
<td>100</td>
<td>6</td>
<td>5</td>
<td>83</td>
<td>4</td>
<td>80</td>
<td>4</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Level 1*</td>
<td>969</td>
<td>85</td>
<td>943</td>
<td>97</td>
<td>826</td>
<td>794</td>
<td>732</td>
<td>92</td>
<td>494</td>
<td>67</td>
<td>446</td>
<td>93</td>
</tr>
<tr>
<td>Level 2</td>
<td>389</td>
<td>85</td>
<td>381</td>
<td>98</td>
<td>328</td>
<td>314</td>
<td>284</td>
<td>90</td>
<td>205</td>
<td>72</td>
<td>187</td>
<td>93</td>
</tr>
<tr>
<td>Level 3</td>
<td>268</td>
<td>88</td>
<td>264</td>
<td>99</td>
<td>229</td>
<td>220</td>
<td>206</td>
<td>94</td>
<td>148</td>
<td>72</td>
<td>127</td>
<td>95</td>
</tr>
<tr>
<td>Level 4</td>
<td>149</td>
<td>81</td>
<td>140</td>
<td>94</td>
<td>119</td>
<td>116</td>
<td>107</td>
<td>92</td>
<td>70</td>
<td>65</td>
<td>59</td>
<td>90</td>
</tr>
</tbody>
</table>

*Level 1 Trust/Boards are defined as those Trusts/Boards that had 12 or more proceeding donors per year, averaged over 2014/15 and 2015/16 financial years. Trusts/Boards are categorised as Level 2 if there was 5-12 proceeding donors on average over the two year period and Level 3 Trusts/Boards are those that had an average of 3-5 proceeding donors over the two year period. All other Trusts/Boards are categorised as Level 4.

Table A.3.2 National DCD key numbers and rates by Trust/Board level, 1 April 2016 - 31 March 2017

<table>
<thead>
<tr>
<th>Trust/Board Level</th>
<th>Patients for whom imminent death was anticipated</th>
<th>DCD referral rate (%)</th>
<th>Patients for whom treatment was withdrawn</th>
<th>Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contra-indications)</th>
<th>DCD approach rate (%)</th>
<th>Consent ascertained</th>
<th>DCD consent rate (%)</th>
<th>Actual DCD donors from eligible DCD donors</th>
<th>DCD SN-OD involvement rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Trust</td>
<td>20</td>
<td>90</td>
<td>20</td>
<td>15</td>
<td>3</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Level 1*</td>
<td>2644</td>
<td>87</td>
<td>2400</td>
<td>1847</td>
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### Appendix A.4 Definitions

<table>
<thead>
<tr>
<th>POTENTIAL DONOR AUDIT / REFERRAL RECORD</th>
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<tr>
<td><strong>Data excluded</strong></td>
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<td><strong>Donors after brain death (DBD)</strong></td>
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<td><strong>Suspected Neurological Death</strong></td>
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<td><strong>Potential DBD donor</strong></td>
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<td><strong>DBD referral criteria</strong></td>
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<td><strong>Discussed with Specialist Nurse – Organ Donation</strong></td>
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<td><strong>Neurological death tested</strong></td>
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<td><strong>Eligible DBD donor</strong></td>
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<td><strong>Family approached for formal organ donation discussion</strong></td>
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<td><strong>Consent / authorisation ascertained</strong></td>
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<td><strong>Actual donors: DBD</strong></td>
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<td><strong>Actual donors: DCD</strong></td>
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<td><strong>Neurological death testing rate</strong></td>
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<td><strong>Referral rate</strong></td>
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<td><strong>Consent / authorisation rate</strong></td>
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</tr>
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<td><strong>SN-OD involvement rate</strong></td>
</tr>
<tr>
<td><strong>SN-OD consent / authorisation rate</strong></td>
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</table>
Donors after circulatory death (DCD)

**Imminent death anticipated**
A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours.

**DCD referral criteria**
A patient in whom imminent death is anticipated (as defined above)

**Discussed with Specialist Nurse – Organ Donation**
Patients for whom imminent death was anticipated who were discussed with the SN-OD

**Potential DCD donor**
A patient who had treatment withdrawn and death was anticipated within four hours

**Eligible DCD donor**
A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation

**Absolute contraindications**
Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf

**Family approached for formal organ donation discussion**
Family of eligible DCD asked to: support the patient’s expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient’s opt-out decision via the Organ Donor Register

**Consent / authorisation ascertained**
Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation

**Actual DCD**
DCD patients who became actual DCD as reported through the PDA

**Referral rate**
Percentage of patients for whom imminent death was anticipated who were discussed with the SN-OD

**Approach rate**
Percentage of eligible DCD families or nominated/appointed representatives approached for formal organ donation discussion

**Consent / authorisation rate**
Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained

**Expected consent / authorisation rate**
Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known

**SN-OD involvement rate**
Percentage of family or nominated/appointed representative approaches where a SN-OD was involved

**SN-OD consent / authorisation rate**
Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained

**UK Transplant Registry (UKTR)**

**Donor type**
Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)

**Number of actual donors**
Total number of donors reported to the UKTR

**Number of patients transplanted**
Total number of patients transplanted from these donors

**Organs per donor**
Number of organs donated divided by number of donors. The maximum number of solid organs that can be donated are 7 for a DBD and 6 for a DCD.

**Number of organs transplanted**
Total number of organs transplanted by organ type

On 1 April 2013 significant changes were made to the PDA. The main changes that should be borne in mind, especially when making comparisons across time periods, are as follows:

- Upper age limit increased from 75 to 80 years.
- Cardiothoracic ICUs included.
- Changes to imminent death definition to be clear that death was anticipated within four hours.
- Contraindications brought in line with current practice.
- Terminology changes, eg ‘potential donor’ changed to ‘eligible donor’, for consistency with World Health Organisation definitions.
Appendix A.5 Data description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record and the UK Transplant Registry for North Tees and Hartlepool NHS Foundation Trust. The report covers the time period 1 April 2016 to 31 March 2017 and data from 1 April 2015 to 31 March 2016 are also provided in certain sections for comparison purposes.

This report is provided for information and to facilitate case based discussion about organ donation by the Donation Committee and your Trust.

As part of the PDA, patients aged over 80 years of age and those who did not die on a critical care unit or an emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal Intensive Care Units have also been excluded from this report. In addition, some information from this time period may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UK Transplant Registry, as appropriate.

Some percentages in this report were calculated using small numbers and should therefore be interpreted with caution.

Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD)
Appendix A.6 Table and figure description

Each table and figure displayed throughout the report is described below to aid interpretation.

1.1 Donor outcomes
Table 1.1.1 The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).

Table 1.1.2 The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SN-OD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.

Figure 1.1.1 The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2.1 Key rates
Figure 2.1.1 Radar charts are displayed showing specific percentage measures of potential donation activity for your Trust/Board compared with national data for the UK, and compared with an equivalent time period from the previous financial year, using data from the Potential Donor Audit (PDA). The DBD charts show the percentage of potential donors lost at that stage is displayed. Caution should be applied when interpreting percentages based on small numbers and comparing time periods.

Table 2.2.1 A summary of DBD and DCD data and key rates have been obtained from the PDA. A national comparison and a time period comparison are provided. Note that caution should be applied when interpreting percentages based on small numbers and comparing time periods. Appendix A.4 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of one Trust/Board as reflected in the funnel plots (see description for figure 3.2.1 below)

3.1 Overview of lost opportunities
Figure 3.1.1 The stages at which potential donors lose the opportunity to become actual donors have been obtained from the PDA. There are four charts showing the DBD and DCD stages separately for your Trust/Board and the UK, all of which contain a comparison against an equivalent period from the previous financial year. The number of potential donors is shown on the vertical axis for each chart and at each ‘step’ the proportion of patients tested for neurological death, and all four charts also show the referral rates, approach rates, proportion of approaches involving a SN-OD and observed consent/authorisation rates.

3.2 Neurological death testing
Figure 3.2.1 A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The national rate is shown on the plot as a pink horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a ‘funnel’, which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel charts. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the national rate. If a Trust/Board lies outside the 95% confidence limits, shaded silver or amber, this serves as an alert that the Trust/Board may have a rate that is significantly different from the national rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the national rate, while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the national rate. It is important to note that differences in patient mix have not been accounted for in these plots.

Table 3.2.1 The reasons given for neurological death tests not being performed have been obtained from the PDA, if applicable.

Note that caution should be applied when interpreting percentages based on small numbers and when comparing time periods.
3.3 Referral to Specialist Nurse - Organ Donation
Figure 3.3.1 Funnel plots of DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.
Table 3.3.1 The reasons for not referring the patient to the SN-OD have been obtained from the PDA, if applicable.
Table 3.3.2 For patients who were referred, the timings of the first contact with the SN-OD by clinical staff have been obtained from the PDA.

3.4 Contraindications
Table 3.4.1 The primary absolute medical contraindications to solid organ donation have been obtained from the PDA, if applicable.

3.5 Family approach
Figure 3.5.1 Funnel plots of DBD and DCD approach rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.
Table 3.5.1 The reasons why families were not formally approached for a decision about solid organ donation have been obtained from the PDA, if applicable.

3.6 Proportion of approaches involving a SN-OD
Figure 3.6.1 Funnel plots of DBD and DCD SN-OD involvement rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.
Table 3.6.1 The reasons why families did not give consent/authorisation for solid organ donation have been obtained from the PDA, if applicable.

3.7 Consent
Figure 3.7.1 Funnel plots of DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above. In addition the national consent/authorisation target rate is shown in green.
Table 3.7.1 The reasons why solid organ donation did not occur have been obtained from the PDA, if applicable.

3.8 Reasons why solid organ donation did not occur
Table 3.8.1 The reasons why solid organ donation did not occur have been obtained from the PDA, if applicable.

4.1 Key numbers and rates by unit where the patient died
Table 4.1.1 DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Data for the current time period are included, along with an equivalent comparison period from the previous year. If the hospitals/units are not equivalent for the two time periods, this is due to hospital/unit changes, and/or there were no patients for whom neurological death was suspected or imminent death was anticipated in one of the time periods.
Caution should be applied when interpreting percentages based on small numbers and comparing time periods.
Table 4.1.2 DCD key numbers and rates by unit where the patient died have been obtained from the PDA. See description for Table 4.1.1 above.

Appendix A.1 Bar charts of key rates
Figure A.1.1 Bar charts have been used to display the DBD and DCD key rates from the PDA. This is an alternative way of displaying the information in Figure 2.1.1.
The percentages for your Trust/Board in the latest time period are displayed on each bar. Note that caution should be applied when interpreting percentages based on small numbers and comparing time periods.
Figure A.1.2 If your Trust/Board has a paediatric ICU, bar charts have been used to display DBD and DCD key rates for paediatric data. See description for Figure A.1.1 above. Note that caution should be applied when interpreting percentages based on small numbers.

Appendix A.2 National rates by unit type
Table A.2.1 For each of the units in Table 4.1.1, the national DBD key rates from the PDA are displayed to aid comparison with equivalent units. Units have been grouped to aid a more meaningful comparison.
Table A.2.2 For each of the units in Table 4.1.2, the national DCD key rates from the PDA are displayed to aid comparison with equivalent units. Units have been grouped to aid a more meaningful comparison.

Appendix A.3 National rates by Trust/Board level
Table A.3.1 National rates for level 1, 2, 3 and 4 Trusts/Boards are displayed to aid comparison with equivalent Trusts/Boards. Caution should be applied when interpreting percentages based on small numbers.
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Outcome of NHS Improvement Quarterly Review Meetings

Report of the Chief Executive

Strategic Aim (The full set of Trust Aims can be found at the beginning of the Board Reports)
Maintain Compliance and Performance

Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)
Maintain Compliance and Performance
Effective Board Governance

1. Purpose of the report

The purpose of the Quarterly Review Meeting is to allow NHS Improvement and the Trust to have a meaningful discussion about the current situation of the Trust, the key challenges it is currently facing and how these might be addressed, and to review the progress the Trust has made over the past 3 months.

2. Key Issues

NHS Improvement set the agenda for the meeting, which focuses on the Trust’s current performance in the following categories:
- Single Oversight Framework Segmentation;
- Quality of Care;
- Financial Performance;
- Operational Performance;
- Strategic Change; and
- Agreed actions.

3. Conclusion

The Trust has had two meetings with the NHS Improvement relationship team held on 27 March and 13 June 2017. The outcome letters from both meetings have been considered by the Executive Team and are appended for information.

4. Recommendations

The Board of Directors is asked to receive the outcome letters from the Quarterly Review Meetings that were held with NHS Improvement on 27 March and 13 June 2017.

Alan Foster
Chief Executive
25 May 2017

Alan Foster
Chief Executive
North Tees and Hartlepool NHS Foundation Trust
Chief Executive’s Office, 4th Floor North Wing
University Hospital of North Tees
Hardwick Estate
Stockton-on-Tees
TS19 8PE

Dear Alan,

Outcome of the Quarterly Review Meeting (QRM) held on 27 March 2017

Following on from our meeting on 27th March I am writing to confirm the outcome of our discussion. A list of attendees from NHS Improvement and the Trust is contained in an annex to this letter. As you are aware, the purpose of the QRM is to allow us to have a meaningful conversation about the current situation of the Trust, the key challenges it is facing and how these might be addressed, and to review the progress the Trust has made over the past three months.

SOF Segmentation

North Tees and Hartlepool NHS Foundation Trust is currently categorised in segment 2 of the Single Oversight Framework. The driver of the Trust’s segmentation is its CQC rating of “Requires Improvement.” The Trust was most recently assessed in July 2015 and there is no planned date for re-inspection. NHS Improvement aims to work with the Trust and offer targeted support to improve its segmentation and as the CQC rating is a key driver, will endeavour to work with the CQC to bring about early resolution on the next stage of the inspection process. Segmentation can also be affected by changes in financial and operational performance, or other areas related to quality of care.

Quality of Care

The Trust is currently rated “Requires improvement” by CQC and has implemented an action plan to address the areas for improvement. Feedback from CQC and commissioner assurance visits in 2016 has been positive and confirms actions have been implemented. I would be grateful if the Trust could share a copy of its ongoing or outstanding action plan with NHS Improvement, so that we can support the Trust to improve its rating at the next inspection.

We discussed a recent external maternity services review also commissioned by the Trust, which was conducted in September 2016 and reported in January 2017, a copy of the report has been shared with us.

The Trust reported 36 cases of C.Difficile to date in 2016/17 and expressed disappointment that the position has not improved despite a significant number of measures including participating in a national improvement programme; review by external experts and benchmarking practices locally and nationally with trusts which had remained within
trajectory. The Trust raised concerns that this is a wider healthcare community issue and I will discuss antibiotic prescribing with local CCGs in my role at NHS England.

Financial Performance

At month 10 the Trust reported a £2m deterioration against its forecast outturn position. The Trust has identified several reasons for this underperformance and articulated that support measures had been implemented and all contingencies were being explored. The Trust noted difficulties with signing off income and activity numbers with NECS and the CCG and believes there is opportunity for balance in the health economy.

The difficulties associated with implementation of the Trakcare System rolled over into 2016/17 and led the Trust to submit its Q1 data later than planned in August 2016. As a result, the Trust only received in January 2017 challenges back from its CCGs, valued at £2.5m, which it did not anticipate. The Trust and its commissioners were also unable to follow national timetables during Q2, however Q3 data was submitted on time. In our discussion, the Trust noted that resourcing issues on both sides affected the ability to follow national processes. The Trust has assumed a 100% of the income in the draft accounts. The Trust asked NHS Improvement to support a 50/50 risk share on the 2016/17 income, which has not yet been agreed with commissioners.

Since the QRM, the Trust has engaged with NHS Improvement to provide a breakdown of the £2.5m risk which indicates its assessment of the legitimacy of the challenges. Additionally the Trust is undertaking an initial piece of diagnostic work supported by NHS Improvement, the results of which will ensure tailored support is provided in the most appropriate manner. The Trust is also seeking to engage a PbR expert to perform an external review of coding and billing. NHS Improvement will enhance its work with the Trust and conduct monthly Additional Support Meetings going forward, to discuss these actions in more detail.

The Trust noted that it had £2m of unidentified CIPs at the start of 2016/17 and additionally built separate cost reductions for agency expenditure directly into budgets which added to the efficiency requirement. The Trust made efforts to mitigate underperformance by raising targets in appropriate areas. NHS Improvement is keen to support the Trust with CIP delivery as part of our Additional Support Meetings.

Since the QRM, the Trust has posted draft year-end achievement of its Control Total, and further work is ongoing with the CNE finance team to support this position.

Operational Performance

Our discussion focused on the delivery of Emergency Care, which reached a monthly low of 90.7% against the four hour standard in December 2016, although performance has subsequently improved. The Trust has surpassed the national and Cumbria/North East average throughout 2016/17 and remains in the top 20 performing trusts in the country. The Trust noted that its biggest concerns are the delayed transfers of care, extended lengths of staff absence and bed occupancy levels. I would like to thank you and your team for your work during a challenging winter period. You have been a local exemplar and I am keen to ensure that your good practice is shared across the region.

We also discussed the opportunities for primary care streaming alongside emergency activity and note that the Trust’s Integrated Urgent Care Centre is due to open in April 2017. Please continue to engage with national returns and reporting requests related to primary care streaming.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
Finally, we discussed the Trust’s approach to delivery of Seven Day Services core standards. The Trust reported that its most significant concern is Standard 2 (14 hour consultant review) and we will engage further with the Trust on this following the survey submission in May 2017.

## Strategic Change

The Trust is currently working with partners across Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby in order to identify a preferred configuration option for services in the region. I met with local leaders on Tuesday 11th April in order to support this process. Please share any capacity or resource requirements you have to support the STP and I will endeavour to facilitate this from an NHS England perspective.

## Agreed actions

The meeting identified a range of important actions for the Trust, which are summarised below:

- Provide NHS Improvement with a copy of your CQC action plan (as soon as possible);
- Assess the requirements pertaining to infection control and share these with the Quality Lead to arrange support (as soon as possible);
- Commence monthly Additional Support Meetings with NHS Improvement to monitor the Trust’s financial performance (NHS Improvement to lead);
- Assess the resource requirements to support delivery of the Sustainability and Transformation Plan and share these with me to arrange support (as soon as possible).

## Additional items

Our next QRM will be held on 12th June 2017. In the meantime, the Trust will have monthly Additional Support Meetings related to its financial performance and we will continue to monitor your progress against the agreed actions and overall operational performance.

I would ask that you share this letter with your Board in public session. If you would like to discuss the contents of this letter further, please contact in first instance your relationship manager Rob Robertson (rob.robertson@nhs.net).

Yours sincerely,

Tim Rideout
Delivery and Improvement Director
NHS Improvement Cumbria and the North East

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
Annex 1 - List of QRM Attendees

Attendees

NHS Improvement
Tim Rideout, Delivery and Improvement Director
Hayley Wardle, Head of Finance
Jessica Kenny, Delivery and Improvement Lead
Kris Mackenzie, Finance Lead
Yvonne Evans, Quality Lead

North Tees and Hartlepool NHSFT
Alan Foster, Chief Executive
Caroline Trevena, Director of Finance
Julie Gillon, Chief Operating Officer/Deputy Chief Executive
Deepak Dwarakanath, Medical Director
Julie Lane, Director of Nursing, Patient Safety and Quality
Graham Evans, Chief Information and Technology Officer
Peter Mitchell, Director of Estates and Facilities Management
27 June 2017

Alan Foster MBE
Chief Executive
North Tees and Hartlepool NHS Foundation Trust
Chief Executive’s Office, 4th Floor North Wing
University Hospital of North Tees
Hardwick Estate
Stockton-on-Tees
TS19 8PE

Dear Alan,

Outcome of the Quarterly Review Meeting (QRM) held on 13 June 2017

Following the QRM on 13 June 2017 I am writing to confirm the key points and actions from our discussion. I am grateful to you and your team for making the time to meet with us.

As you are aware the purpose of the QRM is to allow us to have a meaningful conversation about the current situation of the trust, the key challenges you are currently facing, how these might be addressed and a review of the progress the trust has made against these.

SOF Segmentation

The trust is currently categorised as being in Segment 2 of the Single Oversight Framework (SOF). We discussed that in order to move into Segment 1 the trust needs to achieve a CQC rating of good or outstanding;

It is our objective for all the trusts in Cumbria and North East to be in Segment 1 of the SOF and to achieve a rating of Outstanding from the CQC, we will work closely with you and your team to support this ambition.

Quality of Care

The trust described progress against the CQC action plan, and the ambition to achieve a rating of outstanding. All of the ‘must-do’ actions are complete and the progress against the small number of longer term ‘should-do’ actions was described:

- Risk Management process progressed with recent Audit One increased assurance
- Deployment of electronic check in desks in the OPD setting being implemented
- Review of nursing documentation and intentional rounding – complete in some areas and being rolled out to others
The trust also described the further improvement work regarding quality dashboards, quality heat maps and the quality reference group. The trust is undertaking a programme of organisational development.

The implementation of 7 day services (7DS) was discussed and it was noted that the trust is performing above both the sub regional and national mean for the four priority clinical standards. The trust described the arrangements in place regarding 24/7 access to Echocardiographs with South Tees. The results of the 7DS survey are awaited but early indications would suggest the trust is on track to deliver by April 2018.

The trust is currently significantly above trajectory for the number of C Diff cases for the year to date, and described the ongoing work as part of the HCAI improvement plan:

- Every case is being reviewed by the Nursing Director and Medical Director to understand any underlying causes.
- Antibiotic guidelines are being reviewed and compared to peer trusts.
- An appeals panel with CCG team has been established.
- Whilst environmental issues have not been identified as a cause, there is a recognition that the hospital estate itself is not ideally laid out and it is hoped that the STP system-wide reconfiguration will help.
- A supportive site visit will take place on 23rd June with Professor Kate Gould and Pauline Bradshaw in attendance.

The trust described the maternity RCOG report and action plan and highlighted progress to date identifying that a number of actions are due to complete by June 2017. Progress in the following areas was noted:

- Documentation issues.
- Escalation – there have been no further incidents or concerns re: professional challenge.
- SBAR tool implemented across maternity services. The Trust have been asked to present their progress in this area to RCOG/RCM conference in London June 2017.
- Staffing concerns and sickness have improved, though there was recognition of current and future pressures due to a number of staff taking maternity leave.
- Maternity Dashboard is now in place.
- As part of a successful patient safety bid-CTG master classes, Human factors master class, simulation training, ALSO have been implemented.
- Trust is the CNE Trust taking part in the 1st wave of the Maternity / Neonatal Collaborative.

Financial Performance

The trust closed 2016/17 with a planned deficit of £5.8m (excluding STF), and a surplus of £3.2m including STF and STF bonus funding. The trust’s significant efforts to achieve this result were noted and NHS Improvement thanked the trust for the positive outcome.

The trust then described the position in 2017/18, and outlined a number of key risks to control total delivery:
• The trust is required to deliver a CIP of £18.9m (6.5%); £13.3m has been allocated to schemes and £5.6m is classified as unidentified. The trust has a number of schemes in the pipeline and has strengthened CIP governance arrangements.
• 2016/17 CCG Income (IUCS); £1.5m was invoiced in 2016/17 and is disputed by the CCG.
• 2016/17 CCG Income (PbR) of £2.5m; a proposal is being discussed with the CCG and the governance for monthly sign-off has been strengthened by the trust.
• 2016/17 Accrued Expenditure – a change in policy in 2016/17 released circa £1.3m of accruals of which £400k have now arisen in M1.
• A number of other, as yet unquantified, risks were described along with the ongoing work to mitigate them. These include:
  o Possible impairment error in the 2016/17 accounts,
  o 2017/18 PbR Contract (growth / QIPP),
  o Decommissioned services and the ability to remove cost at the same rate as income,
  o CQUIN delivery.

It was confirmed that NHSI would undertake a financial diagnostic exercise to identify areas where improvements can be made in the trust’s financial processes, procedures and governance to facilitate and support the delivery of savings. It was also agreed that monthly Additional Support Meetings (ASMs) would continue, to monitor progress and identify any additional areas of support.

Operational Performance

The trust described the ongoing recovery work against the 62 day cancer standard and the key focus on working differently, it was also highlighted that the Tees wide breast service has led to a 50% increase in referrals into the trust. The robust governance arrangements for monitoring cancer performance were outlined. The key recovery actions described were:

• Governance processes, reviewing accountability, escalation processes and waiting list monitoring procedures,
• Capacity and demand review commenced April 2017,
• Review of themes for breaches,
• Working with tertiary centres to address pathways across multiple organisations,
• Tumour specific improvement initiatives.

The impact of primary care streaming and the new Integrated Urgent Care service was outlined, early results in April and May are positive and we agreed to monitor progress closely to ensure any learning and best practice can be shared with other health economies.

I would like to take this opportunity to thank your team for the generally very strong performance achieved by the trust not just in A&E but across all the national performance standards.

Strategic Change

The Trust is continuing to work with partners across Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby in order to identify a preferred configuration option for services in
the region. Alongside this we noted that you are playing a lead role in the potential establishment of a Cumbria and North East wide STP. We look forward to hearing how this work develops as well as how the trust will seek to manage the increasing personal commitments for yourself that this entails.

Agreed actions

The following next steps and actions were agreed at the meeting:

- The trust to work with NHSI to undertake a financial diagnostic exercise,
- NHSI are to undertake an HCAI visit on 23rd June,
- Maternity action plan updates will be received at future QRM.

In addition NHS Improvement will continue to work with the trust separately in routine monthly ASMs regarding financial performance. Our next QRM will be held in three months; though we will be in touch regarding the above on a regular basis.

Yours sincerely,

Edmund King
Head of Delivery and Improvement
NHS Improvement (Cumbria and the North East)
North Tees and Hartlepool NHS Foundation Trust

Minutes of a Board of Directors Meeting
held on Thursday, 25 May 2017 at 1.00pm
at the University Hospital of North Tees

Present:

Paul Garvin, Chairman*  Chairman
Brian Dinsdale, Non-Executive Director*  BD
Steve Hall, Non-Executive Director*  SH
Jonathan Erskine, Non-Executive Director*  JE
Kevin Robinson, Non-Executive Director*  KR
Alan Foster, Chief Executive*  CE
Julie Gillon, Chief Operating Officer/Deputy Chief Executive*  COO/DCE
Caroline Trevena, Director of Finance*  DoF
Ann Burrell, Director of Human Resources and Education  DoHR&E
Julie Lane, Director of Nursing, Patient Safety and Quality*  DoN,PS &Q
Graham Evans, Chief Information and Technology Officer  CI&TO
Peter Mitchell, Director of Estates and Facilities Management  DoE&FM
Chris Tulloch, Deputy Medical Director  DMD
Barbara Bright, Company Secretary  CS

In attendance

Sarah Hutt, Assistant Company Secretary (Note taker)
Norman Mackey, Healthcare User Group Representative
Linda Hunter, General Manager, Business Development, Performance and Quality
(Shadowing Julie Gillon)
Cheryl Trigg, Member of the Public

BoD/3403  Apologies for Absence

Apologies for absence were noted from Deepak Dwarakanath, Medical Director, and Rita Taylor, Non-Executive Director.

BoD/3404  Declaration of Interest

There were no declarations of interest on open agenda items.

BoD/3405  Minutes of the meeting held on, Thursday, 27 April 2017

Resolved: that, the minutes of the meeting held on Thursday, 27 April 2017 be confirmed as an accurate record.

BoD/3406  Matters Arising

There were no matters arising.

* voting member
BoD/3407 Chairman’s Report

a. Consultant Appointments

Since the last meeting, the following Consultant appointments had been made:
Mr Yogesh Jain, Consultant Breast Surgeon
Mr Zia Khan, Consultant Urologist

b. Chairs Meeting

The Chairman reported that he recently attended a Northern Chairs meeting in Leeds, where it was discussed the Northern Region would potentially end 2016/17 £500-560m in deficit, and the control total for 2017/18 would be to break even. However, plans were showing that a deficit of £250-500m was more likely. NHS England and NHS Improvement required CCGs to hold back funding so financial balance at a regional level could be achieved, which would have an impact on the Trust. It was noted that CIP figures across the region appeared to be 4.2% on aggregate. There had also been discussion around plans to achieve greater gender balance across NHS Boards.

c. Collaborative Working

The Chairman reported that he and the Chief Executive had met with the Chairs and Chief Executives of South Tees Hospitals NHS Foundation Trust, and County Durham and Darlington NHS Foundation Trust as part of the work for the Committee in Common. Final Terms of Reference were agreed, and further discussions were had regarding ways in which the two trusts could support each other clinically, for example in breast services and haematology.

Resolved: that the information be noted.

BoD/3408 Chief Executives Report

a. Cyber Attack

The CE reported on the Cyber Attack that affected the NHS and other organisations globally on Friday, 12 May 2017. Although the Trust was not directly affected, all necessary precautions were undertaken to minimise the impact and Business Continuity Plans were initiated to maintain services for patients. Following the terror attack in Manchester on Monday, 22 May, the national threat level had been increased to critical and guidance had been circulated to NHS organisations regarding preparedness arrangements.

The CI&TO provided a detailed overview regarding the Cyber Attack which had been due to malware. Indications suggested that 47 trusts had been directly affected, and although the Trust was not in this number it did immediately shut down its externally connected systems as a precautionary measure. In addition North East Commissioning Service (NECS) had taken the decision to shut down its external networks to GP practices which had an unintended consequence and impact on the Trusts network disabling access to external patient systems and in particular the community services SystmOne, thereby requiring business continuity arrangements to be activated. Following the attack in depth reviews of the Trust’s Business Impact Assessments and Business Continuity arrangements would be undertaken in addition to dependency on third party systems.

The COO/DCE reported that a number of operational issues had occurred due to the Cyber Attack, however only a small number of patient appointments had been cancelled. Following notification that the national threat level had been increased to critical the Trust
was required to ensure staff were aware of the increased threat and were to remain vigilant. Mutual aid policies with partner organisations would be reviewed along with blood stock levels and capacity of the organisation.

BD, Chair of the Audit Committee sought assurance regarding the Trust’s major incident arrangements in the event of a terrorist attack similar to Manchester where a large number of relatives were attending various hospitals seeking information about relatives and the strain it was placing on the organisations to cope. The COO/DCE explained that this would be factored in along with the additional resource that would be required, however, were a similar incident to occur in this area, the receiving trust would be South Tees Hospitals NHS Foundation Trust as the major trauma centre and this trust as a trauma unit would be expected to aid in triage and treatment.

JE, Non-Executive Director sought confirmation had the 111 service been affected by the Cyber Attack. The COO/DCE explained that the service used algorithms and not live patient systems. The CI&TO confirmed that to his knowledge no residual issues existed in the provision of the 111 service.

b. Sustainability and Transformation Plan

The CE reported that following publication of the 5 year Forward View – Next Steps, the direction of travel was towards the development of partnership Accountable Care Organisations and Accountable Care Systems. However, no decision making would be made until after the General Election on Thursday, 8 June. Re-engagement with local authority partners would resume post-election.

The CE outlined key deliverables for the next two years, and specifically for 2017/18: Deliver financial balance across the NHS; Improve A&E performance; Strengthen access to GP and primary care services; Improve cancer and mental health services. In addition, there were specific deliverables trusts would be required to meet, which included:

- Seven day services phased rollout in hospitals covering four priority clinical standards and five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by April 2018;
- Deliver aggregate A&E performance in England above 90% by September 2017 then increasing to 95% by the end of 2018, and the majority of trusts meetings 95% by March 2018;
- Meet agreed standards on A&E, ambulances, diagnostics and referral to treatment;
- Achieve the 62-day cancer waiting times standard, and maintain performance against the other cancer waiting times standards;
- Reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care by September 2017;
- Support delivery of the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations.

c. Additional Social Care Allocations

The CE reported that following announcement in the Chancellor’s budget statement to invest £2bn in social care, trusts had been asked to work with local authorities to help reduce delayed transfers of care. Both NHS commissioners and local authorities were still awaiting guidance regarding how the funds would be allocated and utilised, until this was received, it was difficult to make progress. However it was anticipated that of the £1bn expected to be available during 2017/18 a third of the money would be required to offset further cuts, a third to support hospital at home initiatives, and a third to tackle delayed transfers of care/delayed discharges.
Resolved:
(i) that, the information be noted, and;
(ii) that, the Trust’s response to the Cyber-attack be noted; and
(iii) that, thanks be placed on record for the work of the CI&TO and his team during the Cyber-attack and all staff for their response in keeping business continuity; and
(iv) that, an update be provided at the Board of Directors meeting on 22 September regarding reviews of the Trust’s Business Impact Arrangements and Business Continuity Plans, and 3rd party external system arrangements; and
(v) that, the heightened national terrorist threat level to critical be noted.

BoD/3409 Safety, Quality and Infection Prevention Report

The DoN, PS&Q presented the Safety, Quality and Infection Prevention Report and drew members’ attention to the key points.

The number of patient falls had increased slightly from the previous month, for the reporting period of April 2016 to March 2017 the Trust had seen a decrease of 12 in the number of falls with fracture when benchmarked against the same reporting period in 2015/16. There had been no never events in the reporting period.

The number of grade 2 pressure ulcers had slightly decreased from the previous month, and when benchmarked against the same period of April 2016 to March 2017, the Trust had reported 168 fewer pressure ulcers.

The Trust had reported six cases of Clostridium Difficile (C-Diff) in April 2017 which was disappointing; the annual trajectory for 2017/18 was 13 cases. Work was being undertaken to identify any reasons for the increased number of cases. An improvement plan had been developed and NHS Improvement would be visiting the Trust on 23 June to provide external scrutiny. An appeals process was now in place and from the six cases in April, it was anticipated that two would be appealed against.

There were zero Trust-attributable cases of MRSA, and two cases of Trust-attributable MSSA and E.coli bacteraemia respectively in April. The DoN, PS&Q reported that from 1 April 2017 two additional organisms had been added to the mandatory surveillance system. The two new infections were bloodstream infections or bacteraemia: Klebsiella species bacteraemia and Pseudomonas aeruginosa bacteraemia. There was one case of Pseudomonas aeruginosa reported. The hand hygiene score for April was 97%, exceeding the internal target of 95%.

The latest HSMR value was 104.55 (March 2016 to February 2017), which was a decrease from the rebased 105.72 (February 2016 to January 2017) and continued to remain within the ‘as expected’ range. The latest SHMI value was 111.95 (October 2015 to September 2016), which was also in the ‘as expected’ range.

In April 2017, the Trust had received 90 complaints, of which 20 were stage 3. The Trust continued to make progress in complaint resolution before escalation to a formal complaint (stage 3) when comparing the same period in previous years: 114 – 2016/17 and 84 – 2015/16. The Trust’s response rate for stage 3 complaints for March 2017 was 95%.

SH, Chair of the Transformation Committee sought assurance regarding any recurring themes in respect of formal complaints, and whether in necessary circumstances complaints were escalated to be dealt with outside the standard timeframes. The DoN, PS&Q explained that there was not one single recurring theme, but instead three main reasons which were reviewed, and yes where appropriate a complaint could be dealt with outside of the formal
complaints process.

The Registered Nurse/Midwife day shift fill rates across inpatient areas for April 2017 was 84.33% and 89.68% for the night duty fill rate. The registered nurse fill rate had consistently remained above the 80% for both day and night since October 2016, with all areas adhering to the red rules ensuring safe staffing was maintained. Variances in percentage fill rates occurred for a number of reasons including staff vacancies, sickness and maternity leave, and in some areas higher fill rates were required due to increased acuity.

From April 2017 the revised Trust Staff, Patient Experience and Quality Standards (SPEQS) process incorporating the five CQC domains of safe, effective, caring, responsive and well-led would be rolled out to Outpatients, with other areas such as Emergency Care and Maternity being included in due course. During April there were 12 in-patient and 3 outpatient reviews undertaken.

The Quality Accounts for 2016/17 had been reviewed by the Trust’s external auditors, PWC. 

**Resolved:**
(i) that, the content of the report be noted; and  
(ii) that, work underway to improve performance against the quality indicators be noted; and  
(iii) that, the work in respect of C.Difficile be noted; and  
(iv) that the improved HSMR figures be noted.

**BoD/3410 Nursing and Midwifery Workforce Report**

The DoN,PS&Q presented the Nursing and Midwifery Workforce Report outlining that a number of reports and guidance had been published in relation to safe staffing including work undertaken by the National Quality Board. In 2015 the Department of Health published Creating a Modern Nursing Workforce which emphasised how organisations must make sure that they have nurses in sufficient numbers to provide exceptional clinical care, whilst ensuring that nurse training is of the highest standard. This was further supported by the Shape of Caring Review 2015 which sought to ensure that nurses receive consistent high quality education and training which supports high quality care delivery.

The Carter Report published in 2016 highlighted the need for live electronic rosters across the NHS to enable the right numbers of staff being in the right place at the right time, so patients receive the correct level of care and hospitals do not waste valuable resources over deploying staff when they are not needed. Within his report, Lord Carter developed a ‘model hospital’ advising trusts on the most efficient allocation of resources and allowing hospitals to measure their performance against other Trusts.

The DoN,PS&Q provided an overview of nursing and midwifery staffing across the Trust with the base establishment calculated by the continued usage of three tools, which included the Trust’s nursing and workforce tool, the Safer Nursing Care Tool overlaid with the professional judgement of the Ward Matron and Senior Clinical Matron in that area.

A new tool was being implemented, Safe Care Live, which would be rolled out to Medicine in June, followed by other areas, and would allow the Trust to establish staffing models which were supported by live patient demand rostering. The Trust currently had 88.92 RN vacancies and was actively recruiting both in the UK and overseas. It was anticipated that 22 wte would be filled during 2017 by nurses due to arrive from the Philippines. A further visit to the Philippines was due to take place in July.

The CE requested an update regarding the number of Romanian nurses that had joined the organisation. The DoN,PS&Q explained that the 10 members of staff were employed by NHSP and not the Trust and a number of settling in issues had arisen including a substantial
difference between UK healthcare training and European. This had resulted in a number of
the nurses returning to Romania or being employed elsewhere. There were no plans to
undertake further European recruitment at present.

Following the development of a Nursing Academy in conjunction with the University of
Sunderland, the first cohort of students arrived in April. Work was on-going to reduce usage
of temporary and agency staff. As part of Lord Carter e-rostering recommendations, nursing
rotas were completed 8 weeks in advance, allowing sufficient time for all vacant duties to be
sent to NHSP. An Enhanced Care model was being established to centrally manage a
number of Enhanced Care Workers who would be appropriately deployed to clinical areas as
required.

Advance planning plays a vital role in winter preparations and arrangements were already in
place to prepare for winter 2017/18 and it was anticipated that a nurse and therapy led
approach would be used again on the winter resilience ward.

Resolved: (i) that, the work undertaken to date in reviewing the nursing and
midwifery staffing levels across the organisation be noted; and
(ii) that, the on-going work in reducing the Nursing and Midwifery
bank and agency usage across the organisation be noted; and
(iii) that, the progress in relation to overseas recruitment into
current nursing vacancies and the future planned recruitment drives
both in the UK and overseas be noted; and
(iv) that, the proactive work relating to winter planning and
specifically the workforce solutions to manage the anticipated risks
be commended; and
(v) that, continued achievement of safe staffing levels be noted.

BoD/3411 Annual Report and Accounts 2016/17 including Quality Accounts
2016/17

The Company Secretary presented the draft Annual Report and Accounts 2016/17, and
Quality Accounts 2016/17, explaining that the documents had been prepared in accordance
with statutory guidance: the Annual Reporting Manual (ARM), Department of Health
Accounting Manual and requirements for the Quality Accounts.

The Annual Report and Accounts were required to be submitted to NHS Improvement by
31 May 2017, would be laid before parliament in June. Each of the documents had been
audited and reviewed by the Trust’s external auditors, PWC to ensure they were fully
compliant with the requirements of the ARM, and had subsequently been presented to the
Audit Committee. In addition, the Quality Accounts had been reviewed by third party
stakeholders and several third party declarations provided.

External publication of the information could take place once the information was laid before
parliament. It would be published on the Trust website, NHSI website and be formally
presented at the Trust’s Annual General Meeting in October.

There was a statutory requirement for delegated authority to be passed to the Chairman and
CE to sign off letters of representation which was agreed.

BD, Chair of the Audit Committee confirmed that overall the Committee was happy with the
Annual Report, Accounts and Quality Accounts, noting in particular that the Quality Accounts
were balanced. There had been some minor concerns regarding the Annual Accounts,
however, these had been resolved.

Resolved: (i) that, the Annual Reports & Accounts 2016/17, and Quality
Accounts 2016/17 be approved; and
(ii) that, delegated authority be given for the CE and Chair to sign off the letters of representation.

BoD/3412  Compliance and Performance Report

The COO/DCE presented the Compliance and Performance Report for the month of April 2017, drawing members’ attention to the key points. The Corporate Dashboard and reporting framework was reflective of both the mandatory performance frameworks for 2017/18 and additional internal reporting requirements, including the Lord Carter Review.

As part of the STP conditions for 2017/18 trajectories were agreed against key access standards, however, funding conditions related solely to achievement of the control total. As a result index 5 of the Corporate Dashboard had been removed from the performance framework. With effect from 1 April 2017, NHS Improvement had changed the self-certification process with trusts ceasing to submit quarterly returns, but instead trusts would be randomly selected to be audited.

In April 2017 overall performance against key operational standards and trajectories remained persistently challenging. Emergency activity saw a slight decrease of 0.23% when compared to the same period last year, and included 776 patients who were treated via Ambulatory Care, which equated to 22.66% of the total emergency admissions. There had been a decrease of category 1 patients by approximately 30%, however, the commencement of the Integrated Urgent Care Service (IUCS) would have contributed to the decrease.

Performance against the emergency care standard had achieved in April reporting at 97.97% against the national requirement of 95%, a significant improvement compared to previous months. Nationally 26 of the 139 provider trusts had achieved the standard, and in March the Trust was positioned 11th nationally. The Integrated Urgent Care Service achieved the standard reporting at 99.42%, and 99.14% of patients were seen and treated within 4 hours at the University Hospital of Hartlepool and at the University Hospital of North Tees; 98.28% were seen within 2 hours at the University Hospital of Hartlepool and just under 95% at the University Hospital of North Tees.

The Trust achieved against the Referral to Treatment (RTT) standard reporting at 94.19% for April, performing above the national average of 90%, and there were no over 52 week waits.

Delayed Transfers of Care (DTOC) saw a reduction towards the end of 2016/17, however, April 2017 saw an increase on the same period last year with an average of 19 per day. DTOC continued to impact on bed occupancy with 3.74% reported in April, this was below the agreed NHSI monthly target of 4.4%, however, significantly higher than the same period in 2015/16 and 2016/17. The Trust was focusing on stranded patients, working with partners to improve patient flow, and a number of additional care home beds would become available later in the year in Hartlepool improving the situation.

The Trust continued to experience significant pressures within the delivery of the cancer standards across all tumour groups, with increased cancer referrals evident. A tentative position indicated the Trust had underachieved against the 62 day referral to treatment standard at 84.38% for April; the two week rule reporting at 89.54%, and the breast symptomatic two week rule standard at 90.75%. Issues continued with patient choice, complex pathways, tertiary referrals and diagnostic pressures.

The Trust had managed a cancer standard recovery plan to support improvement in compliance and focus on service delivery across all tumour specific groups. There had been a funding allocation for cancer recovery of £10m with £930K to the North Region, however, the majority of funding had been allocated to non-achieving trusts, which would be
It was noted that due diligence had been paid by the Board of Directors in assessing on-going compliance and that of new requirements specifically illustrated in regular seminars and committee structures in relation to self-certification.

Resolved:  
(i) that, the content of the report be noted; and  
(ii) that, the on-going challenges and key risks be noted; and  
(iii) that, the position regarding DTOC be noted;  
(iv) that, the significant pressure on achieving the cancer standards be noted; and  
(v) that, the Board of Directors delegate responsibility to the Chairman to sign the statements of self-certification.

BoD/3413 Financial Performance Report as at 30 April 2017

The DoF presented the Financial Performance Report as at 30 April 2017 and drew members’ attention to the key points. There was no Use of Resource Metric (UOC) issued from NHS Improvement (NHSI) for April, it was anticipated it would commence from month 2.

The Trust’s in month position was a deficit of £1.521m, which was £1.544m behind the NHS Improvement control total plan. Sustainability and Transformation Funding (STF) income for 2017/18 was solely dependent upon hitting financial targets. No STF funding had been accrued in Month 1 as the Trust had not met its financial targets, and therefore was behind planned STF income of £0.344m, and excluding STF the Trust had planned an operational deficit of £0.322m, therefore the position was £1.200m behind plan.

Income was behind plan by £0.203m; NHS clinical income behind plan by £0.037m, non NHS clinical income behind by £0.043m, and non-clinical income behind by £0.466m. The majority of clinical income had been accrued to planned levels at this stage of the year.

Pay was overspent by £0.251m, largely due to non-delivery of CRT. Non-pay was over spent by £0.776m, and non-pay CRT was behind plan by £1.049m, which was offset by £0.281m underspend on clinical supplies. The CRT for 2017/18 was £18.8m and £0.185m had been achieved in month 1. The Trust’s cash balance was slightly ahead of plan at £21.769m.

The Trust capital allocation for 2017/18 was £22.174m, of which £6.021m was internally generated ‘block capital’, £14.148m was from the ITFF loan for the infrastructure and energy centre upgrades at the University Hospital of North Tees. £0.150m was additional capital from charitable donations and £1.855m was allocated to develop services in line with the Clinical Services Strategy. It was assumed that this expenditure would be funded by a further capital loan. At month 1, the Trust had spent £0.735m against the plan of £1.395m; the variance against plan was in relation to the timing of cash payments.

The CE reiterated that the CRT was challenging, and at 7% was much higher than the national average of 4.2%. SH, member of the Finance Committee provided assurance that individual directorates would be invited to attend the Finance Committee promptly regarding non-achievement to address the issue quickly.

Resolved:  
(i) that, the current financial position be noted; and  
(ii) that, the challenging CRT for 2017/18 be acknowledged.
The Chief Operating Officer/Deputy Chief Executive presented the Operational Resilience Report, summarising the Trust's current position, the pressures faced during the winter period of 2016/17, and how resilience has been managed.

Significant pressures were again faced across the health economy locally and nationally. In preparation for the winter 2016/17 and other surges of activity, the Trust reflected on winter 2015/16, learning from application of plans and responses. The Trust’s Winter Capacity and Surge Plan 2016/17 was produced in line with national requirements, with planning commencing in April 2016, and was now merged into an Operational Resilience Plan.

Winter 2016/17 again saw unprecedented surges in activity, with an increase in admissions and the level of patient acuity, testing the effectiveness and resilience of emergency care, however, the Trust responded effectively having applied learning from the previous winter. The monthly conversion rate of A&E attendances to admissions between November 2016 and March 2017 ranged from 27.73% to 30.75%, the average conversion rate the previous winter was 26.34%.

To establish sustainable year round delivery required robust on-going system planning, and the Trust had worked with partners towards a proactive system of year round operational resilience. There continued to be an emphasis nationally for trusts to meet the four hour 95% target, hence the introduction of A&E Delivery Boards; the COO/DCE being chair of the local A&E Delivery Board. The increase in breaches of the four hour target was as a result of several pressures in the system and not just the increased volumes of A&E attendances.

Resilience funding for 2016/17 was significantly lower than the previous year at £866k, with £500,000 to strengthen clinical leadership in emergency care. The actual cost to the Trust of resilience schemes, excluding the £500,000 emergency care allocation was c. £1.3m.

Admission avoidance and transfers of care remain a focus. A bed re-profiling exercise was undertaken during 2016 to try to reduce occupancy levels and accommodate escalated activity. Elective beds were swung to non-elective to manage capacity and minimise the financial impact. A new model of care was introduced in January 2017, using a nurse/therapy led approach for patients not requiring medical intervention via a resilience ward. Following evaluation the model has continued to ensure medically fit patients receive the intense support required to enable transfers of care to take place.

Two ‘perfect week’ initiatives were performed in January and March 2017 focusing on delayed discharges, and patient escalation and flow from A&E in relation to emergency care and the four hour standard. The Trust has maintained above national average performance consistently during 2016/17, remaining in the top 10 until February when it dropped to 26th before returning to 11th in March. In February only 9 trusts achieved the four hour standard.

Strengthened clinical leadership particularly out of hours supported the focus on safety and quality of care provision. There was limited assurance that primary and social care plans would support the Trust in managing the expected increase in demand. The system wide approach has not had a significant bearing on the demand for acute services and as such presented a real risk to the Trust.

Resolved:  
(i) that, the content of the report be noted; and  
(ii) that, the winter pressures and system risks be noted; and  
(iii) that, the performance during the winter pressures and robust plans in place be noted.
The DoHR&E presented the Human Resources and Education Report for Quarter 4.

The Trust headcount had increased by 126 in quarter four when compared to the same period the previous year. The sickness absence rate for quarter four was 4.99% which was higher than 4.73% at the same period last year, however, improvements had continued to be seen for the last 3 months and the position for April 2017 was 4.23%. The top three reasons for sickness absence remained: Anxiety & stress, musculoskeletal, and gastrointestinal problems. The regional average sickness rate for quarter two (latest data) was 4.52% compared to the Trust’s quarter two position of 4.71%.

A new attendance Management Policy had commenced from 1 December 2016, which included a revised process for the management of short-term, intermittent absence which would allow managers to deal with concerns at a line manager level saving time spent preparing for formal disciplinary hearings, and would support managers to deal with individual long term sickness cases.

The turnover rate for quarter four was 11.83%, with foundation doctors included, and 11.16% without. During quarter four, 46.9% exit interviews were provided for leaving members of staff, 100% compliance was required for quarter 1: 2017/18. The main reason for leaving remained as flexi-retirement. There were only 5 live medical vacancies and the F1 junior doctor allocation for August was 100%, with only 3 planned vacancies for F2.

Overall mandatory training compliance was 91% for quarter four. Some areas of training were being reviewed to increase compliance levels including making safeguarding training available on e-learning, and bringing forward the due date for Information Governance training to allow more time for completion in advance of year end.

The new Integrated Urgent Care Service commenced on 1 April in conjunction with Hartlepool and Stockton Health and North East Ambulance Service (NEAS). Eligible staff from the previous providers Virgin Healthcare and Vocare had been successfully TUPE transferred to the Trust. Work continued to ensure successful delivery of the exit strategy in relation to the transfer of the 0 to 19 Service to Hartlepool Borough Council on 1 May 2017.

In recognition of the Trust’s commitment to the Armed Forces community as a friendly employer, the Trust signed the Armed Forces Covenant, and also was awarded the Ministry of Defence’s (MOD) Bronze Award as part of their Employer Recognition Scheme in respect of employability of veterans. The Trust was also committed to ensure members of the armed forces or their dependants were not disadvantaged in respect of care and 30 trusts had been chosen to take part in the scheme. The CE reported that he had attended a meeting regarding the possibility of providing improved healthcare at Catterick Garrison for members of the armed forces, dependants and local people through an integrated healthcare provision.

KR, Chair of the Performance, Planning and Compliance Committee sought clarity regarding the impact of Brexit on staff and what support was provided. The DoHR&E explained that the Trust was a member of the Cavendish Group which covered the impact of Brexit on the NHS as an employer, although to date there had not been a great deal of output. The Chair felt a communication to staff around the continued focus of Brexit and its impact would provide assurance.

In respect of mandatory training compliance, JE sought clarity regarding the effectiveness of e-learning compared to traditional methods. The DoHR&E explained that currently no evaluation was carried out, however, using e-learning had made training much quicker to undertake.
Resolved: (i) that, the content of the report be noted; and
(ii) that, the Trust’s achievement of the MOD Bronze Award be noted; and
(iii) that, a communication be provided to staff in respect of the impact of Brexit.

BoD/3416 NHS National Staff Survey 2016

The DoHR&E presented the outcomes of the NHS National Staff Survey 2016. A total of 1,228 questionnaires had been hand delivered to staff, and 745 had been completed, which was a response rate of 61%. This was a 16% increase on the response rate the previous year, and placed the Trust the second highest in the region.

Positively, out of 32 findings, the Trust had rated better than average for 20 of them and average for a further 5, and there had been no negative findings. The DoHR&E provided a summary of the key findings, highlighting the top five and bottom five ranking scores for the Trust. Areas where concerns were raised would be subject to deep dive reviews.

A number of positive initiatives had been developed following feedback from reward and recognition focus groups, which included star of the month, team of the month, and a Seventh ‘C’ Culture Conference. A new app was being launched to allow staff to access a wide range of centrally held information for the first time. KR, Chair of the Performance, Planning and Compliance Committee queried whether the use of a SLIDO type voting tool would increase the survey response rate further. The DoHR&E explained that there was strict guidance regarding confidentiality of the responses received.

Resolved: (i) that, the results of the staff survey 2016 be noted; and
(ii) that, the survey improvements be noted; and
(iii) that, follow up in respect of concerns be noted.

BoD/3417 Carbon Reduction Programme Performance Targets

The DoE&F presented the Carbon Reduction Programme Performance Targets.

JE, Chair of the Strategy and Service Development Committee commended the Trust’s performance in halving its carbon emissions over the last 10 years. The DoE&FM explained that ceasing to use coal as a fuel in 2002 provided a huge reduction, and small reductions had continued to date.

Resolved: that, the Carbon Reduction Programme Performance Targets be noted.

BoD/3418 Corporate Health & Safety and Non Clinical Risk 2016/17 Annual Report

The DoE&F presented the Corporate Health & Safety and Non Clinical Risk 2016/17 Annual Report. Highlights included reducing the number of false fire brigade attendances by managing the fire systems better. A new fire alarm system would be installed at the University Hospital of North Tees. Design work had commenced and capital expenditure was expected to be in 2018/19.

Resolved: that, the Corporate Health & Safety and Non Clinical Risk 2016/17 Annual Report be received.

BoD/3419 Annual Adult, Children & Young People Vulnerability Report

The DoN,PS&Q presented the Annual Adult, Children & Young People Vulnerability Report
2016/17 (formerly Safeguarding Annual Report). It was noted that there had been a positive effect following the combining and co-locating of the adult and child safeguarding teams.

**Resolved:** that, the Annual Adult, Children & Young People Vulnerability 2016/17 Report be received.

**BoD/3420 Annual Director of Infection Prevention and Control Report 2016/17**

The DoN,PS&Q presented the Annual Director of Infection Prevention and Control Report 2016/17.

**Resolved:** that, the Annual Director of Infection Prevention and Control Report 2016/17 be received.

**BoD/3421 Equality and Diversity Annual Report 2016/17**

The DoHR&E presented the Equality and Diversity Annual Report 2016/17.

JE, Chair of the Strategy and Service Development Committee sought assurance that following the terrorist incident in Manchester on 22 May where there was potential for an increase in hate speech aimed at individual faith groups, the Trust were providing guidance and support to staff. The DoHR&E explained that staff had been informed regarding the increased national threat level but not specifically in relation to reactionary behaviour. It was agreed that a brief summary would be communicated to staff via a standard briefing such as the next Chief Executive's briefing.

**Resolved:** (i) that, the Equality and Diversity Annual Report 2016/17 be received; and
(ii) that, a brief communication be provided to staff in respect of possible adverse behaviour towards individual faith groups.

**BoD/3422 Any Other Notified Business**

a. **HUG Visits**

Norman Mackey, the Healthcare User Group (HUG) Representative reported that since the last meeting visits had been undertaken to Wards 40 and 42 at the University Hospital of North Tees. The visits provided the opportunity to speak to both patients and staff and the feedback had been very positive.

**BoD/3423 Date and Time of Next Meeting**

**Resolved:** that, the next meeting be held on Thursday, 27 July 2017, at 1.00pm in the Boardroom, University Hospital of North Tees.

**BoD/3424 Exclusion of Press and Public**

**Resolved:** that, representatives of the press and other members of the public be excluded for the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2), Public Bodies (Admission to Meetings) Act 1960).

The meeting closed at 3.15pm.
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Chairman’s Report

Report of the Chairman

Strategic Aim *(The full set of Trust Aims can be found at the beginning of the Board Reports)*

Manage Our Relationships

Strategic Objective *(The full set of Trust Objectives can be found at the beginning of the Board Reports)*

Effective Board Governance

1. Introduction

1.1 The Chairman’s Report aims to provide information to the Board of Directors on key local, regional and national issues.

2. Key Issues and Planned Actions

2.1 The following consultant appointments have been made since the last meeting:

   Dr Ramkumar Dhanancheyan, Consultant Anaesthetics
   Mr Kevin Etherson, Consultant Colorectal Surgeon
   Mr Yogesh Jain, Consultant Breast Surgeon
   Mr Ziauddin Khan, Consultant Urologist
   Dr Naveed Altaf, Consultant Radiologist

2.2 I attended the Clinical Commissioning Group (CCG) Governing Body meeting held at Billingham Forum on 30 May 2017. Their meetings cover Hartlepool and Stockton CCG plus Darlington CCG and provide an insight into primary, acute and tertiary services across the Tees Valley.

   It was pleasing to see that despite the significant challenges facing the Trust, our operational performance remains strong when compared with other Foundation Trusts. However, the size of the financial challenge facing this Trust is substantial and the ability of the CCG to deliver against their QIPP challenge and our ability to delivery against our control total is questionable.

2.3 I attended a meeting of the North East Foundation Trust Chairs Group along with the Chief Executive who had been invited to discuss STP progress and the potential for the wider North East to work more closely together.

2.3 The Trust hosted another Shining Stars event at Hardwick Hall to celebrate the work of the Trust and the major contribution of our staff over the past year.

   Many thanks to Alan Sheppard and Stephen Hall for hosting the event and thanks to the many senior staff who hosted tables and made the evening a great success.
2.4 The Trust hosted a volunteers and retired staff event at North Tees to show our appreciation for the countless hours of support freely given by our volunteers and Governors. Many thanks to those who organised and helped support the event.

2.5 The Chief Executive and I have commenced the process of carrying out joint appraisals of the Executive Directors focussing on their Board role as opposed to their functional directorate role. These should all be completed by early August.

3. **Recommendations**

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

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Paul Garvin  
Chairman  
20 July 2017
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Chief Executive’s Report

Report of the Chief Executive

Strategic Aim (The full set of Trust Aims can be found at the beginning of the Board Reports)
Manage Our Relationships

Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)
Effective Board Governance

1. Introduction

1.1 The Chief Executive’s Report aims to provide information to the Board of Directors on key local, regional and national issues.

2. Key Issues & Planned Actions

2.1 Emergency Preparedness Resilience and Response Assurance

Following the recent terrorist attacks, NHS cyber attack and the Grenfell Tower fire in London, our regular update with regard to NHS resilience has taken on an even greater significance. Several briefings and learning from these events is already being communicated across the NHS. These issues were discussed at the recent Board Seminar on Thursday, 13 July 2017 and detailed guidance has been received on the issues which need to be reviewed which will result in a Statement of Compliance from each NHS organisation.

With respect to fire safety, a detailed annual review was carried out by Cleveland Fire Brigade in February and May at North Tees and Hartlepool hospital respectively, a full report has been received which includes some minor recommendations which are being actioned. Further recent discussions with Cleveland Fire Brigade in the last month confirm they do not consider any additional actions are required at this time. I can assure the Board that none of our buildings contain any of the cladding material that was present in the Grenfell Tower.

2.2 Delayed Transfers of Care

I wish to inform the Board that we have just received a letter from the Department of Communities and Local Government which sets out the requirement placed upon local government and the NHS to reduce delayed transfers of care using the additional resources provided by the Government in the March budget. The additional money has been provided to do three things:-

1. Meet adult social care needs
2. Reduce pressure on the NHS by supporting more people to be discharged from hospital when they are ready
3. Ensure that the local social care provider market is supported

This further guidance that has been provided is timely in that it makes it clear that action needs to be taken in order to free up NHS beds in advance of this winter.

2.3 Ambulance Response Programme

The Secretary of State for Health has accepted Sir Bruce Keogh’s recommendations to fundamentally redesign the ambulance service’s operating model. The key components of this redesign are as follows:-

- Quicker identification of life-threatening conditions using a pre-triage system
- Introduction of new response times standards which cover every single patient, not just those in immediate need
- A new dispatch model, giving staff more time to identify patients’ needs
- A change to the rules around what “stops the clock”, so standards can only be met by doing the right thing for the patient

This new operating model will be live in all Trusts by this winter and bring significant clinical benefits for patients.

3. Recommendations

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

Alan Foster  
Chief Executive  
17 July 2017
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Report of the Chief Executive

Retrospective Approval of Documents Executed Under Seal

Strategic Aim *(The full set of Trust Aims can be found at the beginning of the Board Reports)*

Maintain Compliance and Performance

Strategic Objective *(The full set of Trust Objectives can be found at the beginning of the Board Reports)*

Maintain Compliance and Performance
Effective Board Governance

The following documents have been executed under the Common Seal of the Trust.

<table>
<thead>
<tr>
<th>Document</th>
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<th>By</th>
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<tbody>
<tr>
<td>Under lease relating to part of Wynyard Road, Primary Care Centre, Wynyard Road, Hartlepool TS25 3DQ</td>
<td>29 June 2017</td>
<td>Mr A Foster Miss Caroline Trevena</td>
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<td>1) Community Health Partnerships Limited</td>
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<td>2) North Tees &amp; Hartlepool NHS Foundation Trust</td>
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<tr>
<td>Under lease relating to part of One Life Hartlepool Medical Centre, Park Road, Hartlepool, TS24 7PW</td>
<td>29 June 2017</td>
<td>Mr A Foster Miss Caroline Trevena</td>
</tr>
<tr>
<td>Between:</td>
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<tr>
<td>2) North Tees &amp; Hartlepool NHS Foundation Trust</td>
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The Board is requested to grant retrospective approval for the sealing of these documents.

Alan Foster
Chief Executive
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Executive Summary

Safety, Quality and Infection Prevention Report
Report of the Director of Nursing, Patient Safety and Quality

Strategic Aim (The full set of Trust Aims can be found at the beginning of the Board Reports)
Putting Patients First

Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)
Putting Patients First/Patient Safety

1 Introduction

1.1 This safety, quality and infection prevention report aims to describe progress in relation to aspects of patient safety and experience along with the healthcare associated infection performance position.

2 Safe

2.1 Patient Falls, May 2017 (101) decreased from April 2017 (114)

2.2 Pressure Ulcers, May 2017 (11) decreased from April 2017 (20)

2.3 There have been no never Events in the reporting period.

2.4 Clostridium difficile - The Trust has reported three Trust attributed cases of Clostridium difficile infection for May 2017 and four for June 2017.

2.5 MRSA bacteraemia - The Trust has reported none Trust attributed cases of MRSA bacteraemia in May 2017 and none for June 2017.

2.6 MSSA bacteraemia - The Trust has reported one Trust attributed cases of MSSA bacteraemia for May 2017 and four for June 2017.

2.7 E.coli bacteraemia - The Trust has reported three Trust attributed cases of E coli bacteraemia in May 2017 and four for June 2017.

2.8 Klebsiella species bacteraemia – The Trust has reported two cases of Klebsiella bacteraemia in May 2017 and one for June 2017.

2.9 Pseudomonas aeruginosa bacteraemia – The Trust has reported one case of Pseudomonas aeruginosa bacteraemia in May 2017 and one for June 2017.

2.10 Hand hygiene - The overall Trust compliance score for hand hygiene was 95% in May 2017 and 97% for June 2017; these values meet the Trust internal target of 95%.

2.11 The Trusts overall Harm Free care in May 2017 was 98.76% this has decreased from 99.71% in April 2017. The Trusts overall New Harm increased from 0.29% in April 2017 to 1.24% in May 2017.
3 Caring

3.1 In June 2017, 94.81% would recommend the service to family members; this has increased from 94.26% in May 2017. In June 2017, 1.59% wouldn’t recommend the service to family members; this value has decreased from 1.80% in May 2017.

4 Effective

4.1 The latest HSMR value is now 103.73 (April 2016 to March 2017) from the rebased 104.96 (March 2016 to February 2017), this new value continues to remain inside the ‘as expected’ range; the national mean is 100. The Trust crude mortality rate for HSMR has decreased slightly to 3.55% from the rebased 3.59%.

4.2 The latest SHMI value is 110.29 (January 16 to December 16), this has decreased from the previous rebased value of 111.25 (December 15 to November 16), the value maintains the Trust in the ‘as expected’ range. The Trust crude mortality rate for SHMI is now 3.55%.

5 Responsive

5.1 The Trust has received 55 complaints in June 2017, compared with 61 for May 2017.

5.2 The Trust’s response rate for stage 3 complaints for May 2017 is 100%

6 Well-Led

6.1 The registered nurse fill rate has consistently remained above 80% for both day and night duty with all areas adhering to the red rules ensuring maintenance of safe staffing.

7 Staff, Patient Experience and Quality Standards (SPEQS)

7.1 The SPEQS process utilising the five CQC domains of Safe, Effective, Caring, Responsive and Well-Led is currently in use in In-patient and Out-patient areas.

8 2016-17 Quality Accounts

8.1 The 2016-17 Quality Account document has officially been signed off by PriceWaterhouse Coopers and the Trusts Audit Committee in May 2017, with the document uploaded to NHS Choices and the Trusts website in June 2017, meeting the national deadline of 30 June.

9 Recommendation

The Board of Directors is asked to note the content of the report, the current HSMR and SHMI values, the Trust quality indicators and the work underway to improve performance.

Julie Lane
Director of Nursing, Patient Safety and Quality
1 Introduction/Background

1.1 The purpose of this report is to inform the Board of Directors of aspects of quality, patient safety and experience along with the healthcare associated infection performance.

1.2 The Trust Safety and Quality Dashboard (see appendix 1), utilises the CQC domains of Safe, Caring, Effective, Responsive and Well-Led. The dashboard allows users, to see month on month trending.

Safe

2 Falls data for 2017-18 – In-hospital (data up to 31 May 2017)

2.1 For the reporting period of May 2017 the Trust has seen 101 falls (72 falls with no Injury, 27 falls with injury no fracture and 2 fall with fracture). This has decreased from April 2017 when there was 114 falls (94 falls with no Injury, 19 falls with injury no fracture and 1 fall with fracture).

2.2 The month of May 2017 has shown a decrease in the number of falls from 114 in April 2017 to 101 in May 2017. When benchmarked against April-May 2016 data, the Trust had experienced a total of 5 fewer falls, 215 (Apr to May 2017) against 220 (Apr to May 2016).

3 Pressure Ulcers 2017-18 – In-hospital (data up to 31 May 2017)

3.1 Pressure ulcers are reported via the Trusts incident reporting system (Datix) and the data undergoes an initial level of validation i.e. removal of duplicate reports for the same ulcer.

3.2 The second level of validation is undertaken by the tissue viability team who look at the clinical picture and assess whether any skin lesions are a true pressure ulcer and the appropriate grade.

3.3 For May 2017 the Trust experienced 11 pressure ulcers of which 9 were grade 2 and above, this has decreased from April 2017, where the Trust reported 20 pressure ulcers of which 16 were grade 2 and above.

4 Never Events

4.1 There have been no Never Events in the reporting period.

5 NHS Safety Thermometer (data up to May 2017)

5.1 The Trusts overall Harm Free care in May 2017 was 98.76% this has decreased from 99.71% in April 2017. The Trusts overall New Harm increased from 0.29% in April 2017 to 1.24% in May 2017.
6 Healthcare Acquired Infections (data up to 30 June 2017)

6.1 **Clostridium difficile** - The Trust has reported **three** Trust attributed cases of Clostridium difficile infection for May 2017 and **four** for June 2017. This exceeds the trajectory for the year to date. The investigations completed have been reviewed by an internal panel and a number which may be suitable for appeal have been identified. Documentation is being completed to submit to commissioners for support in the appeals process. A support visit from NHS Improvement and the Regional Microbiologist went ahead on 23 June 2016 and a small number of initial recommendations were made. A full written report is expected in late July 2017.

6.2 **MRSA bacteraemia** - The Trust reported **none** Trust attributed cases of MRSA bacteraemia in May 2017 and **none** for June 2017.

6.3 **MSSA bacteraemia** - The Trust reported **one** Trust attributed cases of MSSA bacteraemia for May 2017 and **four** for June 2017.

6.4 **E.coli bacteraemia** - The Trust has reported **three** Trust attributed cases of E coli bacteraemia in May 2017 and **four** for June 2017.

6.5 **Klebsiella species bacteraemia** – The Trust has reported **two** cases of Klebsiella bacteraemia in May 2017 and **one** for June 2017.

6.6 **Pseudomonas aeruginosa bacteraemia** – The trust has reported **one** case of Pseudomonas aeruginosa bacteraemia in May 2017 and **one** for June 2017.

6.7 **Hand hygiene** - The overall Trust compliance score for hand hygiene is **97%** for June 2017, this meets the Trust internal target of 95%, however it has increased slightly from the 95% achieved in May 2017.

Caring

7 Family and Friends Test (FFT) (data up to 30 June 2017)

7.1 The Trusts ‘Would Recommend’ for Friends and Family returns increased to **94.81%** for June 2017 from 94.26% in May 2017. The percentage of patients who stated they ‘Wouldn’t Recommend’ decreased to **1.59%** in June 2017 from 1.80% in May 2017.

Effective

8 Mortality - Hospital Standardised Mortality Ratio (HSMR)

8.1 The latest HSMR value is now **103.73** (April 2016 to March 2017) from the rebased 104.96 (March 2016 to February 2017), this new value continues to remain inside the ‘as expected’ range; the national mean is 100.

8.2 The Trust crude mortality rate for HSMR has decreased slightly to **3.55%** (April 2016 to March 2017) from the rebased 3.59% (March 2016 to February 2017).

9 Mortality - Summary Hospital-Level Mortality Indicator (SHMI)

9.1 The latest SHMI value is **110.29** (January 16 to December 16), this has decreased from the previous rebased value of **111.25** (December 15 to November 16), the value maintains the Trust in the ‘as expected’ range.

9.2 The Trust crude mortality rate has decreased to **3.55%** (January 2015 to December 2016 from 3.60% (December 15 to November 16).
Responsive

10 Trust complaints performance (data up to 30 June 2017)
10.1 For June 2017 the Trust received 55 complaints, this is down from 61 in May 2017. Of the 55 complaints in May 2017, 11 (20%) are stage 3 requiring a formal response from the Chief Executive.

10.2 The Trust has continued to make improvements in complaint resolution. The complainant is given a choice of how the complaint is dealt with and a number of complainants choose stage 3 rather than one of the less formal approaches.

10.3 Formal stage 3 complaint numbers for 2017-18 total 42, 19 for April, 12 for May and 11 for June 2017.

10.4 When benchmarked against 2016-17 for the period of April to June, the Trust experienced 120 fewer complaints, 206 (April to June 2017) against 326 (April to June 2016). The Trust has received 42 complaints requiring a formal response from the Chief Executive during 2017-18; this has reduced from 75 same period of 2016-17.

10.5 The Trust’s response rate for stage 3 complaints for May 2017 is 100%.

Well-Led

11 Nursing and Midwifery Workforce (data up to 30 June 2017)
11.1 Registered Nurse/Midwife day shift fill rates across inpatient areas for the month of June 2017 is 80.87% down from 85.83% in May 2017. The night duty fill rate for June 2017 is 90.28% down from 93.75% in May 2017.

11.2 Variances in percentage fill rates occur for a number of reasons including staff vacancies, sickness and maternity leave and in some areas higher than planned fill rates due to increased acuity and care needs of the patient group.

12 Staff, Patient Experience and Quality Standards (SPEQS) (Data up to 30 June 2017)
12.1 The Trusts SPEQS process utilising the five CQC domains of Safe, Effective, Caring, Responsive and Well-Led has been rolled out to Outpatients from April 2017. Additional areas including Emergency Care and Maternity will be rolled out in July 2017.

12.2 For the month of June 2017, there was a total of 13 SPEQS visits conducted (9 in-patient and 4 Outpatient), with an overall SPEQS score of 94.37%, this has increased from 89.80% in May 2017 where 18 visits were conducted (12 in-patient, 5 Outpatient and 1 community).

13 2016-17 Quality Accounts
13.1 The 2016-17 Quality Account document has been officially signed off by PriceWaterhouseCoopers in May 2017, with the document uploaded to NHS Choices and the Trusts website in June 2017, meeting the national deadline of 30 June.

14 Recommendation
14.1 The Board of Directors is asked to note the content of this report, the current HSMR value, the Trust quality indicators and the work underway to improve performance.

Julie Lane
Director of Nursing, Patient Safety and Quality
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Appendix 1

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North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 July 2017

Sustainability and Transformation Plan update

Report of the Chief Executive

Strategic Aim (The full set of Trust Aims can be found at the beginning of the Board Reports)
Putting patients first

Strategic Objective (The full set of Trust Objectives can be found at the beginning of the Board Reports)
Putting patients first

1. Introduction

This report provides information to the Board of Directors on the development of the Sustainability and Transformation Plan (STP) for Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby Footprint.

2. Key Issues & Planned Actions

2.1 General Update

It has been agreed that the North East and West, East and North Cumbria will operate as a single unified STP going forward. Work is currently in hand to formally identify and appoint a leader for the single STP and this should be in place by the end of August 2017 at the latest.

At the time of writing this report, I have been informed that a baseline assessment of STPs will be published and I will update the Board on this when the figures become available.

2.2 Consultation on Service Changes in South Tyneside and Sunderland

A major public consultation has started across the NHS in South Tyneside and Sunderland. Called the ‘The Path to Excellence’ it sets out a range of proposals that have been developed by local clinical teams about how some aspects of hospital care can be improved.

The public consultation will run for 14-and-a-half weeks until Sunday 15 October, and will focus particularly on areas of hospital care which are delivered at South Tyneside District Hospital and Sunderland Royal Hospital including:

- Three options to improve stroke services, specifically hospital care and hospital-based rehabilitation services
- Two options to improve maternity services, covering hospital-based birthing facilities, ie. where women give birth and special care baby units and women’s services covering inpatient surgery where an overnight hospital stay would be required
- Two options to improve children and young people’s (paediatrics, urgent and emergency) services
This period of consultation will include a series of public events and a range of ways for local people to get involved, find out more about the issues under consideration and to give their views.

2.3 GP Engagement

I attended a GP engagement event for the Better Health Programme on Wednesday, 12 July 2017 in Darlington. This event was organised by Dr Andrea Jones who is the Clinical Chair of Darlington Clinical Commissioning Group. Several presentations were given in order to bring local GPs up to speed with the work so far. The Local Medical Committee was also invited and gave a presentation. It was agreed that further GP involvement in the planning and delivery of services was critical in order to ensure a joined up approach in respect to clinical leadership. It was agreed to arrange a further meeting in the Autumn.

3. Recommendations

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

Alan Foster
Chief Executive

17 July 2017