North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 26 January 2023
at 10.30am

Boardroom
University Hospital of North Tees

North Tees and Hartlepool
NHS Foundation Trust
University Hospital of North Tees

Hardwick
Stockton on Tees
TS19 8PE
Telephone: 01642 617617
www.nth.nhs.uk

19 January 2023

Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 26 January 2023 at 10.30am** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(10.30am)	Apologies for Absence	Chair
2.	(10.30am)	Declaration of Interest	Chair
3.	(10.30am)	Patient Story (verbal)	L Robertson
4.	(10.50am)	Minutes of the meeting held on, 24 November 2022 **(enclosed)**	Chair
5.	(10.55am)	Matters Arising and Action Log **(enclosed)**	Chair
Items for Information			
6.	(11.00am)	Report of the Joint Chair **(enclosed)**	Chair
7.	(11.10am)	Joint Partnership Board Update **(enclosed)**	S Hall
8.	(11.20am)	Report of the Chief Executive **(enclosed)**	J Gillon
9.	(11.35am)	Board of Directors Declarations of Interests and Fit & Proper Persons Declaration **(enclosed)**	M Brown
Performance Management			
10.	(11.40am)	Board Assurance Framework Quarter 3 Report 2022/23 **(enclosed)**	H Heslop
11.	(11.50am)	Integrated Compliance and Performance Report **(enclosed)**	L Hunter, L Robertson, N Atkinson & S Cook

Professor Derek Bell OBE
Chair

Julie Gillon
Chief Executive

Strategic Management

12. (12.05pm)	Capital Programme Performance Q3:2022/23 **(enclosed)**	N Atkinson
13. (12.15pm)	Elective Recovery Update **(enclosed)**	L Buckley

Quality

14. (12.25pm)	Registered Nursing and Midwifery Workforce Annual Report **(enclosed)**	L Robertson
15. (12.35pm)	Care Quality Committee & Improvement Journey Update **(verbal)**	J Gillon /Robertson
16. (12.40pm)	Maternity Report **(enclosed)** - CNST Maternity Incentive Scheme Year 4	L Robertson

Governance

17. (12.50pm)	Learning from Deaths Report Q3: 2022/23 **(enclosed)**	D Dwarakanath
18. (1.00pm)	Any Other Business	

Date of next meeting
(Thursday, 23 March 2023, Boardroom, University Hospital of North Tees)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

- Create a culture of collaboration and engagement to enable all healthcare professionals to add value to the healthcare experience
- Achieve high standards of patient safety and ensure quality of service
- Promote and demonstrate effective collaboration and engagement
- Develop new approaches that support recovery and wellbeing
- Focus on research to improve services

Valuing Our People

- Promote and 'live' the NHS values within a healthy organisational culture
- Ensure our staff, patients and their families, feel valued when either working in our hospitals, or experiencing our services within a community setting
- Attract, Develop, and Retain our staff
- Ensure a healthy work environment
- Listen to the 'experts'
- Encourage the future leaders

Transforming Our Services

- Continually review, improve and grow our services whilst maintaining performance and compliance with required standards
- 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

Health and Wellbeing

- Promote and improve the health of the population
- Promote health services through full range of clinical activity
- Increase health life expectancy in collaboration with partners
- Focus on health inequalities of key groups in society
- Promote self-care

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors held on Thursday, 24 November 2022 at 10.30am at the University Hospital of North Tees / Via Video Link

Present:

Professor Derek Bell, Joint Chair*	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	Vice Chair
Ann Baxter, Non-Executive Director*	AB
Fay Scullion, Interim Non-Executive Director*	FS
Chris Macklin, Interim Non-Executive Director*	CM
Ian Simpson, Interim Non-Executive Director*	IS
Julie Gillon, Chief Executive*	CE
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Neil Atkinson, Director of Finance*	DoF
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Levi Buckley, Chief Operating Officer*	COO
Gillian Colquhoun, Interim Chief Information and Technology Officer	ICITO
Linda Hunter, Director of Performance and Planning	DoP&P
Susy Cook, Chief People Officer	CPO
Mel Brown, Interim Director of Governance	IDoG
Hilton Heslop, Associate Director of Corporate Affairs & Strategy	ADoCA&S
Ruth Dalton, Associate Director of Communications & Marketing	ADoC&M

In Attendance:

Sarah Hutt, Company Secretary [note taker]
Professor Tim Thompson, Appointed Governor, Teesside University
Kath Tarn, Making Every Contact Count Lead **(Item No BoD/4913)**
Ian Armstrong, Associate Practitioner EAU **(Item No BoD/4913)**

Via video link
Tony Horrocks, Lead Governor / Elected Governor for Stockton

BoD/4911 Apologies for Absence / Welcome

There were no apologies for absence noted.

The Joint Chair welcomed everyone to the meeting and formally welcomed Mel Brown, newly appointed Interim Director of Governance.

BoD/4912 Declaration of Interests

Declarations of interest were noted from the Vice Chair in respect to his role with Optimus Health Ltd, and the DoF for his role as a member of the LLP Management Board.

BoD/4913 Staff Story

The CN/DoPS&Q introduced two members of staff Kath Tarn, Making Every Contact Count Lead and Ian Armstrong, Associate Practitioner EAU, and invited Ian to share his story. He had joined the Trust at 16 years old and enjoyed his work. During the pandemic Ian gained weight which began to affect his demeanour and confidence, he also commenced a nursing degree apprenticeship and welcomed the arrival of a new baby and the associated stress contributed to him gaining more weight. There was a family event arranged for July 2022, which was the catalyst for Ian to lose weight. He started to see an improvement in his energy levels and enthusiasm, as well as a notable change to his mental health and overall wellbeing which had a positive effect on delivering patient care. Ian was keen to work with

* voting member

and influence other staff to do the same and support them on their own journey. Having the support of Kath during his weight loss had been important as Ian felt it had kept him motivated to carry on and boosted his morale.

Individual board members thanked Ian for sharing his powerful story and Kath for her partnership working with him. The story brought home the importance of staff wellbeing as a whole and the Board were very keen to provide the necessary support around the health and wellbeing of staff.

Resolved: that, the staff member's story be noted.

BoD/4914 Minutes of the meeting held on, Thursday, 22 September 2022

Resolved: that, the minutes of the meeting held on, Thursday, 22 September 2022 be confirmed as an accurate record.

BoD/4915 Minutes of the Extra Ordinary meeting held on, Thursday, 6 October 2022

Resolved: that, the minutes of the extra ordinary public meeting held on, Thursday, 6 October 2022 be confirmed as an accurate record.

BoD/4916 Matters Arising and Action Log

There were no matters arising and an update was provided against the action log. It was agreed that the CN/DoPS&Q would combine the maternity actions from the action log into one piece of work. A mechanism to thank patients for their stories was still being considered. The revised Code of Governance guidance was published on 27 October 2022 and a meeting had been planned to review and discuss this in detail.

Resolved: that, the verbal update be noted.

BoD/4917 Report of the Joint Chair

A summary of the Joint Chair's report was provided with key points highlighted.

- The preliminary Carnall Farrar Report was expected on 25 November 2022.
- The North East Regional Chairs' meeting took place on 6 October 2022 and included items on the Ockenden Report and mental health support and wellbeing of staff.
- The flu vaccination and Covid-19 booster programme commenced in early October and it had been predicted that flu would peak during Christmas week, with patients already being admitted to hospital with flu and RSV. All staff were encouraged to be vaccinated against flu. The MD/DCE reported that along with a peak in flu, the number of Covid positive patients was anticipated to increase in January. Uptake for both vaccines was being encouraged and work continued to ensure it was as easy and accessible as possible for staff to get vaccinated. It was noted that the Hub had been extended until 16 December 2022 and that Flu Vaccinators were visiting Ward areas.
- The Annual Disability Event was taking place on 5 December 2022 as part of the Equality, Diversity and Inclusion (EDI) Agenda.
- Work was ongoing to look at how to assimilate learning from the East Kent Maternity Services Report.
- Following receipt of the report from NHS England an improvement plan had been put in place which incorporated actions from the CQC Report.
- The permanent recruitment exercise to fill the Non-Executive Director vacancies was progressing well and interviews were scheduled for 1 and 2 December 2022.

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

BoD/4918 Joint Partnership Board Update – Carnall Farrar Update

The Vice Chair provided a verbal update from the Joint Partnership Board meeting and highlighted the key issues. Engagement with colleagues from South Tees Hospitals NHS Foundation Trust continued and had been positive in building relationships, including engaging with newly appointed colleagues. He also reported that he had been undertaking site visits and meeting staff who shared their stories and proud achievements.

IS reported on a positive visit he had to the Endoscopy Facility at the University Hospital of Hartlepool.

Discussion took place regarding the power and importance of dialogue with colleagues and stakeholders and sharing the plans for collaboration.

Resolved: that, the verbal report be noted.

BoD/4919 Report of the Chief Executive

The Chief Executive presented the Report of the Chief Executive and highlighted key points.

- The Autumn Statement included an increase in health revenue and social care spending over the next two years, and an independent review of workforce needs for the next 5, 10 and 15 years would be undertaken. Clarity would be required regarding how the additional funding was to be allocated.
- Patricia Hewitt was leading a review into the role and powers of Integrated Care Boards looking at how local systems could be granted more autonomy and appropriate accountability.
- The Trust continued to promote covid booster and flu vaccinations for staff, including volunteers, colleagues in social care and the wider care sector and further promotion would continue through November and December to encourage increased uptake outlining the associated benefits for both staff and patients. Work to further improve the respiratory wards at UHNT was completed in October in order to provide a robust respiratory service in anticipation of covid, seasonal influenza and respiratory illness throughout the winter.
- The Trust continued to report as one of the best regionally regarding elective recovery and had an improved position for Referral to Treatment (RTT).
- Focussed work continued on system, process and governance to improve the backlog and compliance with the best time practice pathways for cancer. Work at an ICS level was underway to review opportunities for further improvement across specific cancer pathways. It was noted that 7% of referred patients join a cancer pathway. The Trust was actively engaged with this work and had recently appointed a new Cancer Lead, Dr Vandana Jeebun.
- Culture and leadership were key areas of focus and staff had been invited to take part in the Trust's 'Big Conversation – Clever Together', by providing comments on how they saw the organisation moving forward. Feedback to date included low morale of staff, which was not just work related. Information received from the exercise would be thematically analysed, used to develop a culture programme and inform the broader cultural work the People Directorate was undertaking. The Scope for Growth pilot had begun, which was a national initiative, an approach that used career conversations to support staff at all levels to grow and develop talent. Progress of these work streams would be monitored at the newly formed People Group, which would provide assurance to the People Committee.
- Research and Development activity remained vibrant, there had been 1841 participants recruited across 25 specialties during the year. The new Tees Valley Research Alliance (TVRA) contract between North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts, continued to grow and site visits were planned to promote research participation.
- The Obstetrics and Gynaecology Research Team won Trust Team of the Month in October for collaborative and proactive work with stakeholders and clinical teams. The Trust was the first and only UK site that had recruited into the pre-diagnosis cancer trial regarding the Oncotype diagnosis test.
- The Shining Stars Awards were held on 4 November 2022, which was the first opportunity to physically meet for more than three years, it had been a great event with inspiring examples of excellent work carried out across the Trust. It was hoped that more regular events could be held

to share learning and good practices.

- The Trust was embedding an Improvement and Transformation journey to support the strategic ambitions for the future within the context of collaboration in the system. This was being launched throughout the organisation and would also include actions from the CQC report, a review of capability and capacity, and an operating model to stabilise and sustain during the winter challenges and beyond, with a focus on improving quality in practice through review and support.
- The Integrated Care Systems (ICS) continued to work through system governance, strategic Integrated Care Partnership (ICP), strategy and place-based arrangements to be in place by early 2023.
- The NENC Provider Leadership Board had supported a proposal for Foundation Trusts to work together on addressing strategic clinical risks and work on the programme continued.
- The Tees Provider Collaborative was drawing to a conclusion with the final report expected at the end of November/early December. The Trust had worked with partners at South Tees Hospitals NHS Foundation Trust and across the system, with Governors also being involved.
- The Community Diagnostic Centre (CDC) proposal was moving forward and a Short Form Business Case had been developed to secure capital funding for the development and construction of the hub, which was due to be considered for approval by the national team by the end of November 2022.
- The Endoscopy Training Academy at the University Hospital of Hartlepool had been completed and an official opening event was organised for 16 December 2022. The Academy had received Joint Advisory Group (JAG) accreditation and three areas positively noted; quality of care and excellence of the training programme, leadership and patient experience. The MD/DCE advised it was the Team's fourth sequential pass for JAG accreditation, which was something to be proud of. The contribution by North Tees & Hartlepool Solutions (LLP) towards the establishment of the training academy facility was noted.
- The Faculty for Leadership and Improvement continued to expand incorporating the learning agenda and seeking accreditation to create the Faculty of Learning, Leadership and Improvement. This work would enable further development as an enabler to transformational change across the organisation.
- The 100 Leaders continued and was almost at the end of cohort 2. The leaders would be supporting the transformation work of the future, with a clear link to strategic intent.
- Trade unions representing NHS staff advised the Secretary of State for Health and Social Care that they were in dispute over the 2022/23 pay award. A number of the unions had signalled their intention to ballot in the industrial action expected to take place during the Christmas period. Planning was in progress to ensure resilience across the system.
- Since the North Tees and Hartlepool Education Alliance was formed five years ago, the team had helped train around 5,700 carers across the Tees Valley in a range of health subjects to improve the health of care home residents and reduce admissions.
- A new Managing Director had been appointed at Stockton Borough Council, Mike Greene who would take over the role following the retirement of Julie Danks.

CM sought to understand whether as a consequence of the Trust's positive elective recovery to date additional referrals had been received over and above the usual pathways, however, there was no substantive evidence to suggest that.

The Vice Chair noted that the 100 Leaders programme was greatly valued by the Board in order to recognise staff for their ideas and support them on a leadership journey. The CE explained that the programme provided an opportunity for staff at all levels and disciplines to be able to access the learning, develop networks, feel empowered and move forward with the confidence to take action and make change. The CPO advised that involvement does not stop following the programme, with some of those from Cohort one coming forward to work with and support the cultural programme.

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

BoD/4920 Board Assurance Framework 2022/23: Quarter 2 Report 2022/23

The ADoCA&S presented the Board Assurance Framework (BAF) Report for Quarter 2 and highlighted

the key points, including Month 7 data. A copy of the Quarter 2 Risk Radar was provided within the report.

There were currently three principal risks that included a high risk rating with one or more threats:
Strategic Risk 1A – Patient Safety
Strategic Risk 3C – Finance
Strategic Risk 3E – Transforming Our Services

Strategic Risk 1A
Risk 6434 was a high risk that related to the ability to learn from national safety alerts and was being managed through the LLP, in conjunction with the Trust, and monitored through the Patient Safety and Quality Standards Committee and the Master Services Agreement.

Risk 5779 related to the risk of potential delay in diagnosis from delay in reporting radiological imaging and was currently being managed through Radiology. The Joint Chair raised a query regarding how assurance would be sought and how this would be part of the broader process. The COO reported that this had been discussed at length at the Risk Committee held that week.

Risk 6379 related to Pathology Consultant Staffing challenges and was being managed through the Pathology Collaboration.

Strategic Risk 3C – Finance
Risk 6188 related to the delivery of savings and the challenges faced to deliver the CIP programme for 2021/22.

Strategic Risk 3E – Transforming Our Services
The risk related to innovation and integration as a result of external factors, which was under review via the Transformation and Planning, Performance and Compliance Committees.

All Trust Board Committees were reviewing risks to inform a risk appetite statement, which was currently in draft form. It was noted that the IDoG was leading the governance review and that there would be an internal audit review held by Quarter 4 of the BAF.

AB reported that a useful discussion had been held at the last Planning, Performance and Compliance Committee regarding ownership of monitoring risks and it was agreed that a piece of work be undertaken around ownership of individual risks. The CE highlighted that there was a Risk Executive Committee, which fed into the Audit Committee, and that all risks had been reviewed recently to ensure there were no duplications and this would continue to be carried out on a regular basis.

Resolved: that, the Board Assurance Framework Quarter 2 Report 2022/23 be noted.

BoD/4921 Integrated Compliance and Performance Report

The DoP&P presented the Integrated Compliance and Performance report and highlighted the key points.
Performance:

- The Trust had achieved five out of nine cancer standards.
- The Trust continued to achieve the 28 day faster diagnosis standard, making it only one of three organisations across the region to do so.
- The Trust reported at 83.45% against the Two Week Rule standard of 93%, with the regional position reported at 74.45%. This placed the Trust third against the region with only one Trust in the region achieving the standard.
- The Trust reported continued improvement in performance against the 31 Day Cancer standard.
- The Cancer 62-day target remained a pressure across the majority of pathways, which was reflective both regional and nationally.
- The Trust continued to review optimal pathways and compliance and further focussed work

had been planned.

- Fortnightly meetings were being held with the Cancer Alliance to review and improve the position.
- The Trust's reported at 77.85% for RTT in October
- The Trust maintained its trajectory in line with Phase 1 and Phase 2 elective recovery and it had been reported that no patients were waiting longer that 78 or 104 weeks and that 8 patients had waited over 52 weeks for an inpatient elective procedure.
- The regional position for Diagnostics reported at 81.28% with the Trust reporting at 72.58%.
- Increased activity and pressures continued with multiple requests for mutual aid, diverts and deflections being seen across the system. 61% of patients transferred to the Trust were converting to admissions and was impacting on length of stay, which was a 54% increase from the previous month.
- The two hour urgent Community response reported at 80.72% against a target of 70% which was positive.

Quality and Safety:

- The number of complaints received had seen a decrease in Stage 1 and a slight increase in Stage 2 and Stage 3. The numbers and themes continued to be closely monitored and the Trust continued with the drive for local and face to face resolutions of concerns and virtual meetings had been developed to support the process.
- Compliments consistently remained higher than the number of complaints received in to the Trust.
- Hand hygiene compliance across the Trust stood at 96%, against a target of 95%.

Workforce

- Short term sickness was reducing, and turnover continued to reduce.
- Mandatory training had dropped to below target and work was ongoing to identify areas of 'hot spots', how it could be delivered differently and if and how this could be linked to appraisals.

Finance:

- At Month 7, the Trust was reporting an in-month deficit of £0.092m and a year to date surplus of £4.609m.

The MD/DCE commended the fantastic community response and collaborative work with the North East Ambulance Service (NEAS) in assessing patients and reducing admissions. The CE reported there would be an increase in demand and pressure on non-elective resources going forward which created a risk. The Trust was working to deliver things differently across the organisation as part of the improvement and transformation programme. Despite a review of urgent and emergency care standards, it was possible that the four hour standard could be reinstated.

The CPO explained that a task and finish group had been established to review mandatory training and better understand the reason for certain cohorts of staff not completing their mandatory training and exploring how it could be delivered differently. Progress would be reported to the People Committee.

Resolved: (i) that, the performance against the key operational, quality and workforce standards be noted; and

(ii) that, the on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation be acknowledged.

BoD/4922 Capital Performance Report Quarter 2 2022/23

The DoF presented the Capital Performance Report Quarter 2 2022/3 and provided an update at Month 7.

The Trust's overall capital programme plan at month 6 was £21.983m with the Capital Departmental Expenditure Limit (CDEL) reporting at £21,584m and donated/grant funded assets £0.399m. The main split of the budget was being utilised for the continued commitment and investment in reducing the

estates backlog and the remaining budget was split across a number of work streams. There was also a prudent contingency of £1.5m for Service development.

As at Month 6 the Trust was ahead of plan by £0.5m and it was forecasted that the full capital allocation would be delivered by year end. It was reported that the system may exceed CDEL expenditure and organisations would be asked to assist. At Month 7, the Trust was slightly behind plan reporting a £4.9m spend against a year-to-date plan of £5.0m. Delivery of the plan may be impacted with programmes not being increased in line with inflation.

The Trust was reporting an overall estates backlog of £49.2m across all sites with £19.6m relating to Critical Infrastructure Replacement. An overall programme covering all backlog projects was developed with project managers assigned for each project. A detailed spend profile was developed, project by project, to allow for monthly reporting. It was noted that during 2022/23, less work than anticipated would be carried out, however, the Capital Medical Equipment Replacement Programme had been prioritised and was anticipated there would be additional spend in relation to Pathology. The DoF commended North Tees and Hartlepool Solutions for their successful management of the Capital Programme.

The ICITO provided a brief update regarding the Information and Communications Technology (ICT) elements and the broader Digital Programmes capital projects. Following a query by CM, the DoF confirmed that should any of the previously agreed schemes no longer progress there were other schemes that could be developed.

FS sought clarity regarding the impact of the potential ICS capital spend prompting discussion. CM reported that at the last Finance Committee it had been agreed to review plans again to identify any additional invest to save schemes. The Cost Improvement Programme (CIP), was also being reviewed again as there was a lack of recurrent schemes.

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

BoD/4923 Elective Recovery Update

The COO presented the Elective Recovery Report and highlighted the key issues.

The Trust's vision was to maintain an effective elective programme and elective recovery was progressing well with confidence to achieve the zero more than 52 week waits position and continued delivery of zero more than 104 week waits. It was noted there were currently eight patients waiting however, this was anticipated to reduce to only one patient. The Care Groups were monitoring, reviewing and refining all demand and capacity planning and were providing regular recovery updates to the Executive Management Team. An overview of the risks and mitigations was provided, with staff sickness absence and workforce pressures being a significant challenge, although a workforce planning approach had been developed to ensure a strong resilience position going forward.

The COO confirmed the Trust remained one of the top performing organisations both within the NENC system and nationally. The national platform was used to benchmark across providers and surgical specialties. In addition, the Trust remained committed to providing capacity and support to the wider system with continued service provision for the Tees Valley.

Discussion ensued regarding Elective Recovery Funding (ERF) and Payment by Results (PbR) and the funding position going forward. In respect of winter planning to manage and deliver the elective programme it was proposed to move a number of subspecialties to University Hospital Hartlepool (UHH), to increase day case activity at North Tees (UHNT), prioritising demand and using the additional activity flexibly across the week rather than increasing additional weekend lists.

The Chair requested that an update be brought to a future meeting with specific information on how the UHH was being utilised to increase capacity.

Resolved: (i) that, assurance was provided on the continued focus of achieving the elective

trajectory; and

(ii) that, the strong year to date performance including the provision of capacity for the wider Tees Valley be noted; and

(iii) that, the detailed planning for 2022/23 to deliver the national elective trajectories of 104% of baseline activity be noted; and

(iv) that, the ongoing regular monitoring of the elective recovery trajectories through the Executive Management Team be noted; and

(v) that, a report on the utilisation of the University Hospital of Hartlepool to increase capacity be brought to a future meeting.

BoD/4924 Data Protection and Cyber Assurance Report

The ICITO presented the Data Protection and Cyber Assurance Report and highlighted key points.

A number of Information Governance (IG) policies and procedures had been reviewed and updated since the last report. The Trust measured performance against three key indicators to determine compliance with Information Governance (IG) requirements; all three areas achieved compliance with Data Protection Mandatory Training achieving 97%, Subject Access Requests achieving 98% and Data Security Protection Toolkit (DSPT) achieving 'standards met' with 'significant assurance given' provided.

There were 14 open risks on the IG risk register and 22 on the ICT risk register. There was currently one high/red risk highlighted with a mitigating action plan in place. The Data Protection by Design continued to be embedded with a strong compliance and buy in from services with 'data protection by design' principles. The Trust made its Data Security Protection Security Toolkit (DSPT) submission on 23 June 2022; it self-assessed compliance with all 10 standards and all 110 mandatory items were evidenced, therefore, the Trust scored as all 'Standards Met' for the 2022 DSPT. The DSPT had also been independently reviewed by external audit and the overall assessment was 'substantial' across all the 10 standards.

The Trust actively encouraged staff to report any suspected data protection and cyber breaches and during the 2021/22 DSPT period reported four potential high risk incidents to the ICO, which had subsequently been closed with no further actions.

In light of recent global events and in line with National Cyber Security Centre advice new NHS Operational Instructions & Advice on improving cyber security resilience was issued, as part of this there were six immediate actions, and the Trust had the required mitigations in place. The Trust continued to provide cyber security training as part of its mandatory IG training (97% compliance) and plans were in place to further strengthen the cyber element of this training into 2023.

A joint South Tees Hospitals NHS Foundation Trust (STHFT) and Trust board session, focusing on Cyber security took place in March 2022 and work was ongoing with STHFT and Tees Esk and Wear Valleys NHS Foundation Trust (TEWV).

There were currently 12 cyber security risks on the corporate risk register, all rated as 'Medium Risk' and the top three risks had been escalated via the Board Assurance Framework. Action plans were in place:

- Risk 1 – File shares (covered by Risk 6192);
- Risk 2 – Medical Equipment / Devices (covered by Risk 6166);
- Risk 3 – Zero-day threat (virus) – (covered by Risks 6154 to 6161).

The CE commended the ICITO for the outstanding work and results to date, which should not be underestimated, and was reiterated by the Joint Chair. A great performance.

The MD/DCE sought to understand whether there had been a large increase in the number of subject access requests following the removal of a charge to make a request. The ICITO explained initially there had been an increase in requests for copies of medical notes, however, this had tapered off and additional resource to manage the requests had not been required.

Resolved: (i) that, the progress to date be noted; and
(ii) that, approach, governance and assurance methods outlined in the report be approved.

BoD/4925 NHS Core Standards for Emergency Preparedness Resilience & Response – Compliance and Organisational Capabilities

The COO presented the NHS Core Standards for Emergency Preparedness Resilience & Response (EPRR) – Compliance and Organisational Capabilities Report and highlighted the key issues as well as reminding colleagues of the requirements under the Civil Contingences Act 2004.

The NHS Core Standards for EPRR set out the minimum standards expected of NHS organisations in England to ensure they were able to meet their statutory obligations. Following a critical change review of core standards there were now 64 applicable standards for acute trusts for the current reporting period, which was an increase from the previous 46 applicable standards. Following an assessment of the Trust's existing EPRR arrangements it had been determined that the Trust was fully compliant against 91% of the applicable standards, with an overall submission of partial compliance.

Each year a focused deep dive review across specified areas was carried out and it was noted that the focus of the 2022 deep dive review was Evacuation and Shelter Plans. The current plans were finalised and agreed for use in November 2020 and were aligned to the Trust's fire evacuation and wider incident response processes. The deep dive review indicated that the Trust was fully compliant against 10 of the 13 associated standards. Further work continued to gain full compliance in all 13 standards.

The year ahead would see a shift in focus on the robustness of EPRR plans by NHS England and a training programme and a refresh of internal arrangements would be undertaken, with new business continuity plans continuing to be implemented.

Industrial action standards were provided by NHS England to provide assurance regarding service delivery and resilience. Three workshops were planned with the Care Groups and would include aspects of resilience, industrial action and adverse weather conditions. The national Covid Inquiry was currently in phase 3.

AB advised that the Trust's EPRR organisational plans were robust and provided assurance but sought to understand system wide preparedness. The COO commented it had been suggested to establish an EPRR Network to work with partners on joint plans, for example the Trust had updated its fuel plans which could be shared with partners. The Vice Chair sought to understand how the EPRR Plan was linked and managed with core activity. The COO explained that an impact on service delivery was assessed using the Business Continuity Plans learning from any issues to minimise future impact. Monitoring via the Committee structure was used when required.

During the pandemic training and exercise cycles were stood down, however, a full EPRR training and exercise calendar, aligned to the updated requirements set out within the national EPRR Framework had been developed.

Resolved: (i) that, the content of the report provide assurance that the Trust continues to meet its statutory requirements in respect of EPRR compliance; and
(ii) that, the essential role EPRR plays in the effective operation of the Trust be acknowledged, and the identified proposals for the ongoing development of associated plans, policies and processes be supported; and
(iii) that, the continued oversight of EPRR functions through the Trust Resilience Forum be supported.

BoD/4926 Winter Resilience Plan 2022/23

The COO presented the Winter Resilience Plan for 2022/23 and highlighted the key points, which included the embedding of learning from previous winters, the identifying and managing of enhanced

patient experience and appropriate deployment of staff resources.

The Winter Plan aligned to the revised operating model and wider system approach and reflected all aspects of services provided. Further information was expected with regards to surge management as it was anticipated that it would be a complex and particularly challenging winter with further covid waves, flu and respiratory diseases.

Work was ongoing around admission avoidance, out of hospital services and discharge processes and £500m funding had been provided to support work with social care nationally to plan resilience and ensure it was supported by a range of internal plans and policies. A full assurance document had been produced regarding the ten point recovery plan and a peer review undertaken with no challenges received. There was a focus on ambulance handover times and the COO agreed to share the ICB Resilience Plan with members.

The CE highlighted that more detail was required in order to demonstrate what good looked like for the Trust within the contextual position and that any elements with a risk of harm to the patient such as waiting times over 6 hours should be monitored by the Trust's Patient Safety and Quality Standards Committee.

Resolved: (i) that, the content of the report and the due diligence applied to the winter planning process and proposals for managing surges in activity over the winter months, and throughout the year, whilst maintaining quality, patient experience and operational and financial efficiency be noted; and

(ii) that the system approach to the production of the Winter Plan and the engagement with partners through formal structures that provides assurance of system engagement and collaboration with partners be noted; and

(iii) that, the Board be cognisant of the dynamic external environment and the potential impact of evolving national and regional directives that may impact on overall recovery and resilience; and

(iv) that, the NENC ICB Resilience Plan be shared with members.

BoD/4927 Care Quality Commission Update

The CN/DoPS&Q provided a verbal update in respect of the 'must do' actions following the Care Quality Commission inspection and the improvement plan that had been developed. From the must do actions there were 79 sub actions, which were split across the review areas of Childrens and Young People Services, Maternity and Trust wide. The current position was identified as 90% in progress with 10% completed for Children's and Young People, 70% in progress and 30% completed for Maternity and Trust wide 90% in progress and 10% completed.

Timeframes for the remaining actions were being reviewed and there were no issues to escalate regarding delivery. An event was scheduled to take place on 2 December 2022 focusing on risk and governance from Board to Ward, which would form part of the next update to the Board.

Resolved: (i) that, the content of the report be noted; and

(ii) that, an update from the event scheduled for 2 December regarding risk and governance from Board to Ward form part of the next update to Board.

BoD/4928 Learning from East Kent Maternity and Neonatal Services Report

The CN/DoPS&Q presented an overview of the report into Maternity and Neonatal Services at East Kent Hospitals University NHS Foundation Trust following its recent publication. An independent review was undertaken by Dr Kirkup with 202 cases assessed by a panel, and it was found that the outcome could have been different in 97 cases and from those cases, the outcome could have been different in 45 of the 65 resulting deaths, which was very significant.

It was noted that the Ockenden Review had assessed c1800 cases however, Dr Kirkup reported that for the East Kent review only the cases of families that had come forward were assessed and it was felt the evidence gathered from the cases was sufficient.

It was highlighted that trust, culture and compassion were crucially important in the delivery of care and the report referenced flawed team working with staff being pulled in different directions, the egos of staff and provided examples of patients' concerns not being listened to or addressed.

The CN/DoPS&Q shared an example from the report involving staff deflecting blame onto patients where they were normalising the wrong culture. The Trust Board involved did not challenge the outcomes effectively to gain an understanding as to whether the outcome was expected or not and that they were adversarial. Key staff members involved were removed rather than a full investigation taking place to identify the causes of the failures.

The CN/DoPS&Q provided an overview of the recommendations and action themes and a discussion ensued. The importance of the Board's duty to learn from such reports, listening to informal intelligence to gain a greater understanding of issues and how information was collated and brought back to Board was highlighted. It was a requirement of the Report for it to be considered by Trust Boards at a public board meeting.

The CN/DoPS&Q highlighted that the Trust had already been on a journey with its Maternity Services and made many improvements including implementing a Maternity and Neonatal Safety Champion and linking to the Maternity Safety Partnership with NHS England. AB referenced that the Trust had spent a great deal of time as part of its journey to get the right leadership in place for maternity services. The CE reiterated that the maternity journey had been difficult, however, it was recognised the importance of speaking to staff to understand the issues.

The Joint Chair expressed it was important for the Board to review the output from the East Kent Report, Ockenden and other national reviews thematically and the wider learning. It was agreed that a further update would take place at a Board Seminar in January 2023. A lot of work had already been undertaken and a regular update would continue to be provided at future Board meetings.

Resolved: (i) that, the content of the Learning from East Kent Maternity and Neonatal Services Report be noted; and
(ii) that, thematic learning from the East Kent Report, Ockenden and other national reports be presented at a Board Seminar in January 2023.

BoD/4929 Learning from Deaths Report Quarter 2: 2022/23

The MD/DCE presented the Learning from Deaths Report Quarter 2: 2022/23 and highlighted the key points.

The Trust HSMR value was 94.08, a slight increase from 94.08 in the previous report and was currently the 13th lowest nationally. The latest SHMI value was 98.26, which was an increase from 97.50 in the previous report and was currently the 23rd lowest nationally for SHMI. Both statistics remained "within expected" ranges.

Comparative mortality data was provided over a four year period and the quality of clinical documentation and clinical coding within the organisation was noted. The report highlighted the key areas of peak deaths during the comparison period, which were linked to influenza over the winter period of 2017/18 and Covid-19 from March 2020. All patient deaths were scrutinised by the Medical Examiners team and from April 2023 would include community/GP deaths. Two new Mortality Leads had recently been appointed. To date during 2022/23, there were four Serious Incidents cases which had all been investigated.

Resolved: (i) that, content of the report be noted; and
(ii) that, the information provided in relation to the identification of trends to assist in learning lessons from mortality reviews be noted; and

(iii) that, the on-going work programme to maintain the mortality rates within the expected range for the organisation be noted.

BoD/4930 Guardian of Safe Working Hours Report

The MD/DCE presented the Guardian of Safe Working Hours Report and highlighted the key issues.

The Trust had appointed a new Guardian of Safe Working who commenced in post in September 2022. Exception reporting continued, with a rise noted during the autumn, and the main cause of reporting being additional hours worked. The majority of the exception reports were from Medicine, Respiratory and Gastroenterology. The Medicine leadership team were identifying opportunities to address concerns raised and exploring the feasibility of implementing suggestions made. A further update would be provided in the next Guardian of Safe Working Hours Report. It was noted that other factors outside of the Trust's control were presenting a challenge, such as sickness absence, increasing numbers of less than full time doctors (in full time training slots), occupational health recommendations which restricted out of hours and weekend work, and delays in home office immigration processes.

The MD/DCE reported that the Trust was reported favourably in the GMC Survey, largely from trainee feedback received. It had scored low for workload however high in terms of supervision, both in and out of hours and staff feeling supported.

The Joint Chair highlighted that junior doctors were the future workforce and it was important to meet their needs and made reference to the initial recommendations from the Guardian of Safe Working to address concerns raised.

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

BoD/4931 Board of Directors and Council of Governors Meeting Dates 2023

The Board of Directors and Council of Governors meeting dates for 2023 were circulated for information.

Resolved: that, the meeting dates for 2023 be noted.

BoD/4932 Any Other Business

There was no any other business reported.

BoD/4933 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 26 January 2023 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 2.05pm.

Signed:  Date: 26 January 2023

#REF!

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
8 June 2022	BoD/4795	***Patient Story*** A mechanism to thank patients for their stories to be considered.	L. Robertson		Completed	Patients who agree to share their experience are met with by a member of the the Chief Nurses' team and invited to come in person to share their story. Each patient is written to formally on behalf of the Board to thank them for sharing their story.
8 June 2022	BoD/4804	***Nursing and Midwifery Workforce Report*** The disparity in turnover data compared to the data in the Integrated Performance Report to be reviewed as part of a workforce review and an update would be provided at a future meeting regarding the integration of the newly appointed international nurses from the Philippines and India into the Trust. A showcase event highlighting the improvements made in Maternity Services was still under consideration.	L. Robertson		Completed	It was agreed to combine all Maternity Actions into one item. The annual workforce report was being presented at the meeting on 26 January 2023.
8 June 2022	BoD/4806	***Maternity Update*** An update regarding Ockenden Report: Part 2 to be presented at a future Board of Directors meeting.	L. Robertson		Completed	The Maternity Board Report provided a comprehensive update of all progress and actions to date.
no new actions from the meeting on 28 July 2022.						
22 September 2022	BoD/4885	***Foundation Trust Governance Update*** Work would be progressed to ensure that the Trust was compliant following publication of the revised national guidance	H. Heslop		Completed	The new Code of Governance was published in October 2022 and had been reviewed by the relevant people.
22 September 2022	BoD/4886	***Review of the Trust Constitution*** The Board approve proposed changes to the Constitution in respect of Governor terms of office and the proposed changes be formally ratified by the Council of Governors	M Brown		Completed	A wider review of the Constitution was being undertaken to combine all necessary changes from the revised Code of Governance and a Governor Working Group was planned.
24 November 2022	BoD/4923	***Elective Recovery Update -*** A report on the utilisation of the University Hospital of Hartlepool to increase capacity be brought to a future meeting.	L Buckley	23 March 2023		To support delivery of the elective programme a number of subspecialties were moving to University Hospital Hartlepool (UHH), to increase day case activity at North Tees. A report would be presented at the Board meeting on 23 March 2023.
24 November 2022	BoD/4928	***Learning from East Kent Maternity Services Report -*** thematic learning from the East Kent Report, Ockenden and other national reports be presented to a Board Seminar in January 2023	L Robertson		Completed	Themes from the variety of national reports would be presented at the Board Seminar in April 2023

NHS
North Tees and Hartlepool
NHS Foundation Trust

Board of Directors

Title of report:	Joint Chair's Report									
Date:	26 January 2023									
Prepared by:	Sarah Hutt, Company Secretary									
Sponsor:	Professor Derek Bell, Joint Chair									
Purpose of the report	The purpose of the report is to update the Board of Directors on key local, regional and national issues.									
Action required:	Approve		Assurance		Discuss		Information	X		
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X		
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level.

Key issues for Information:

- Trust Governor and Membership Drive
- Hartlepool Visit
- Joint Collaborative Working
- System Wide Pressure
- Operational Planning Guidance 2023/24
- NHS Confederation Chairs Briefing

How this report impacts on current risks or highlights new risks:

There are no risk implications associated with this report.

Committees/groups where this item has been discussed	N/A
Recommendation	The Board of Directors are asked to note the content of this report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26 January 2023

Report of the Joint Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Trust Governor and Membership Drive

A meeting of the Membership Strategy Committee took place this week on 19 January, the first with me as Chair and we had a very useful discussion around ways to invigorate the Trust's membership and fill the vacancies from the 2022 Governor elections with a further set of elections planned. A face to face member event would be held in late Spring.

2.2 Hartlepool Visit

A visit to Hartlepool Hospital has been scheduled for Wednesday 25 January which will include a tour of the Urgent Care Centre, Procurement and Supplies and Endoscopy. I will also meet with staff from NTH Solutions LLP to see and hear about the work that they have been carrying out including the new lifts, fire alarms and tarmacking outside the entrance to the building.

2.3 Joint Collaborative Working

Since the last report, the Joint Partnership Board has met on 14 December and 18 January and the joint working is increasing in momentum. The joint Pathology laboratory collaboration is progressing as well as the plans for the Community Diagnostic Centre in Stockton.

2.4 System Wide Pressure

Pressures continue to be seen across the whole system around Covid, Flu, RSV and the impact from the days of industrial action by the ambulance service and RCN members that have recently taken place. Staff, patients and the wider public continue to be encouraged to receive their flu vaccinations to protect themselves and help to reduce hospital admissions.

2.5 Operational Planning Guidance 2023/24

The Operational Planning Guidance and Priorities for 2023/24 was published on 23 December with a focus on further reducing elective long waits and cancer backlogs; improving ambulance response times and A&E waiting times; improve access to primary care services; progress delivery of the Long Term Plan and continue to transform the NHS for the future

2.6 NHS Confederation Session Briefing for Chairs

NHS Confederation held a briefing session for Chairs on 12 December which focused on the Covid-19 inquiry. The inquiry was covering four areas: preparedness; the public health response; the response in the health and care sector and our economic response and had reached the third phase. This phase would consider the impact of Covid-19 on people's experience of healthcare; core decision-making and leadership within healthcare systems

during the pandemic; staffing levels and critical care capacity and healthcare provision and treatment for patients.

3. Recommendation

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

Professor Derek Bell
Joint Chair

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Partnership Board Update										
Date:	26 January 2023										
Prepared by:	Sarah Hutt, Company Secretary										
Executive Sponsor:	Steve Hall, Vice Chair										
Purpose of the report	The purpose of the report is to provide the Board of Directors with an update on discussions at the Joint Partnership Board.										
Action required:	Approve		Assurance		Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People		Transforming our Services	x	Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led		
Executive Summary and the key issues for consideration/ decision:											
The Trust has been working together with our colleagues at South Tees Hospitals NHS Foundation Trust, to continue to look beyond the pandemic as two NHS organisations with ambitions of delivering more together for the populations we serve. The Joint Partnership Board as the governance vehicle for these discussions.											
Financial Impact											
There are no financial risks associated with this paper. Any financial implications in relation to the group model will be continually assessed as the movement to this new structure progresses.											
How this report impacts on current risks included in the Board Assurance Framework/Risk Register or highlights new risks.											
Consideration will be given as to the impact on existing or new risks.											
Legal and Equality and Diversity implications											
There are no legal, equality and diversity implications associated with this paper and will be continually assessed as the movement to a new group model structure progresses.											
Committees/groups where this item has been discussed	N/A										
Recommendation	The Board of Directors is asked to note the report.										

Summary

Since the last board meeting on 24 November 2022, the partnership board met on 18 January. At this meeting we agreed to form a hospital group to support both trusts' shared goals for patients, service users and colleagues.

Under the hospital group model, each trust will remain as a statutory organisation and are not merging. The new group model will be developed over the next two years, with a strong focus on place-based working with communities and partners across Teesside, North Yorkshire and neighbouring areas.

By formalising our partnership working through the creation of a hospital group, our two trusts will be better able to retain and attract specialist doctors and nurses in hard-to-recruit areas through better joint workforce planning and collaboration on both trusts' shared goals.
Creating a hospital group will also strengthen our ability to collectively innovate together to continue delivering better outcomes for our patients, service users and communities in the future.

We are now working through the arrangements of formalising the Group and will be providing regular updates to the Board on progress and outcomes.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Report of the Chief Executive										
Date:	26 January 2023										
Prepared by:	Julie Gillon, Chief Executive Donna Fairhurst, Personal Assistant										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

The report provides an overview of the health and wider contextual related news and issues that feature at a National, Regional and Local level from the main statutory and regulatory organisations of NHS England, Care Quality Commission and the Department of Health and Social Care. In addition, information is provided on strategic delivery and positioning and operational issues not covered elsewhere on the agenda. Key issues for Information:

- Operational Challenges
- Culture and Leadership Development
- Research and Development
- 2023/24 Priorities and Operational Planning Guidance
- Integrated Care System and Integrated Care Board
- North East and North Cumbria Provider Collaborative
- Tees Provider Collaborative
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy
- Community Diagnostic Centre
- Endoscopy Training Academy
- Faculty for Leadership and Improvement
- Workforce Development
- Wider National Contribution

How this report impacts on current risks or highlights new risks:

Consideration will be given to the information contained within this report as to the potential impact on existing or new risks.

Committees/groups where this item has been discussed	Items contained in this report are discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.
Recommendation	The Board of Directors is asked to note the content of this report and the refocus and pursuance of strategic objectives and work to improve system working, operational resilience and a new operating model to support future positioning.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26 January 2023

Report of the Chief Executive

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues. In addition, information is provided on strategic delivery and positioning and operational issues not covered elsewhere on the agenda.

2. Strategic Objective: Putting our Population First

2.1 Operational Challenges

In line with national and regional trends, the Trust's Emergency and Urgent Care departments have continued to see increased activity and acuity. The Trust has extended the operational footprint of the Emergency Department to provide additional capacity and continues to implement the effective triage of type 1 and Type 3 activity to differentiate patients to the most appropriate treatment pathway including Same Day Emergency Care and Out of Hospital pathways.

Attendances of Type 1 and Type 3 activity have seen a significant increase of 45% (December 2022 compared to December 2021), (n= 12,750 vs 18,427) an increase of 5,677 attendances. Within Type 1 activity, the greatest increase being in the resuscitation and majors stream at n=649 demonstrating increased activity in December 2022.

2.1.1 Discharge

Timely discharge of patients continues to be challenging with the impact of covid and flu affecting admissions and care home staffing. The Trust retains a high performance level for timely discharge and continues to be a top performer nationally. The next phase of improvement work for discharge pathways includes dedicated Discharge Patient Process Flow Facilitators to support clinicians on daily ward rounds to improve discharge planning. The extended use of pharmacy support, discharge lounge, volunteer drivers and the transport hub remain key enablers to the organisation's strong performance. The Trust continues to host national and regional visits to understand the Trust's success and the NENC ICB has facilitated showcasing and improvement lessons across the system.

2.1.2 Ambulance Handovers

Ambulance handover delays continue to present a national and system challenge in the NENC. The number of ambulance diverts and deflections received to the Trust has significantly increased by n=119 (23 in Dec 2021 compared to 142 in Dec 2022).

the Trust remains committed to achieving under 30 minute handover delays as a priority and the improvement plan will be incorporated into a focused improvement journey during January to revisit the Operating Model with plans to develop a model fit for the future and one which will improve patient experience and support staff resilience.

2.1.3 COVID-19 and Seasonal Flu

Whilst flu and covid patient numbers continue to fall for the first time this winter, the impact of screening and patient cohorting places additional pressures on patient flow and capacity including staff absence. The approaches to Infection Prevention Control are reviewed on a daily process, both to keep staff and patients safe, but to also ensure the effective use of resources.

2.2 Elective Recovery

The Trust, having enacted elective recovery planning during the first wave of the Covid pandemic, remains one of the top performing, in the country, on waiting times' standards, 52, 78 and 104 weeks. This has included a system contribution and maintaining activity over the 104% national standard (compared to 2019/20 baseline position). In addition, the Trust has ensured a focus on health inequalities, offering a 'waiting well' programme to eligible patients, to ensure alternative pathway options.

The Trust continues to perform well in the Getting It Right First Time (GIRFT) High Volume, Low Complexity benchmarking metrics of efficiency and effectiveness.

2.3 Industrial Action

The North East Ambulance Services (NEAS) industrial action on the 21st December 2022 resulted in reduced patient activity due to uncertainty around the NEAS agreed derogations for escalation of care between hospital sites. The Trust was able to make alternative transport arrangements for the NEAS industrial action on 11th January 2023, which avoided cancellations and allowed the elective programme to proceed as planned.

Further planning meetings at system and locality level continue to address the anticipated increase in urgent treatment centre self-presenters. At the time of writing the derogations with Unison members for the industrial action on 23rd January were still being negotiated.

RCN industrial action is due to take place at County Durham and Darlington and South Tees Foundation Trust's on 18 and 19 January 2023. Local planning is in place with limited impact expected for wider system partners. Further coordinated days of industrial action are anticipated on 6th and 7th February 2023 with further RCN and NEAS industrial action taking place across the NENC.

3. Strategic Objective: Health and Wellbeing

3.1 Culture and Leadership Development

Working in Collaboration with *Clever Together* the Trust has hosted its first '*Our Trust, Our Future'* conversation. This took place from November to December 2022 and 11% of staff across the Trust took part focussing on four key areas: becoming an outstanding organisation; how we treat each other and work together, our workplace and our Leadership. The conversation resulted in over 200 ideas of how the Trust can move forward with the next steps being the thematic analysis from the Clever Together team prior to hosting a second conversation in February which will help clarify areas of focus.

The leadership strategy is complete and work continues to develop the three levels of leadership programmes; it all starts with me, Leading with CARE and Leading with Unity. These programmes will support the three-year plan with staff having an awareness of leadership and understanding the role they play in making the organisation a great place to work and receive care. A rounded development offer has been established to support management development, difficult conversations, resilience, and wellbeing. The work will be monitored at the People Group, which in turn will provide assurance and control at the People Committee

3.2 Research and Development

Patient recruitment during 2022 was positive with over 2488 participants recruited into the National Institute for Health and Care Research (NIHR) portfolio trials versus 737 during the same period in 2021. There are several high recruiting studies with our reproductive health and children's portfolios that have contributed to this with the Trust noting a healthy post-COVID recovery of trials in most areas.

The research team has developed a real time newsletter, which is available to all staff and will be regularly updated with recruitment information, reports on performance and notifications of accolades or training opportunities https://infogram.com/tvra-newsletter-1hmr6g7rdm3ro6n

4. Strategic Objective: Transforming our Services

4.1 2023/2024 Priorities and Operational Planning Guidance

The 2023/2024 priorities and operational planning guidance was published on 23 December 2022. The guidance reconfirms the ongoing need for NHS Trusts to recover their core services and improve productivity, as well as the requirement for progress in delivering the key NHS Long Term Plan ambitions and to continue to transform the NHS for the future.

4.2 Integrated Care System (ICS)

Chief Executives from across the North East and North Cumbria continue to meet with the ICB Executive Team to support the ongoing development of the system governance. There has been an increased focus operational resilience, system working, performance and financial planning.

4.3 North East and North Cumbria Provider Collaborative (PvCv)

The Provider Leadership Board (PLB) continues to deliver in elective care recovery, clinical services strategy, cost efficiency and health and wellbeing.

4.4 Tees Provider Collaborative

Options for future collaborative working across the Tees Provider system continue to evolve with a future road map and delivery plan to be developed in the near future.

4.5 Service and Estate Developments

4.5.1 Trust Estates Strategy

Following the approval of the Estates Strategy and the resulting case for investment into future service and estate provision, the Board of Directors discussed the Strategic Outline Case (SOC) on 12th January 2023.

The SOC included: the development of an options appraisal with stakeholders; a compelling case for change; vision for the future; value proposition and benefits realisation which is supported by robust demand & capacity work and financial and economic models. It is anticipated that formal approval of the SOC will be required at an extra-ordinary Board meeting in February and hence an Outline Business Case (OBC) will be developed to build upon the work to date with wider engagement from the Trusts collaborative partners. It is expected that it will take approximately 18 – 24 months to develop an OBC and seek subsequent approvals with a 4-year construction phase thereafter.

Given the Trusts deteriorating estate and 9 year remaining life on key buildings (currently highlighted as a red risk in the Board Assurance Framework), it is imperative that the OBC is progressed at pace. Furthermore, this will help to mitigate the impact of inflation / increasing capital costs, which are currently estimated at circa £4m per quarter.

4.5.2 Community Diagnostic Centre – Proposed Plans Teesside

A strategic plan for the health system in the Tees Valley to develop diagnostic capacity, including a proposed new build Community Diagnostic Centre (CDC) has been agreed by the Tees system.. Following final approval of the business case in line with a national process, the planned CDC will be developed on the Castlegate Campus site in Stockton on Tees and will be part of the Stockton on Tees Borough Council Waterfront Masterplan development. The site recommendation was considered and approved by the former Tees Valley CCG following an independent site appraisal.

To achieve the revised timescales a fast track procurement process (mini-competition) has been adopted with early engagement with the contractors on the framework.

Developing the future workforce is a key priority with significant workforce planning in conjunction with strategic workforce leads, clinical leads, Health Education England and Universities. A key element of the plan is the development of radiology and physiological apprenticeships, which will add to existing routes of entry into the profession. This will provide opportunities for people from the local areas and beyond to consider a career in diagnostics.

This is a major step forward for the Tees Valley, focusing on early diagnosis and treatment, improved core outcomes under economic regeneration in the strive to improve health inequalities.

4.5.3 Endoscopy Training Academy

The Academy was officially opened on 16 December 2022 in conjunction with partners from Health Education England and the North East and North Cumbria Cancer Alliance. As part of the opening at the University Hospital of Hartlepool, four new training spaces have been opened, boasting the latest virtual and simulation technology to aid trainees in their academic journey. The facility enhances the excellent training offer provided by North Tees that was recognised in the recent accreditation assessment by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

5. Strategic Objective: Valuing our People

5.1 Faculty for Leadership and Improvement

The Faculty continues to be expanded incorporating the learning agenda and seeking accreditation to create the Faculty of Learning, Leadership and Improvement. This work will enable further development as an enabler to transformational change across the organisation.

Work has begun to provide support for each of the three Quality Improvement levels details within the Quality Improvement strategy. Supported by Teesside University there will be opportunities for staff to attend PDSA (Plan, Do, Study, Act) sessions and learn about the model for improvement.

Preparations have begun for Cohort 3 of the 100 Leaders, which has been renamed NTH100 ensuring that the programme represents both leadership and improvement within its approach. The programme has been reviewed and developed with feedback from previous cohorts to ensure we build upon the work achieved. The approach for this cohort will be solutions based using QSIR (Quality Service Improvement Redesign) approaches to support development and progress.

5.2 Workforce development

The upcoming Health and Care Academy continues to progress with recent engagement events including a design sprint to scope out branding and a stakeholder event, which provided an update on progress and timelines and continued conversations about potential future courses and opportunities.

The North Tees and Hartlepool Education Alliance (NTHEA) continues to support the development of staff working within care homes across Stockton-On-Tees and Hartlepool. Following a successful roll out of '*Soft Signs'* work has been undertaken to develop this concept in Community services within the Trust.

5.3 Wider National Contribution

5.3.1 Visit by Dr Joanne Lee, Head of Data Analysis, Secretary of State, Private Office – 16 December 2022

The Trust hosted a successful visit by Dr Joanne Lee from the SoS Private Office on 16 December to understand how the OPTICA (discharge tool) works and integrates with the electronic patient

record. Further work continues on appropriate metrics to support progressive measurement of successful discharge.

5.3.2 Downing Street discussion with Health Leaders

Dr Catherine Monaghan, Clinical Lead for Healthy Lives joined a Cabinet Meeting chaired by the Prime Minister and Secretary of State for Health on 7 January 2023 to discuss crucial challenges" on the NHS and allow key leaders to share best practice and ideas to improve the quality of care provided to patients throughout the country.

6. Recommendation

The Board of Directors is asked to note the content of this report and the refocus and pursuance of strategic objectives and work to improve system working, operational resilience and a new operating model to support future positioning.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Declaration of Interests and Fit and Proper Persons Declaration										
Date:	26 January 2023										
Prepared by:	Sarah Hutt, Company Secretary										
Executive Sponsor:	Mel Brown, Interim Director of Governance										
Purpose of the report	The report presents the annual declaration of interests and fit and proper persons declaration for members of the Board of Directors										
Action required:	Approve		Assurance	x	Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing our People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe		Caring		Effective	x	Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

In accordance with Annex 7, of the Trust's Constitution, the Board of Directors of NHS Foundation Trusts are required to declare interests that may conflict with their position as a Director or Non-Executive Director of the Trust. Interests are to be declared at an open meeting of the Board, minuted as such, and then recorded in a register which is referred to in the Trust's Annual Report and is available for inspection by the public.

The 'fit and proper persons' standard is part of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) which places a duty on NHS Providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent, or a Non-Executive Director under given circumstances. For existing appointments, assessment of continued fitness for the role must be undertaken on an annual basis, this is to be facilitated by completion of a fit and proper person declaration and recorded in a register.

A copy of the register is appended to this report for information.

How this report impacts on current risks or highlights new risks:

No risks were identified in relation to this report.

Committees/groups where this item has been discussed	N/A
Recommendation	The Board of Directors is asked to: • note the contents of the appended updated register; and • note that the register will be referred to in the Annual Report 2022/23 and will be available for public inspection.

Declaration of Interest by Chairman, Non-executive and Executive Directors of North Tees and Hartlepool NHS Foundation Trust

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Prof Derek Bell Joint Chairman	NHS Scotland Non-Remunerated Clinical Advisor	None	None	None	None	√
Mr Stephen Hall Vice Chair / Non-Executive Director	Director, Trading Company for North Tees and Hartlepool NHS Foundation Trust (Optimus Health Ltd)	None	Shareholder in Regional Training Partners Limited	None	None	√
Ms Ann Baxter Non-Executive Director	None	None	None	Independent Scrutiny – Darlington Safeguarding Partnership Governor – Thirsk School & Sixth Form College	None	√
Mrs Fay Scullion Non-Executive Director	None	None	None	Governor – Jarrow School Associate Tutor – Learning Curve Group	None	√
Mr Chris Macklin Non-Executive Director	Chair of Consortium Board – Audit One	None	None	None	None	√
Mr James Bromiley Non-Executive Director (Designate)	Director/Trustee, Horizons Specialist Academy Trust	None	None	Governor – East Durham College Governor – Northumbria University Board Member/ Safeguarding Officer – Yarm Cricket Club	None	√

Declaration of Interest by Chairman, Non-executive and Executive Directors of North Tees and Hartlepool NHS Foundation Trust

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Mrs Elizabeth Barnes Non-Executive Director (Designate)	Non-Executive Director – Aspire Housing Trustee – University of Sunderland Trustee – Middlesex University Trustee – Peter Coates Foundation	None	None	Member – Uttoxeter Learning Trust Member – Queen Elizabeth Grammar School Multi-Academy Trust	None	√
Mrs Alison Fellows Non-Executive Director (Designate)	Commercial Director – Teesside International Airport Limited (until 31st March 2023) Non-Executive Director – Gentoo Group (Housing Association)	None	None	Trustee - Tyneside Cinema	Husband is a Partner at Ward Hadaway Solicitors	√
Mrs Julie Gillon Chief Executive	None	None	None	None	None	√
Dr Deepak Dwarakanath Executive Director / Deputy Chief Executive	None	None	None	None	None	√
Mr Neil Atkinson Executive Director	Trust Representative on NTH Solutions Management Board, a Trading Company for North Tees and Hartlepool NHS Foundation Trust	None	None	None	None	√
Mr Levi Buckley Executive Director	None	None	None	None	None	√
Gillian Colquhoun Interim Executive Director	Director NTH on the HealthCall Board	None	None	None	None	√

Declaration of Interest by Chairman, Non-executive and Executive Directors of North Tees and Hartlepool NHS Foundation Trust

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Mrs Linda Hunter Executive Director	None	None	None	None	None	√
Mrs Lindsey Robertson Executive Director	None	None	None	None	None	√
Mrs Susy Cook Executive Director	None	None	None	Governor Laurence Jackson School	None	√
Mrs Barbara Bright Executive Director	Trust Representative on NTH Solutions Management Board, a Trading Company for North Tees and Hartlepool NHS Foundation Trust	None	None	None	Company Secretary for Optimus Health Ltd (Trading Company of North Tees and Hartlepool NHS FT operating Panacea (Outpatient Pharmacy)	√

North Tees and Hartlepool
NHS Foundation Trust

Meeting of the Board of Directors

Title:	Board Assurance Framework Quarter 3 2022/23										
Date:	26 January 2023										
Prepared by:	Hilton Heslop, Associate Director of Corporate Affairs & Strategy										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	The aim of this paper is to provide assurance to the Board of Directors on the progress made to mitigate and manage the strategic risks within the Board Assurance Framework (BAF) for Quarter 3 2022/23 and the actions for addressing the identified gaps in controls and assurance.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

The BAF has **12 risk domains** associated with delivery of the four strategic objectives – Putting our population first, Valuing People, Transforming our services and Health and Wellbeing. The principal risks consist of **35 threats*.***

There are currently 3 principal risks that include a **high** risk rating within one or more threats:

Strategic Risk 1A has a high risk aligned that relates to the ***ability to learn from national safety alerts linked to procurement (6434)*** and the inability to easily identify and quickly identify real time stock position in response to patient safety alerts / product recalls. This is being managed by the LLP in conjunction with the Trust and is monitored through the Patient Safety and Quality Standards Committee and the Master Services Agreement.

Strategic Risk 1A – has one associated risk relating to ***Pathology Consultant Staffing (6379)*** with challenges experienced due to vacancies, inability to recruit and increasing demand. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future.

Strategic Risk 3C has two associated high risks identified through the work of the Finance Committee in December 2021. ***1) Delivery of Savings (6188)*** and the challenges to deliver the CIP programme for 2021/22, the current rate of progress to identify CIP for 2022/23, and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions, and ***2) Ageing Estate (6581)*** reflecting the rapid decline of the construct of 3 main building at North Tees following the 6 Facet Survey, the ongoing delay in announcement of the Government's New Hospital programme and the Trust's bid for capital funding, and the potential escalation of risk of serious injury to staff, patients and members of the public if the buildings are left unmaintained beyond their natural lifespan.

Strategic Risk 3E – relates to the progress of the Joint Partnership Board, specifically the formation of a Joint Committee with a view to accelerate collaborative plans with South Tees Hospital following an independent strategic review of both organisations. Due to an absence of risk and due diligence within this process, and until this aspect of governance is developed by the Joint Partnership Board, this will remain a high risk on the Board Assurance Framework.

How this report impacts on current risks or highlights new risks:

In Quarter 3 (interim) no individual strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated threats linked to operational risks.

The Corporate Risk Register has five risks reporting a current risk rating of >15 (high) as follows:

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	**3C**	**16**	**16**	**9**
6581	Ageing Estate	**3C**	**25**	**16**	**9**
6379	Insufficient Microbiology and Histology Consultant staff with substantive availability to support / advise clinical services.	**1A**	**20**	**16**	**4**
6407	Collaboration – Joint Partnership Board	**3E**	**20**	**15**	**12**
6434	Procurement – Inability to easily identify real time stock position	**1A**	**15**	**15**	**5**

Committees/groups where this item has been discussed	Audit Committee Patient Safety and Quality Standards Committee Planning, Performance and Compliance Committee Finance Committee People Committee Transformation Committee Digital Strategy Committee Executive Management Team
Recommendation	The Board of Directors is asked to note the risks contained in the BAF and specifically those based on a current risk rating of >15 (High).

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26 January 2023

Board Assurance Framework, Quarter 3 Report 2023

Report of the Associate Director of Corporate Affairs and Strategy

1 Purpose

1.1 The purpose of the report is to provide assurance to the Board of Directors on the principal risks to achieving the Trust's strategic objectives.

2 Background

2.1 The role of the Board Assurance Framework (BAF) is to provide evidence and structure to support effective management of strategic risk within the organisation. The BAF also provides evidence to support the Annual Governance Statement.

2.2 The BAF provides assurance to the Board of the key risks and identifies which of the objectives are at risk of not being delivered, whilst also providing assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources or otherwise take mitigating action and address the issues identified in order to deliver the Trust's strategic objectives.

2.3 The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. In order to do this the Board tasks its Board Sub Committees with undertaking scrutiny and assurance of the following:

- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to close gaps and mitigate risk

2.4 Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board.

2.5 The Board of Directors has reviewed the risk appetite and the appropriateness of its strategic risks on a regular basis. Board Committees have been asked to review individual risks and threats and this will be fedback through committees to the Board of Directors in Quarter 4. In 2018/19, Good Governance Institute (GGI) conducted a review of governance within the Trust and received substantial assurance that the Trust was operating strong and robust governance procedures. In order to demonstrate evidential assurance in 2023, the Trust has commissioned GGI to undertake an independent governance review, and this review commenced on 12 December.

2.6 The review is based around the Trust's responsibility for maintaining a sound system of internal control and governance that supports the delivery of strategy within the context of system working and the achievement of the Trust's strategic aims and objectives, and that those systems remain fit for purpose. The review will report back to Executive Team with interim findings in February and is scheduled to provide a full report to Board of Directors in March.

2.7 An internal audit of the Board Assurance Framework is planned before end of 2023.

3 Details

3.1 The BAF has **12 risk domains** associated with delivery of the four strategic objectives Putting our Population first, Valuing People, Transforming our Services and Health and Wellbeing. The principal risks consist of **35 threats.**

3.2 There are currently three principal risks (1A, 3C and 3E) that are assessed with a **high** risk rating within one or more of the threats contained within each risk. A summary of the individual high rated risks is noted below.

3.3 The Board of Directors annual cycle of business ensures that all risks are reviewed within the sub-Committee structure to ensure there is consistency, alignment and relevance to the principal risks for the appropriate Committees.

3.4 All committees have reviewed and approved their respective BAF reports/templates as part of the assurance process.

4 High Rated Risks/threats – Quarter 3: 2022/23

4.1 Strategic Risk Patient Safety 1A

4.2 **Risk 6434** is an aligned threat that relates to the ability to learn from national safety alerts. This is specifically linked to procurement and the inability to easily identify and quickly identify real time stock position in response to patient safety alerts / product recalls. This is being managed by the LLP in conjunction with the Trust and is monitored through the Patient Safety and Quality Standards Committee and governance arrangements with the Master Services Agreement.

4.3 **Risk 6379** relates to Pathology Consultant Staffing with challenges being experienced due to vacancies, inability to recruit and increasing demand, and this is in a national context as well as locally. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future.

4.4 Risk 5779 was previously rated as High in Quarter 2 and relates to the risk of potential delay in diagnosis from delay in reporting radiological imaging. However, the risk has been reviewed at Patients Safety and Quality Standards (Ps&Qs) committee and has been downgraded to Moderate as a result of the Trust ensuring that additional resource is in place to facilitate plain film reporting. The risk will continue to be monitored closely.

4.5 Strategic risk Finance 3C

4.6 **Risk 6188** relates to the delivery of savings within the Trust's Cost Improvement Programme (CIP) and specifically the challenges to deliver the CIP programme for 2022/23, the current rate of progress to identify CIP for 2022/23, and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions and the external system requirement to deliver additional savings in year following the submission of a revised financial plan.

4.7 A CIP plan for 2022/23 has been developed and is regularly reported to the Finance Committee. The PMIO team provides support to facilitate delivery of identified schemes and reasonable assurance on CIP report from AuditOne in 2021/22 with a planned follow-up audit in 2022/23.

4.8 **Risk 6581** relates to the ongoing concern linked to the Trust's ageing estate at University Hospital of North Tees following an independent 6 Facet Survey of Tower Block, South Wing and North Wing whereby the buildings were given a ten year lifespan. Board members should note that the 6 Facet Survey was undertaken over 12 months ago therefore the effective lifespan of the buildings is rapidly reducing year on year. Currently, the buildings are deemed to be beyond their effective use/purpose by 2031.

4.9 This presents a significant risk to the Trust from 1) a health and safety perspective i.e. condition of concrete within the fabric of the buildings which could endanger staff, patients and the general public if left unmaintained, and 2) the ability or inability to secure capital funding to regenerate/rebuild purposeful buildings within the North Tees site and the subsequent cost of the strategic business case process required to proceed further.

4.10 The cost of delivering backlog maintenance to the three buildings on an annual basis is prohibitive, and an application to the Government's New Hospital programme for capital funding to develop new infrastructure that is fit for purpose was submitted just under 12 months ago. The Trust is still awaiting the outcome of the application process.

4.10 At a Board Seminar on 12 January, the Board received a presentation on the Trust's Estate Strategy. However, due to time constraints it was acknowledged by the Board that there should be another opportunity to discuss, debate and make decisions on the required recommendations and this will take place at an extraordinary Board Seminar to be held early in February.

4.8 Strategic Risk 3E

4.9 **Risk 6407** relates to the current collaboration plans with South Tees Hospitals following the NHSE/ICB commissioning of an independent strategic review in which recommendations were made following a consultation and review process with both organisations. The outcome of the review recommended stronger collaborative processes and protocols to be put in place with a focus on governance and leadership.

4.10 A process is underway to deliver the collaborative plans that have been agreed by both Trusts. However, there remains an absence of risk and due diligence within this process and until this aspect of governance is developed by the Joint Partnership Board this will remain a risk on the Board Assurance Framework. In order to mitigate the risk, the Trust will continue to raise within the Joint Partnership Board via the Joint Director of Strategy and Partnerships..

4 Significant Risks

4.1 In Quarter 3 no overall strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated specific threats as noted above and included in the table below. In respect to linked risks from the Corporate Risk Register, the following have been identified as a significant risk based on a current risk rating of >15 (High):

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	**3C**	**16**	**16**	**9**
6581	Ageing Estate	**3C**	**25**	**16**	**9**
6379	Insufficient Microbiology and Histology Consultant staff with substantive availability to support / advise clinical services.	**1A**	**20**	**16**	**4**

6407	Collaboration – Joint Partnership Board	**3E**	**20**	**15**	**12**
6434	Procurement – Inability to easily identify real time stock position	**1A**	**15**	**15**	**5**

5 Key Findings

5.1 However, a summary of the proposed changes/updates to each risk are set out in the table below.

Risk to Objective	**Risk Rating (Sept 2021)**	**Risk Rating (Dec 2021)**	**Risk Rating (Mar 2022)**	**Risk Rating (June 2022)**	**Risk Appetite**
Patient Safety - 1A - There is a risk that the organisation will fail to implement safe and effective clinical practice					
The following High/Red rated risks were identified and continue to be monitored throughout Quarter 4 linked to Patient safety and Quality with risk reduction plans to mitigate risks: • Risk 6434 (High) - Procurement: Inability to easily identify real time stock position; • Risk 6379 (High) – Insufficient consultant staff to support clinical services. The following risk was downgraded from High to Moderate during this Quarter: • Risk 5779 (High) - Delay in diagnosis from delays in reporting radiological imaging (CG2). Mitigations in place through urgent radiological examinations are given priority by administration staff allocating to the reporters including large team of reporting Radiographers to facilitate plain film reporting; The following actions are contained in the risk reduction plan for this strategic risk: • Assurance frameworks for falls, tissue damage and the deteriorating patient were finalised in Q2 and completed in January 2023; • Strengthening of the midwifery leadership within Maternity services has been a priority resulting in the appointment of AD of Maternity Services in January 2023 to commence in March. Interim leadership will be provided by a Midwifery Consultant Advisor; • Cycle one of the quality audit is underway to cover Duty of Candour cases from July 2022. Cycle two will commence in January (Q3) for cases from September 2022 once initial changes have been made. These risks are currently monitored and managed through quarterly updates to Ps & Qs. All current and existing moderate related risks feature as part of ongoing quality data collection results with updates to PS&QS, updates for ICB via CQRG and Excellence is our Standard monitoring and identification of quality improvement activity.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Minimal**

Patient Experience - 1B - There is a risk that patients and service users do not receive high quality care which impacts on patient and carer experience					
There is one new risk identified in this quarter: • 6570 (Moderate) – Patients not able to access counselling in a timely manner The following existing Moderate risks have appropriate controls in place with stringent monitoring and mitigation processes through Patient feedback monitoring, reviewed during Patient Safety & Quality Standards Committee, Patient and Carer Experience Committee, Senior Clinical Professional Huddle, Safety Panel and Executive Reports. The risks include: • 6222 - Significant harm to patients from healthcare acquired skin injuries; • 6448 - Risk of injury to staff or patients due to violence and aggression • 6512 – Structure and process for management of written clinical communication leaving the Trust does not meet the agreed standard. A comprehensive and detailed risk reduction plan includes improved communication flow between patients, carers and relatives on inpatient areas with 2 Pilots to provide dedicated time with staff to enhance communication plans developed and to be discussed at the Patient and Carer Experience Committee for approval to commence Quarter 3 2023 (Care Groups 2 and 3). The service is working with the Digital Team to develop a digital patient satisfaction and feedback survey and this has resulted in a draft online patient survey being completed in December 2022. Digital Team awaiting training on Yellowfin platform. Also included in the risk reduction plan is the development of a Patients, Public and People with Lived Experience Engagement Strategy with an initial engagement session taking place at Billingham Forum at the end of Q3. Feedback will form the basis of an Engagement Strategy.	**9 3x3**	**9 3x3**	**9 3x3**	**9 3x3**	**Minimal towards Open**

Performance & Compliance - 1C - There is a risk that the performance management framework does not identify and manage risk to compliance in a timely way					
No new risks identified. • Risk 6325 MOD 12 (4x3) Recover compliance and performance following delays caused because of Covid • Risk 6393 MOD 12 (4x3) Non-compliance with cancer standards • Risk 6394 MOD 12 (4x3) Non-compliance with diagnostic standard • Risk 6392 MOD 12 (4x3) Non-compliance with RTT standard Implementation of recovery groups and actions plans, along with escalation policies and plans in place with Assurance Framework and Annual Planning ensuring mitigation of all risks through the provision of plans and forecast outturn for the financial year which is signed off by Board. Quality Accounts, Escalation plans have been developed for all Directorates covering Workforce, Bed Capacity, PPE Supplies, Oxygen supplies etc. Performance report presented regularly at PPC committee, Audit Committee, ETM and Board of Directors supported by Planning & Recovery Group with a focus on trajectory of recovery at care group level. Escalation plans are in place and business continuity is managed through the Resilience Command & Control Centre to manage day to day monitoring and management, including defined escalation triggers. Performance improvement is supplemented by a real time dashboard for ED patients displaying current waiting times which is driven by Business Intelligence tools that demonstrate trends for analysis/ actions and patient flow data, backed up by capacity and demand data to understand resource requirement for any surges in activity. A risk reduction plan is in place for all Access Standards incorporating planning guidance, waiting list backlog, estimated capacity requirements to meet the backlog and the future demand, timeline for recovery, Outpatient Transformation Group with key actions such as: reducing review appointments, telephone/virtual appointments, PIFU, to build into future service delivery plans, and a regional focus on Elective Recovery.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Minimal**

Emergency Preparedness Resilience and Response (EPRR) - 1D - There is a risk that an internal and/or external incident could disrupt or present a catastrophic breakdown of services provided by the Trust.					
There are no new risks reported in this quarter: • Risk 6062 - Emergency Planning and Business Continuity (tolerated risk) This is a low rated risk with oversight and assurance of significant EPRR related risks through the Trust Resilience Forum including ongoing monitoring and reporting of relevant local and national risks and/or changes in legislation, including through use of NEY EPRR Regional Risk Register and links with LRF. Gaps in Business Continuity Planning were addressed through the rollout of new business continuity management arrangements in Q2. Phase 2 implementation and validation of service area BCM arrangements to take place between November 2022 and April 2023. Incident Coordination and Management Plans and Escalation Plan agreed for use by TRF in December 2022 to be issued and rolled out for use as part of the 2023 EPRR forward work programme. Fuel Disruption Plan written as a replacement to the Fuel Crisis Policy with agreement sought at TRF in December 2022 for ratification (agreed). Combined Severe Weather Plan developed for use during all periods of severe weather - to be issued and rolled out for use as part of the 2023 EPRR forward work programme. Risk reduction plan contains mitigating actions with current progress and planned areas of work including the development of a severe weather plan as agreed at Trust Resilience Forum (TRF). Mitigations: • Monitoring of corporate business continuity plan to detail tactical and strategic approach and response actions associated with a significant business disruption; • Development of critical and major incident declaration protocol as a replacement to current Major Incident Plan; • Development of stand-alone mass casualty plan based on processes detailed within current major incident plan; • Review and update of CBRN/Hazmat Plan. • Undertake cross organisational review of evacuation and shelter processes with South Tees Hospital and re-develop current evacuation and shelter plan in line with recommendations highlighted during EPRR Core Standards review.	**12 4x3**	**12 4x3**	**9 3x3**	**9 3x3**	**Avoid/Minimal**

Valuing People & Workforce - 2A - There is a risk that the People Strategy principles are not fully embraced or embedded across the Trust resulting in not attracting, developing or retaining the workforce we need in order to take forward the Corporate Strategy and Clinical Services Strategy					
No new risks identified. **Attract** • Risk 5573 - Inability to recruit or retain quality staff – managed through a change in approach to workforce planning resulting in gaps in readiness of leaders in relation to thinking differently with regards to recruiting and flexibility of employment. Longer term plans regarding AfC terms and conditions from a national perspective are under consideration; • Education panels being held across all Care Groups. Involved in Trust website refresh as part of 'attraction' strategy. Talent management/appraisal section in Management Development day. User guide developed for appraisal includes additional support for assessing talent. Scope for Growth roll out commenced.	**16 4x4**	**12 4x3**	**12 4x3**	**12 4x3**	**Open**
Develop • Phased 1 of review complete. Strategy under development as part of the EDI action plan. Full plan discussed at ETM for immediate roll out. Action plan on track for delivery • Robust workforce planning processes in place to ensure long term workforce needs are identified and addressed. Workforce Strategy in development. • Risk 5574 – Failure to establish effective leadership and talent management interventions with evaluation of training programmes underway.	**9 3x3**	**9 3x3**	**9 3x3**	**9 3x3**	**Open**
Retain • Lack of achievement in sickness absence targets (5805) managed through regular and meaningful engagement with staff in relation to workplace risk assessments and mitigation put in place to reduce associated risks. Focus on a prevention approach to absence management in place, specifically in relation to emotional and mental health and wellbeing. • To enable the Trust to attract, grow and train its future workforce and fill any current or expected gaps in professions/services, the concept of Health Academy approved by Towns Deal Board - business plan in development. Internal and external steering groups in place to monitor progress.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Open**

Valuing People & Workforce - 2B – There is a risk that people processes, procedures and policies are not sufficiently robust or consistently applied resulting in ineffective people management practices and employee relations cases/employment tribunals that will have an adverse impact on the Trust from a performance, finance, reputation, quality and people perspective					
No new risks identified. • Risk 6426 - Adverse impact, internally and externally from outcomes of employee relations/ET cases. Plan in place in response to audit recommendations with positive progress made to date. Risk management and mitigation through Executive reports. **High risk down rated** following implementation of appropriate plans, policies and e-learning and managed through People Committee. A full risk reduction plan has been implemented with monitoring of actions by Interim Chief People Officer and Chair of People committee. • All employment policies and procedures relating to Employee Relations to be updated, reviewed and agreed by Workforce committee; • Planned programme of lead investigators rolled-out and reviewed with monitoring to ensure consistency of approach, improve understanding and knowledge of process/policy; • Communication packs for managers implemented via e-learning on ESR to minimise escalation towards grievance and whistle-blowing; • Implementation of schedule of internal audits on ER processes.	**N/A**	**16 4x4**	**12 4x3**	**12 4x3**	**Cautious**

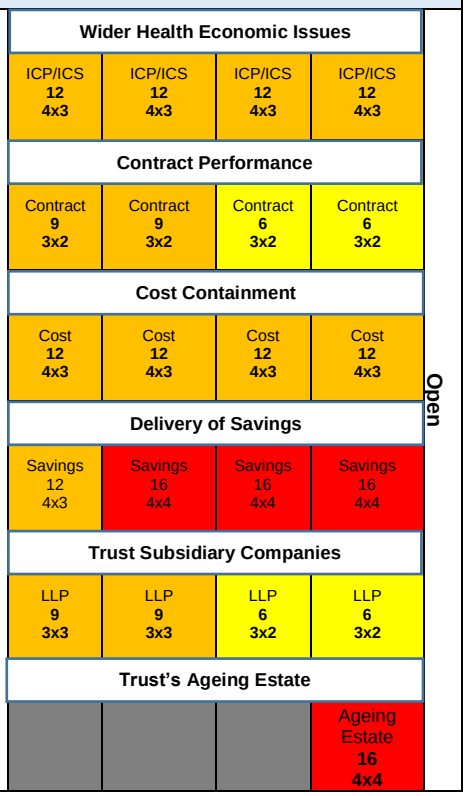
Transforming our Services- 3A – There is a risk of failure to develop a system wide approach with adverse impact upon flow and capacity within the system					
There are two new Moderate rated risks identified in this Quarter: • Risk 6285 - putting patients at risk due to the delay in Medicines Reconciliation process and correcting of prescribing errors - An additional resource of 1 Band 6 pharmacist has been given to support the service to EAU, however this is not a protected post and may be utilised elsewhere due to service need; • Risk 6480 – Operation risk to continuity of Breast PACs. Currently the service is being maintained by moving workstations around the service as they fail. This is a tolerated risk and is being managed and monitored within the Department. Planning and Performance - access to Systmone strategic extract. Consultant deployed to support S1 data extract to support informed decision making. MSK pathways identified as area to consider first - tables loaded and ready to be linked to yellofin July 2022. Development of virtual wards - virtual beds established in Hospital @ Home, Residential/nursing homes - bid in place to support expansion. Ageing Well (UCR 2 Hour response) - Workforce being established, funding received (combination of NREC and REC). Working with partners to understand remote home monitoring to support patients to self-manage and early intervention. Consultant in Public health is currently accelerating the development of the health inequalities agenda in collaboration and partnership with Directors of Public Health work and population health management agenda. Trust work plan for working with system partners has been produced.	**9 3x3**	**9 3x3**	**9 3x3**	**9 3x3**	**Open**

Transforming our Services (Internal) - 3B - There is a risk of failure to deliver transformational improvements that are sustainable, financially effective, aligned with local and national requirements, beneficial and which have secured commissioner support					
No new risks identified. • PMIO conduct evaluation of supporting project documents and consider levels of expertise with a view to delivering pre-project workshops. Process developed to identify required QIA documents reported through Excellence as our Standard; • Reviewed and improved process for business cases with strategic alignment resulting in a more robust process; • In order to provide assurance around improvement planning within departments and care groups, a governed and structured plan to support the approach to carrying out departmental review and support visits across the trust in line with the regulatory and fundamental standards for improvement work was put in place in early December 2022. Initial scoping meetings in place. Project plan agreed, scheme of work agreed. 1st visit took place December 2022. further scheduled visits planned throughout the early part of the year. • 16 January 23 - First visit to ED carried out with a programme plan for further visits of all areas underway. • All projects are monitored through the Project Management & Improvement Office as part of the delivery assurance monitoring, with Business Team providing oversight. A full Clinical Services review and a Trust strategy is in progress with monitoring and ongoing development through Business Team Strategy Sessions. The CSS is currently in development stage and will be finalised during Q3-Q4.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Seek**

Finance - 3C - The Trust does not deliver the 2022/23 financial plan as submitted to NHSI/NHSE (including future years)

There is one new HIGH risk added in this Quarter linked to the Trust's Ageing Estate (6581).

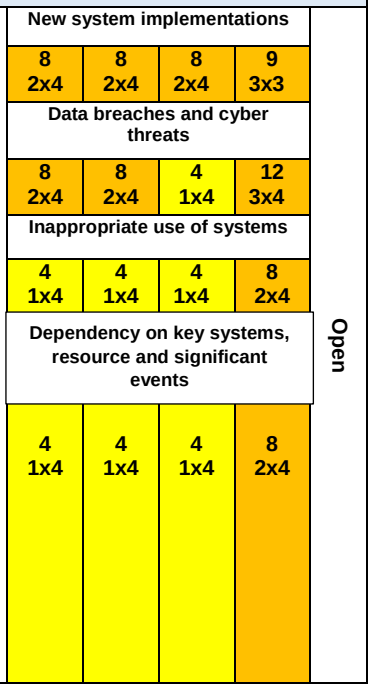
- There is a High risk that Wider Health Economy Issues (6581) are impacted by the draft 6 Facet Survey report and this underlines the significance of capital investment in our estate due to the fact that there is approximately 10 years of remaining life in some of the buildings (e.g. North Wing and Tower Block). Current mitigations include a revised Estate strategy for the Trust and ongoing work to develop a strategic outline case to establish the case for change and investment in the capital infrastructure. This is a financial risk aligned to patient safety/health & safety;
- A High risk remains relating to Delivery of Savings (6188) and the challenges to deliver the CIP programme for 2022/23 and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions and a system requirement for additional CIP savings in year;.
- The risk associated with Delivery of Savings is aligned to Risk 6266 - Capacity and capability issues of the finance department preventing the delivery of services to the Trust (resilience etc). A CIP plan for 2022/23 has been developed and is regularly reported to the Finance Committee alongside a planned follow-up audit of CIP processes in 2022/23 via AuditOne;
- The review of the Master Services Agreement was completed earlier in 2022 and a review of all MSA reverse SLAs is currently underway to ensure Key Performance Indicators are appropriate and measurable.



Information Management & Technology - 3D - There is a risk that the integrity and robustness of systems, and the use of those systems, will not support the business

- The following Moderate risks have been added to this Quarter's BAF:
  - Risk 6164 – Cyber threat from an insider threat
  - Risk 6404 – ICT staffing levels and BAU
  - Risk 5589 – Risk of loss or damage to PID due to storage conditions
- The above risks are monitored and managed through the appropriate workforce channels and through the Digital Strategy Committee.
- Risks relating to cyber threats continue to pose a threat to the organisation as the Trust does not currently carry out regular training of all staff on cyber threats. Staff need to take personal responsibility for understanding how technologies will provide support to business functions and undergo necessary training (including mandatory) in accordance with Trust policy. A High risk has been reported (6562) but has not yet been reviewed and is in the holding area in Datix. This risk handler has been notified.
- Significant events (i.e. pandemic, organisational form impact) pose a potential risk linked to changing health and care landscape, may adversely impact on Trust strategic plans and delivery priorities. Provider Collaborative "Joint" Governance and formal strategic agreements including agreed digital strategies and plans. However, there is no current ICP/Tees Valley Provider joint digital strategy. Business Continuity Planning and risk reduction plans are in place to mitigate risk.

All other controls and assurances have been reviewed by Digital Strategy Committee to mitigate the threats to the overall strategic risk.



Transforming our Services (External Impact) - 3E - The Integrated Care Partnership fails to deliver its financial objective and strategy and therefore a sustainable model of integrated services that meet the needs of the population across Stockton and Hartlepool, and puts at risk the longer term sustainability of healthcare services across the locality and the wider region in the system delivery against the four elements of the work programme.

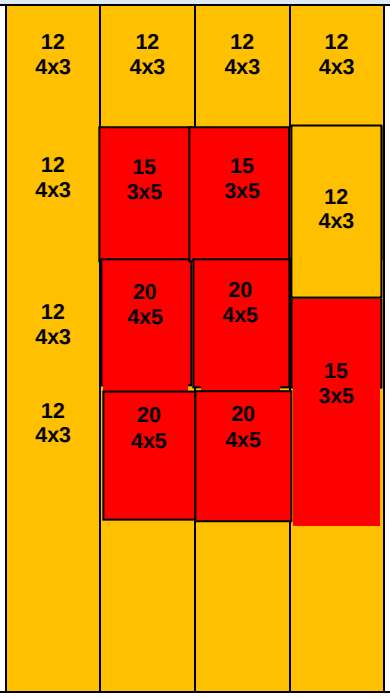
The Trust has reviewed the risks contained within the principle risk and has focussed the risks around three specific areas:

- Integrated Care System (ICS) and developments/progress relating to the Integrated Care Board (ICB);
- Area-based partnerships and place-based planning including the Tees Valley Integrated Care Partnership (ICP) and the risks associated to the completion of the Clinical Services Strategy; and
- Provider Collaboration - Joint Partnership Board

The ICS and ICP development present a moderate risk to the Trust and as much of this relies on the work of other external partners the risk has been downgraded to Moderate and will be review accordingly.

The Joint Partnership Board has received the recommendations of an independent strategic review linked to collaboration of both Trusts without identification of risk strategy or due diligence within the immediate planning phase presents a strategic risk to the organisation.

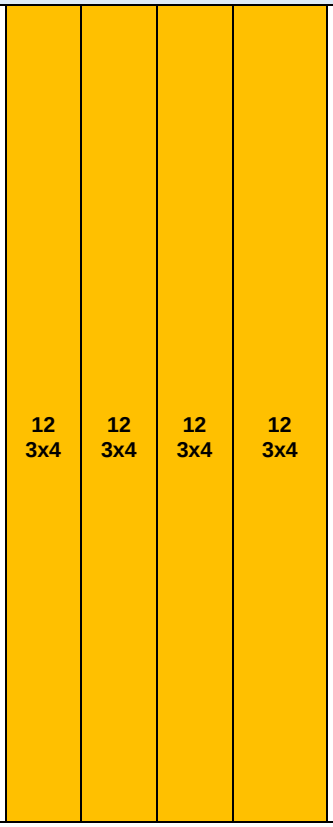
The risks associated with external transformation have been discussed at Board committees on a number of occasions during 2022. However, this review is timely and it is intended that the risks will be fully reviewed in time for the Quarter 3 Board Assurance Framework report to Board of Directors in January 2023.



Health & Wellbeing - 4A - The Trust fails to effectively address population health, prevention issues and strategic co-ordination of the public health agenda across Stockton, Hartlepool and the wider geographies as evidenced by an increase in admissions and patient pathways

- No new risks identified.
- COVID-19 and actions taken to ensure all strategic risks associated with the pandemic are being reviewed under Workforce, Service Provision and Local Partners (Social Care). Every service completed an estate risk assessment to ensure social distancing is maintained - reviewed regular, every service reviewed priority cases and ensure priority patients are seen first, full review of wait times, estimation for recovery based on new referrals and backlog. Trajectory planned for recovery in most services. Prioritisation given to cancer patients (service has been maintained throughout COVID19 position)
- Further prioritisation of RTT through e-review service (via NECS)
- Development of iSPA facility to provide MDT approach to patients including health, social and mental health provision
- MSK actions to support patients waiting over 18 weeks implemented - increase F2F appointments
- Recovery continues, MSK RTT within tolerance, ongoing plan in paediatrics and gynaecology to continue to recover RTT
- Evaluation of schemes deployed in response to COVID19 - Holdforth Hub and Home First schemes - Data collection available for initial review of impact. Requirement to summarise position to date and to look to continue with schemes to further evaluate impact
- Engagement around Personalisation as a system and development of Leadership, incorporating LA, Primacy Care, Patient Representative and Foundation Trust is ongoing;
- Development of Health Inequalities dashboard - Ability to understand which people are most at risk of not engaging with healthcare, ability to potentially put an intervention in place to proactively support these people

This risk will be reviewed as part of the ongoing work on health inequalities and disparities.



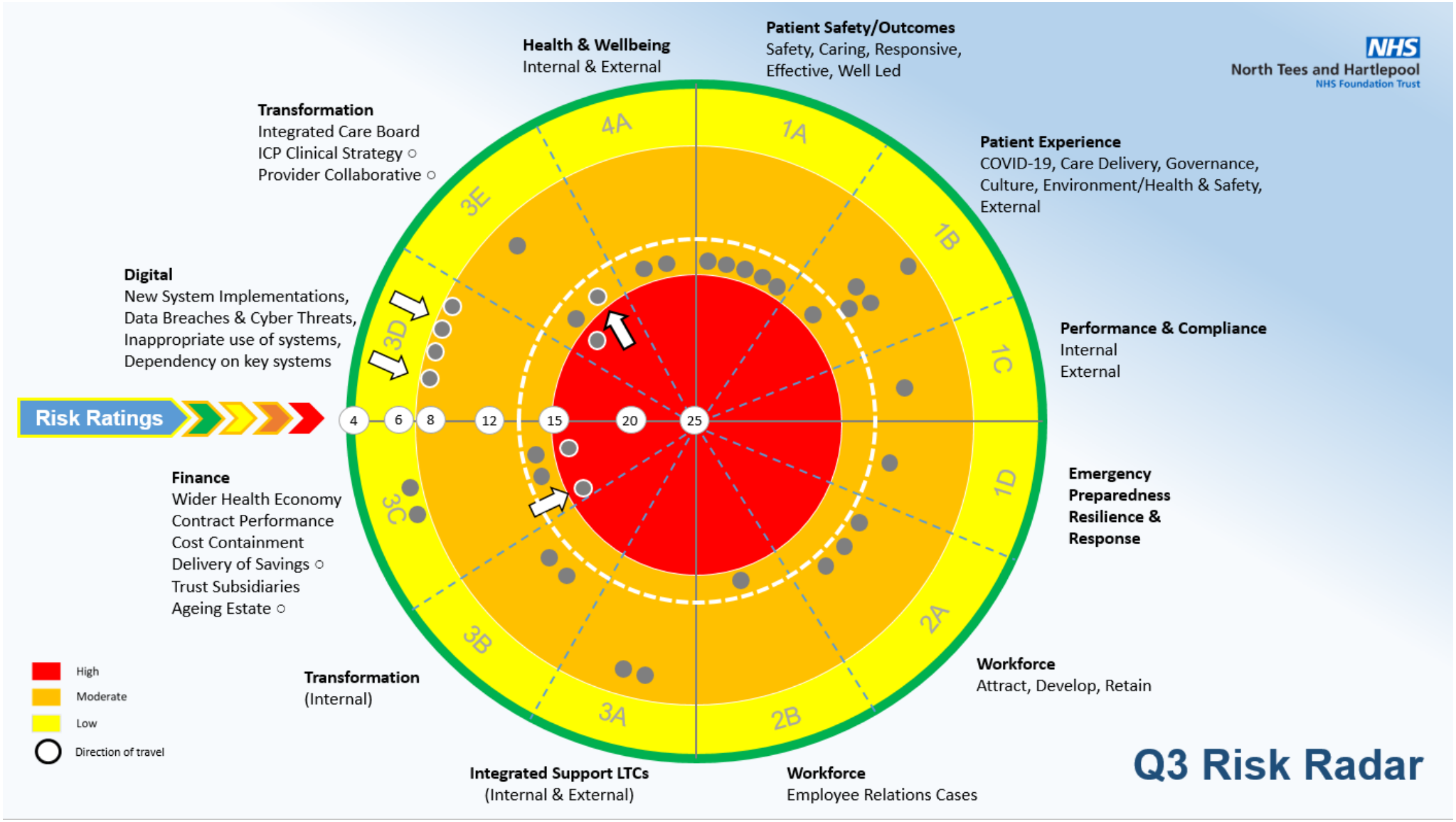
6. Recommendations

6.1 Actions are in place and being taken forward to mitigate the risks in the above sections, and the issues form part of regular discussions at the key Committees as well as being a focus of Executive Team discussions as part of the monthly Risk Management reporting.

6.2 The Board of Directors is asked to note the risks contained in the BAF and specifically those that are based on a current risk rating of >15 (High).

Prepared by: **Hilton Heslop, Associate Director of Corporate Affairs & Strategy**

Appendix 1


Health & Wellbeing
Internal & External
Patient Safety/Outcomes
Safety, Caring, Responsive, Effective, Well Led
NHS
North Tees and Hartlepool
NHS Foundation Trust
Transformation
Integrated Care Board
ICP Clinical Strategy ○
Provider Collaborative ○
Patient Experience
COVID-19, Care Delivery, Governance, Culture, Environment/Health & Safety, External
Digital
New System Implementations, Data Breaches & Cyber Threats, Inappropriate use of systems, Dependency on key systems
Performance & Compliance
Internal
External
Risk Ratings
4
6
8
12
15
20
25
4A
1A
3E
1B
3D
1C
1D
3C
2A
3B
3A
2B
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings ○
Trust Subsidiaries
Ageing Estate ○
Emergency Preparedness Resilience & Response
High
Moderate
Low
Direction of travel
Transformation
(Internal)
Workforce
Attract, Develop, Retain
Integrated Support LTCs
(Internal & External)
Workforce
Employee Relations Cases
Q3 Risk Radar

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Integrated Compliance and Performance Report										
Date:	26 January 2023										
Prepared by:	Keith Wheldon - Business Intelligence Manager Lynsey Honeyman- Planning and Performance Manager										
Executive Sponsor:	Linda Hunter - Director of Planning and Performance Lindsey Robertson - Chief Nurse/ Director of Patient Safety and Quality Susy Cook – Chief People Officer Neil Atkinson- Director of Finance										
Purpose	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our population First	x	Valuing our People	x	Transforming our Services		Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The Integrated Performance report outlines the Trust's compliance against key access standards in December 2022 including quality, workforce and finance.

Summary

- The Trust experienced unprecedented pressures in December in comparison to previous months with increased UEC attendances, increased patient acuity leading to increased emergency admissions and bed pressures.
- Increased admissions from Covid and flu added to the operational pressures including staff sickness.
- The Trust continues to respond to surges in demand and pressures within services including IPC guidelines. All additional surge and resilience beds were opened within available resource.
- The Trust declared OPEL 4 for 6 days during December 2022.
- Whilst operational and workforce pressures continued in December, affecting performance against key standards however, the position for the majority of those key standards remain comparable to national and regional positions.
- Standards continue to be monitored closely through the established and robust internal governance structures, which supports further development of improved clinical pathways, quality and patient safety across the Trust.

- The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI (which have both seen a slight rise recently) and infection control measures.
- The number of patients waiting longer than 52 weeks at the end of December was 33.
- The Trust achieved four of the nine cancer standards in November 2022, with one standard missing by 0.03%.
- Short Term staff sickness has seen a decrease for November 2022, with long term seeing a continued increase since September, these will be continuously monitored.
- Staff Turnover has seen a continued decrease from the previous month, with a positive move toward target.
- Month 9, the Trust is reporting an in-month surplus of £0.389m against a planned deficit of £0.002m, which is £0.391m ahead of plan.

How this report impacts on current risks or highlights new risks:

Continuous and sustainable achievement of key access standards across elective, emergency and cancer pathways, alongside a number of variables outside of the control of the Trust within the context of system pressures and financial constraints and managing Covid-19 and Flu pressures, recovery, winter and staffing resource.

Associated risks are outlined within the Board Assurance Framework

Committees/groups where this item has been discussed	Executive Team Meeting Audit Committee Planning, Performance and Compliance Committee
Recommendation	The Board of Directors is asked to note: • The performance against the key operational, quality and workforce standards. • Acknowledge the on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation.

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report

January 2023

Responsible Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Linda Hunter
Director of Planning & Performance

- Oversight Framework
- Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

- Safety & Quality

Susy Cook
Chief People Officer

- Workforce

Neil Atkinson
Director of Finance

- Finance

Introduction

North Tees and Hartlepool NHS Foundation Trust

Performance highlights against a range of indicators including the Oversight Framework (OF) and the Foundation Trust terms of licence remains. The report is for the month of ***December 2022*** and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance. To view the previous months position, please refer to the individual SPC charts.

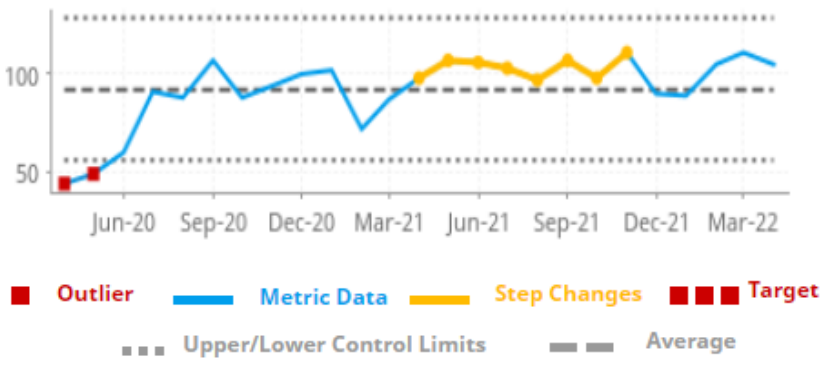
Statistical Process Control (SPC) Charts

A Step Change occurs when there are 7 or more consecutive points above or below the *average*.

Outliers occur when a single point is outside of the Upper or Lower Control Limits.

The *Upper and Lower control limits* adjust automatically so they are always 2 Standard Deviations from the *average*.

Standard deviation tells you how spread out the data is. It is a measure of how far each observed value is from the average. In any distribution, about 95% of values will be within 2 standard deviations of the mean.



Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Oversight Framework and Efficiency & Productivity

The Trust continues with an aspiration to deliver trajectories outlined in the NHS priorities and operational planning for 2022/23. The position for the majority of key standards, including RTT, Cancer and Diagnostics. Additional capacity continues to be delivered through a combination of insourcing, additional lists and clinics with a continued focus on clinical prioritisation within the elective programme.

The Trust faced unprecedented challenges in increased activity across Emergency Department and Urgent Treatment Centre attendances reporting a 15% increase in December (18,427 attendances, up from 15,682 the previous month).

Responding to system pressures continues with multiple requests for mutual aid, diverts and deflections, with the Trust receiving 20 more patients to the organisation in December (142) than in the previous month November (122) with the conversion to an admission in December at 56%. Bed occupancy rates continue to impact upon the waits in the Emergency Department affecting patient flow however, the full implementation of operating model provides additional bed capacity to assist with patient flow.

The Trust achieved four out of the nine cancer standards, demonstrating an improved position comparative to the region with a continued achievement of the 28 day faster diagnosis standard.

The Trust continues to drive to reduce the number of long waiting patients with a focus on those patients waiting over 40 weeks and continues to have the lowest number across the North East and Yorkshire region.

The 2023/24 priorities and operational planning guidance was released in December 2022 confirming the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform our services for the future.

Safety & Quality

The overall position for the majority of key quality standards, including HSMR, infections, falls and complaints remains comparable to the national and regional position, with high quality care maintained despite the pressures.

The latest HSMR value is currently reporting at 93.28 (November 2021 to October 2022), latest SHMI value is now 99.19 (August 2021 to July 2022) which remains within the control limits.

Control of infection remains a priority with all 7 standards displaying natural cause variation and remain within control limits.

The number of complaints has decreased within all Stage's in December 2022, compared with the previous month. The number of complaints received this month continues to be consistent with pre-pandemic levels.

The number of high risks has increased to above the mean this month, however, this remains within the expected variance, demonstrating a dynamic risk management process.

Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Workforce

Sickness has decreased slightly from 6.17% to 6.05% in November 2022, with only 0.68% being due to COVID related absence.

Appraisal compliance has decreased this month by 0.94% and at 84.92% still falls short of the Trust 95% standard.

Turnover continues to reduce in December 2022, from 10.55% to 10.21%; this is the lowest rate since November 2021.

Overall, mandatory training compliance has dipped below the 90% standard and is at 88.04%. It is acknowledged that work is still required to focus on key topic areas which remain below the compliance level required, in particular resuscitation courses. A dedicated working group is being established to explore alternative ways of delivery.

Finance

At Month 9, the Trust is reporting an in-month surplus of £0.389m against a planned deficit of £0.002m, which is £0.391m ahead of plan.

The Trust is reporting a year to date surplus of £5.484m against a plan of £4.742m, which is £0.742m ahead of plan.

Total Trust income in M9 is £31.856m (including donated asset income and finance income).

M9 pay expenditure totalled £21.805m of which £0.074m is additional spend related to the Covid-19 response (including testing costs).

M9 non-pay expenditure totalled £9.768m.

The month 9 year to date net contribution from Optimus is £0.210m against a plan of £0.122m (£0.088m ahead of plan) and the year to date net contribution from the LLP is £0.989m against a plan of £0.915m (£0.056m ahead of plan).

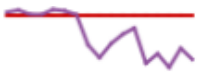
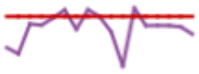
YTD, the Trust continues to benefit from slippage on non-recurrent funding which continues to support the Trust reporting ahead of plan.

Key risks at M9 continue to relate to controlling run rates, ceasing non-recurrent expenditure arrangements, CIP identification and delivery and pay award pressure.

Oversight Framework

6

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
New Cancer Two Week Rule	✗	Nov-22	89.54%	93.00%	
Breast Symptomatic Two Week Rule	✗	Nov-22	89.77%	93.00%	
28-day Faster Diagnosis	✓	Nov-22	83.36%	75.00%	
New Cancer 31 Days	✗	Nov-22	95.97%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Nov-22	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✓	Nov-22	100.00%	94.00%	
New Cancer 62 Days	✗	Nov-22	64.63%	85.00%	
New Cancer 62 Days (Screening)	✗	Nov-22	78.75%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✓	Nov-22	87.50%	85.00%	

Narrative

Cancer

The latest validated position for November 2022 sees the Trust achieving four out of the nine cancer standards.

A continued improving position against the Two Week Rule standard of 93% now reporting at 89.54% placing the Trust in 3rd across the region, with the average reported position of 80.33%.

The report reflects achievement of the 28 day faster diagnosis standard of 75%, reporting above both regional and national position.

Cancer 31 days reported 95.97% with the 6 breaches as a result of elective capacity.

The Trust has met the November improvement trajectory for Cancer 62 seeing an overall reduction in the number of patients waiting longer than 62 days albeit did not achieve against the 85% standard reporting at 64.63%, an improvement on the previous month. Pressures remain across the majority of pathways, reflective of both the regional and national position, reporting respectively at 61.14% and 61.0%.

The Clinical Cancer Lead continues to support the focussed work with colleagues across the organisation and beyond with a clear understanding of the issues and complexity faced by encouraging change solutions to help recover the Trusts position and improve overall waiting times and patient experience.

Oversight Framework

7

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Referral To Treatment Incomplete Pathways Wait (92%)	Dec-22	75.32%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	Dec-22	28.71	28.00	
Incomplete Pathways Wait (Median)	Dec-22	9.14	7.20	
Incomplete Pathways Wait (>52 Week Wait)	Dec-22	33	0	
Diagnostic Waiting Times and Activity	Dec-22	66.90%	99.00%	

Narrative

RTT

The Trust reported at 75.32% for the RTT incomplete standard in December. The latest benchmarking position, November being the latest available data, regionally at 70.4% and national reporting at 59.6%, with the Trust at 77.8%. A reduction in the waiting list of 2% (373) reduction compared to the previous month has been seen.

33 patients were reported to be waiting over 52 weeks, which ranks the Trust 2nd best in the region. Bank holidays and patient choice impacted on elective capacity in December, however the Trust maintained its trajectory in line with Phase 1 and Phase 2 elective recovery from NHS England and reports no patients waiting longer than 78 and 104 weeks.

The Trust continues to drive to reduce the number of long waiting patients with a focus on those patients waiting over 40 weeks and continues to have the lowest number across the North East and Yorkshire region.

Diagnostics

Performance has seen a decrease in December, reporting 66.90% compliance from 74.36% in the previous month. As a comparator, the latest national position relates to November and is 73.13%, with the regional position 80.91% with the Trust reporting 74.36%, with compliance across the region ranged from 74.36% to 95.20%.

Non-Obstetric Ultrasound has seen an increase in the numbers of patients waiting more than 6 weeks with an overall increase in the waiting list. The increase is as a result of reduced capacity due to the bank holidays and the long term sickness within the department, which will be resolved in January which will start to show a trajectory of improvement that will bring the compliance back in line by March 2023.

Oversight Framework

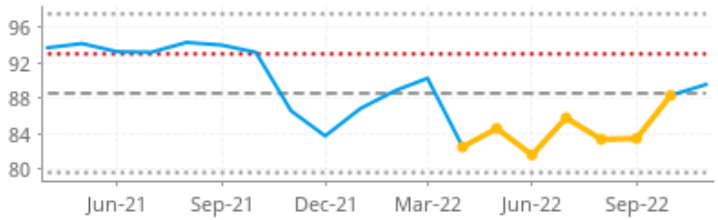
8

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Cancer - 2 Week Rule

Month	Performance	Standard
Nov-22	89.54%	93.00%



Cancer - Breast Symptomatic

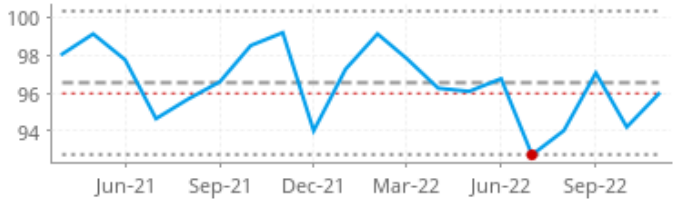
Month	Performance	Standard
Nov-22	89.77%	93.00%

Cancer - 28 day Faster Diagnosis

Month	Performance	Standard
Nov-22	83.36%	75.00%

Cancer - 31 days

Month	Performance	Standard
Nov-22	95.97%	96.00%



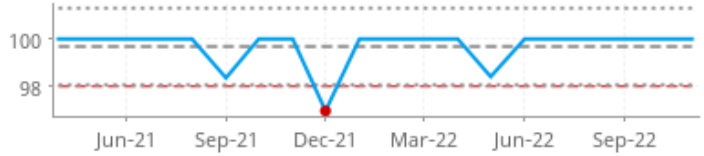
Oversight Framework

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

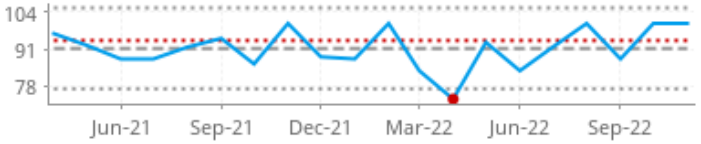
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
Nov-22	100.00%	98.00%



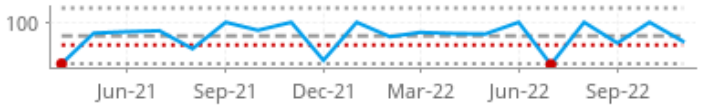
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
Nov-22	100.00%	94.00%



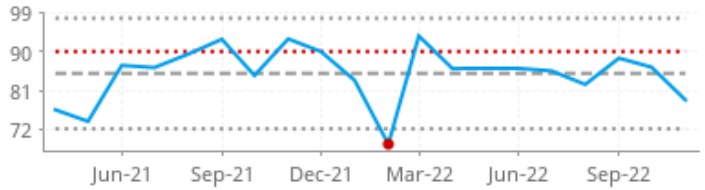
Cancer - 62 Consultant Upgrade

Month	Performance	Standard
Nov-22	87.50%	85.00%



Cancer - 62 Days Screening

Month	Performance	Standard
Nov-22	78.75%	90.00%



Cancer - 62 Days

Month	Performance	Standard
Nov-22	64.63%	85.00%

Oversight Framework

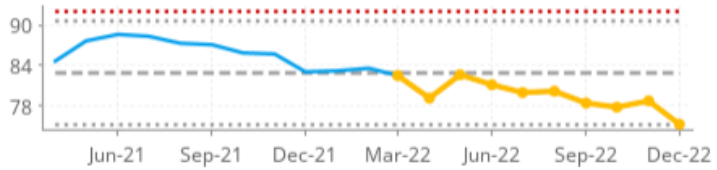
10

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

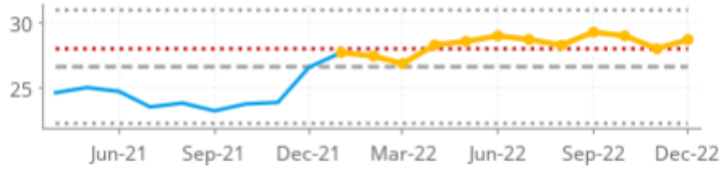
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Dec-22	75.32%	92.00%



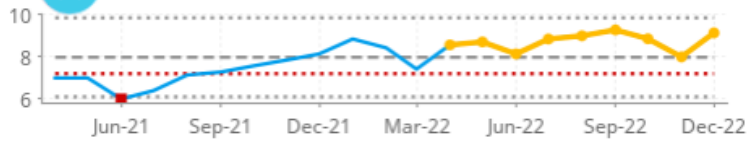
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Dec-22	28.71	28.00



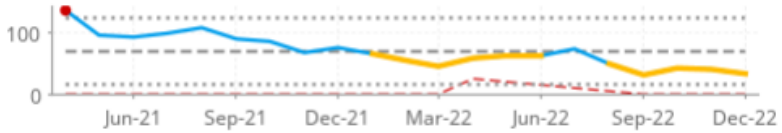
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Dec-22	9.14	7.20



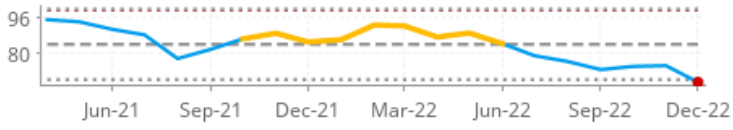
Referral To Treatment- Incomplete Pathways Wait (>52 Week Wait)

Month	Performance	Standard
Dec-22	33	0



Diagnostic Waiting Times and Activity

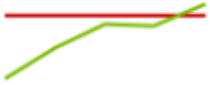
Month	Performance	Standard
Dec-22	66.90%	99.00%



Efficiency & Productivity

11

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*Trend*
Decision To Admit (DTA) (over 12 hours)	✗	Dec-22	46	0	
Time to Initial Assessment (mean) Type 1 & 3	✗	Dec-22	20.32	15.00	
Number of Ambulance Handovers waiting more than 60 Mins	✗	Dec-22	82	0	
65% of Ambulance Handovers completed within 15 Mins	✗	Dec-22	15.07%	65.00%	
95% of Ambulance Handovers completed within 30 Mins	✗	Dec-22	39.29%	95.00%	
2 hour Urgent Community Response	✓	Nov-22	78.93%	70.00%	

Urgent and Emergency Care

There were unprecedented pressures in urgent and emergency care during the month of December 2022, with 18,427 attendances to the Trust, a 15% increase on the previous month activity and 31% increase compared to December 2021. Together with the impact of an increasing prevalence of flu and other respiratory illnesses and the impact of industrial action taken during the month.

Significant pressures are noted across the region affecting ambulance handovers with 82 handovers over 60 minutes in December compared to the 29 reported in November. Benchmarking the Trusts position, the monthly NEAS report is considered and whilst not a mandated measure, ambulance turnaround times reported at 38.2% within 30 minutes (arrival to clear), placing the Trust second in the region. An average turnaround time of 49 minutes was seen in month compared to the regional average of 72 minutes.

The Trust continues to receive a number of ambulance diverts and deflections and mutual aid requests from neighbouring trusts which adds to the pressures within the Emergency Department. 143 patients were transferred during December 2022, an increase from 122 patients transferred throughout November. 79 patients transferred went on to be admitted as an inpatient with an average Length of Stay (ALOS) of 5 days. The Trust requested mutual aid on 2 occasions, both were declined.

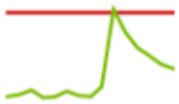
46 patients waited over 12 hours for a decision to admit with the majority of patients waiting for a bed to become available. All patients were made comfortable and cared for appropriately within the Emergency Department until a bed became available.

The 2 hour Urgent Community Response met the standard for this reporting period 78.93%, against the required standard of 75% required by end of quarter 3.

Efficiency & Productivity

12

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Outpatient Did Not Attend (Combined)	Dec-22	11.30%	9.20%	
Reducing Reviews	Dec-22	110.74%	85.00%	
Patient Initiated Follow Up (PIFU)	Dec-22	1.44%	5.00%	
Advice and Guidance	Dec-22	11.35%	16.00%	
Diabetic Retinopathy Screening	Dec-22	98.10%	95.00%	

Narrative

Outpatients

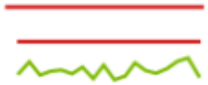
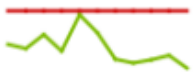
Patients who are unable to attend their appointment (Did not attend – DNA) continues to report above the Trusts standard of 9.2%, with an increase in DNA rates reported for the month (11.3%). Diabetes and Paediatrics reporting the highest DNA rates. A pilot as part of the Health Inequalities focus will commence in January 2023, in which patients will be contacted prior to their appointments to confirm attendance and identify additional support patients may require to enable them to attend hospital.

Care Groups continue to work with clinical teams to include patient initiated follow-ups into their pathways of care. The Trust has also signed up to participate in a national outpatient programme with the aim to share good practice and improve outcomes. The telephone reminder service has been reviewed with 'opt out' rather than 'opt in' now as the as default.

Efficiency & Productivity

13

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Electronic Discharge Summaries	✗	Dec-22	87.75%	95.00%	
Super Stranded	✗	Dec-22	60	43	
Average Depth of Coding	✓	Nov-22	6.07	3.01	
Length of Stay - Elective	✓	Dec-22	2.37	3.14	
Length of Stay - Emergency	✓	Dec-22	2.77	3.35	
Day Case Rate	✓	Dec-22	90.06%	75.00%	
Pre-op Stays	✓	Dec-22	2.84%	4.50%	
Trust Occupancy	✗	Dec-22	92.48%	90.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	✗	Oct-22	8.68%	7.70%	
Not reappointed within 28 days	✓	Nov-22	0	0	

Narrative

Electronic Discharge Summary (EDS)

The Trust performance for December EDS was 87.76%, therefore not achieving the 90% of discharge summaries being completed within the required 24 hours. Focused work across care groups is ongoing with an identified lead to co-ordinate all activities to improve this in the coming months.

Super Stranded Patients

December has seen a slight increase of 4 patients (56 to 60) for those who have been in hospital 21 days or more. The 41 patients are from within area, with Hartlepool & Stockton accounting for 68.33%, this is a reduction from the 71.43% in November. The Trust continues to work with its partners in Local Authorities to ensure timely discharge where clinically appropriate.

Length of Stay

A further reduction to a patients' length of stay (emergency admitted pathways) for December is noted which helped to ease pressure on beds and aid the flow.

Trust Occupancy

The Trust occupancy throughout December consistently reported above 90% at an average of 92.48%. Surges in activity saw the Trust exceed 95% occupancy on 17 occasions despite all available surge and resilience beds being open. Admissions for Covid increase from 100 in November to 142 in December, with 45 patients still in the Trust being treated at the end of December. There were 331 admissions for flu in December, with 106 patients still in the Trust being treated at the end of December.

Readmissions

The latest validated position has seen an increase of 0.42% for readmissions compared to previous month. Pain issues being the reason for the highest elective readmission and Gastrointestinal the reason for the highest emergency readmission. Audit are due to report to the Business Team in January around Readmissions.

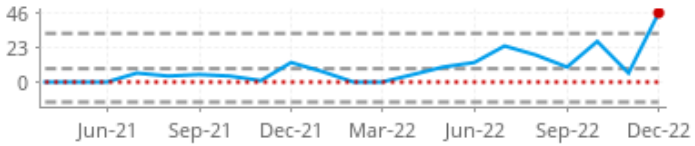
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

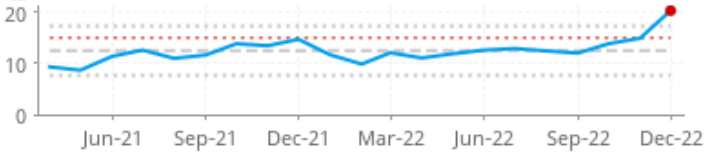
Decision to Admit (DTA) (Over 12 hours

Month	Performance	Standard
Dec-22	46	0



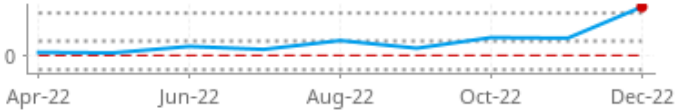
Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Dec-22	20.32	15.00



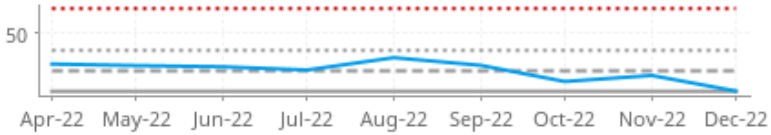
Number of Ambulance Handovers waiting more than 60 mins

Month	Performance	Standard
Dec-22	82	0



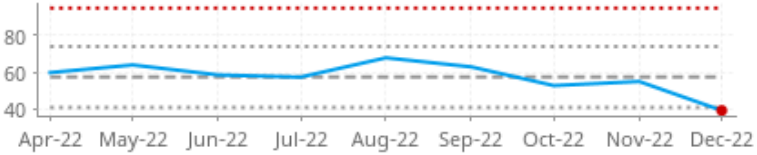
65% of Ambulance Handovers completed within 15 mins

Month	Performance	Standard
Dec-22	15.07%	65.00%



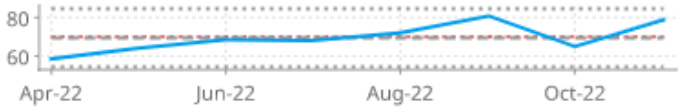
95% of Ambulance Handovers completed within 30 mins

Month	Performance	Standard
Dec-22	39.29%	95.00%



2 hour Urgent Community Response

Month	Performance	Standard
Nov-22	78.93%	70.00%



Efficiency & Productivity

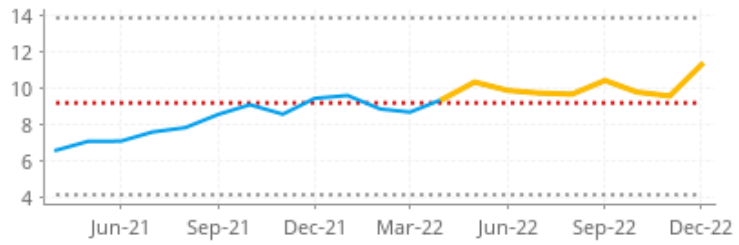
15

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

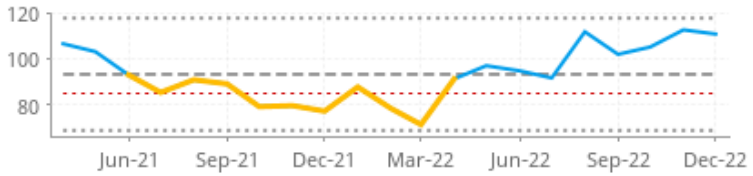
Outpatient Did not Attend

Month	Performance	Standard
Dec-22	11.30%	9.20%



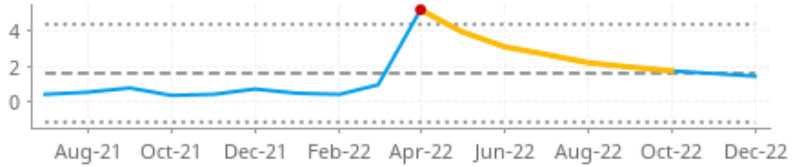
Reducing Reviews

Month	Performance	Standard
Dec-22	110.74%	85.00%



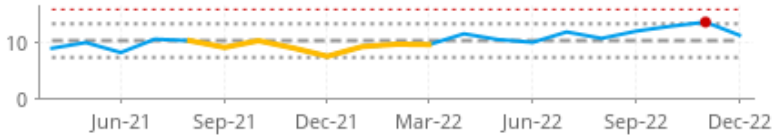
Patient Initiated Follow up

Month	Performance	Standard
Dec-22	1.44%	5.00%



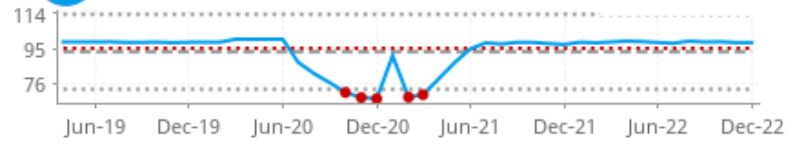
Advice and Guidance

Month	Performance	Standard
Dec-22	11.35%	16.00%



Diabetic Retinal Screening

Month	Performance	Standard
Dec-22	98.10%	95.00%



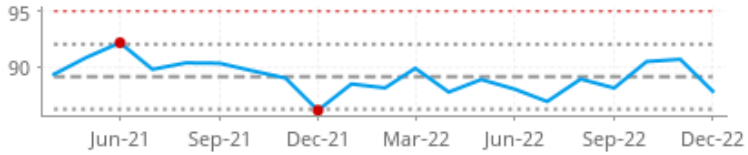
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

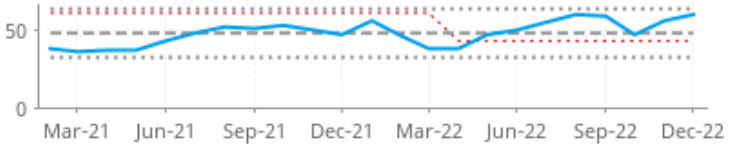
Electronic Discharge Summaries

Month	Performance	Standard
Dec-22	87.75%	95.00%



Super Stranded

Month	Performance	Standard
Dec-22	60	43

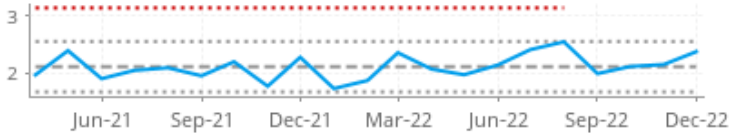


Average Depth of Coding

Month	Performance	Standard
Nov-22	6.07	3.01

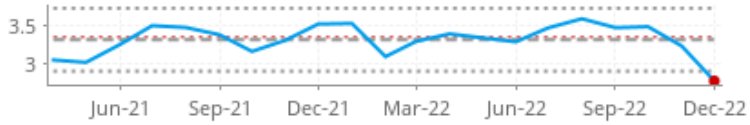
Length of Stay - Elective

Month	Performance	Standard
Dec-22	2.36	3.14



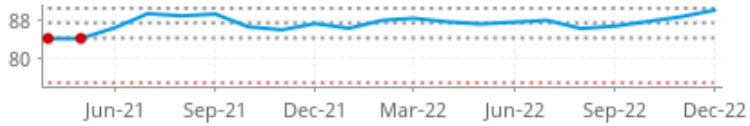
Length of Stay - Emergency

Month	Performance	Standard
Dec-22	2.77	3.35



Day Case Rate

Month	Performance	Standard
Dec-22	90.06%	75.00%



Efficiency & Productivity

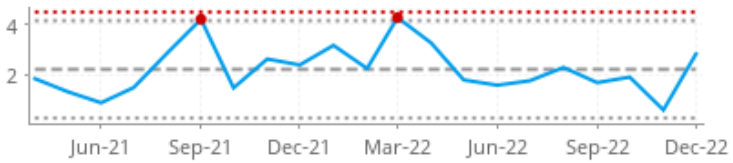
17

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

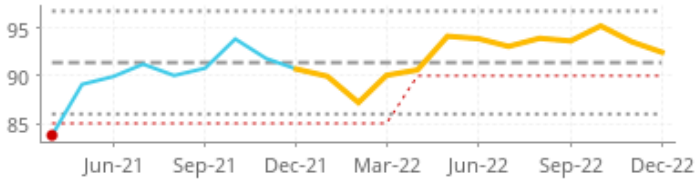
Pre-op Stays

Month	Performance	Standard
Dec-22	2.84%	4.50%



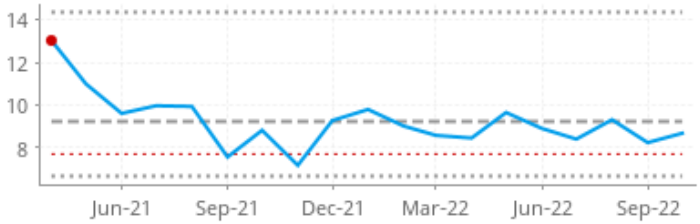
Trust Occupancy

Month	Performance	Standard
Dec-22	92.48%	90.00%



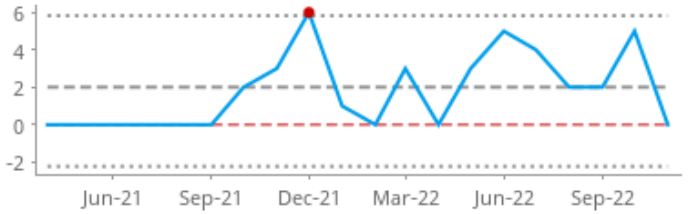
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Oct-22	8.68%	7.70%



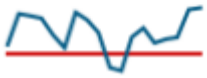
Not Reappointed within 28 days

Month	Performance	Standard
Nov-22	0	0



Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Trend*	
Hospital Standardised Mortality Ratio (HSMR)	✓	Nov 21 - Oct 22	93.28		
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Aug 21 - Jul 22	99.19		
		Month	*Performance*	*Standard*	*Trend*
Stage 1 Complaint	✓	Dec-22	90	107	
Stage 2 Complaint	✓	Dec-22	1	6	
Stage 3 Complaint	✓	Dec-22	2	8	
Compliments	✓	Dec-22	382	278	

Mortality

The latest HSMR value is currently reporting at 93.28 (November 2021 to October 2022), which has increased from the previous unreported value of 92.24 (September 2021 to August 2022). The latest SHMI value is now 99.19 (August 2021 to July 2022) which has increased from the previous rebased value of 98.61 (July 2021 to June 2022).

Complaints

The number of complaints has increased by 43 in December, compared with the previous month. The total number of Stage 1 complaints received is 90, which is a decrease of 30 on the previous month, the number of Stage 2 complaints received is 1 which is a decrease of 8 in the previous month and 3 Stage 3 complaints have been received which is the same as the previous month. The numbers received and themes continue to be closely monitored. The Trust continues with the drive for local and face to face resolution of concerns, virtual meetings are in place to support this process.

During December, Length of Time to be given an Appointment is the highest theme mentioned in 14 concerns/complaints, which is an increase of 6 from December, this is spread across 12 different wards/departments. There is a decrease in Communication (verbal) from 13 to 8 in December and a decrease in Attitude of Staff from 16 to 10.

Increased analysis continues to be presented and discussed during the weekly Safety Panel meetings and in the monthly Patient Experience Report. Trend analysis is also addressed during weekly Senior Clinical Professional Huddles. This robust process continues to support timely identification of the themes.

A Complaint Improvement Project has commenced to identify areas for improvement and associated actions. The Stage 3 complaint process has been reviewed with an updated process implemented on 3 January 2023. An evaluation will take place at 30, 60 and 90 days. The remainder of the complaint process is under review.

Compliments

The Trust records the compliments received onto the Greatix platform. For December 2022 the number of compliments received is 382, which is higher than the mean of 278 compliments. Compliments consistently remain higher than the number of complaints the Trust receives.

Safety & Quality

19

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
High Risks	✗	Dec-22	5	4	
Never Events	✓	Dec-22	0	0	
VTE %	✓	Dec-22	95.88%	95.00%	
Fall No Harm	✗	Dec-22	88	83	
Fall Low Harm	✗	Dec-22	26	17	
Fall Moderate Harm	✗	Dec-22	4	2	
Fall Severe Harm	✓	Dec-22	0	0	

Narrative

Falls

There has been a total of 118 falls reported in December, which is 9 more than the previous month. No harm falls continue to have the highest reported at 88 for the month. Low harm are reported as 26 against a standard of 17 and 4 falls are reported as moderate harm.

One fall reported as moderate harm has been investigated at local ward level with initial findings identifying that all appropriate mitigation for risks had been implemented in a timely manner. Two falls are being investigated as an IRP with consideration given to downgrading to low harm once the investigations are complete. The final fall resulting in moderate harm is being investigated by the Falls Lead as an SI. The patient sustained a fractured neck of femur as a result of the fall. Whilst initial fact finding has identified some good practice it is also noted that there is some immediate learning which has been fed back to the teams in a timely manner. This investigation is on-going.

Whilst the number of reported falls has increased it is noted that Teams and departments continue to implement prevention strategies when required and that compliance with reporting falls remains at an excellent standard.

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Pressure Category 1 (inpatient)	✗	Nov-22	7	4	
Pressure Category 2 (inpatient)	✗	Nov-22	26	21	
Pressure Category 3 (inpatient)	✓	Nov-22	0	1	
Pressure Category 4 (inpatient)	✓	Nov-22	0	0	

Narrative

Pressure Ulcers

In the November 2022 reporting period, there were seven Category one pressure ulcers validated, which is above our expected standard of 4. This demonstrates early identification of pressure damage and prevention of more severe harm. An increase in Category two pressure ulcers is noted to 23, which is above the accepted standard of 20 cases. This is likely reflective of the high occupancy and activity levels faced by the trust. There has been zero Category three pressure ulcer identified in November 2022 and zero Category four pressure ulcers reported, both of which are in line with or below our expected standard.

It is also noted that in November 2022 there were 20 Suspected Deep Tissue Injuries (SDTI) identified and 12 unstageable ulcers, which may be able to be categorised as the damage evolves.

Ongoing work continues with the validation of pressure ulcers, due to the difference between validated and un-validated data positions. A Skin Integrity Collaborative is underway on ward 36 and ward 41 with a focus on prevention, early identification and accurate categorisation. Therefore it is expected that an increase in reporting will be seen over the next six months.

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Hand Hygiene	✓	Dec-22	98%	95%	
Clostridioides difficile (cdiff)	✓	Dec-22	2	5	
MRSA	✗	Dec-22	1	0	
MSSA	✗	Dec-22	7	3	
Ecoli	✓	Dec-22	5	6	
Klebsiella	✓	Dec-22	1	2	
Pseudomonas	✓	Dec-22	0	1	
CAUTI	✓	Dec-22	10	19	

Narrative

Infections

December 2022, the Trust reported two cases of Clostridioides difficile infection, which is below the predicted trajectory of five cases and the same as reported in the previous month. Our yearly objective for 2022-23 is 54 cases of Clostridioides Difficile, with our current case figure of 35.

The Trust has reported five E-coli bacteraemia in December 2022, which is below our projected case rate of six. Our yearly objective for E-coli bacteraemia for 2022-23 is 73, with 63 cases since the start of the financial year. Ongoing project work continues with a catheter care and prevalence audit, which was completed in November.

There has been zero trust attributable cases reported for Pseudomonas infections in December 2022. Our 2022-23 objective is 12 cases, and we currently remain at 13 to date. The trust reported one case of Klebsiella in December 2022, which is below our predicted trajectory and an improvement on the previous month. Our yearly objective for Klebsiella species for 2022-23 is 21 cases, currently the trust stand at 20 cases.

There has been seven healthcare-associated case of MSSA in December, which is above our monthly projected trajectory of three cases. There is no national objective set for MSSA, but our own internal trust target for 2022-23 is 30 cases. The trust have had 29 cases in total for this financial year.

For the month of December, 10 CAUTI cases were reported for the trust, which is significantly lower than previous months and below our standard for the month.

The trust reports 1 MRSA bacteraemia, which was likely a contaminant. A full post-infection review is underway and learning will be shared with the care groups. This takes us over our zero tolerance target for 2022-23. Hand Hygiene compliance throughout the trust increased to 98%, against a target of 95%.

Safety & Quality

22

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	✓	Dec-22	77.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	✓	Dec-22	84.00%	75.00%	
Friends and Family Test (FFT) - Maternity	✓	Dec-22	86.00%	75.00%	
UNIFY - RN Day	✗	Dec-22	79.87%	>=80% and <=109.99%	
UNIFY - RN Night	✓	Dec-22	90.06%	>=80% and <=109.99%	
UNIFY - HCA Day	✓	Dec-22	84.55%	>=80% and <=109.99%	
UNIFY - HCA Night	✓	Dec-22	119.66%	>=110% and <=125.99%	

Friends and Family

For December 2022 the Trust received 1,163 FFT returns, this is a decrease on the previous months updated return of 1,422. The Very Good or Good responses returned for December 2022 is 89.76%.

All three FFT metric percentages fall within their relevant control limits with the recent trends displaying natural cause variation. Work continues to promote FFT particularly from the in-patient areas to improve the amount of feedback.

UNIFY

Nursing fill rates remain challenging due a range of factors including continued vacancies, however this position is improving month on month with a further improved position forecasted for the end Jan23. In wards and departments where there is a reduced RN fill there is clear utilisation of the Nursing Associate role within the workforce models and skill mix of staff and levels of experience are reviewed daily to ensure the right skills are in the right place to deliver the safest and most efficient care to patients at all times. The daily workforce planning decisions continue to be managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse.

Twice daily safe staffing meetings continue to review the acuity and dependency needs of patients to ensure the available staffing resource is deployed to the most suitable areas. Alternative models utilising nursing associate, therapy and un-registered nurse roles continues to support the process to meet the patient acuity and dependency, underpinned by professional judgement.

Monthly recruitment processes are on-going for both Registered Nurses and Unregistered Nurses and cohort 4 of Team Support Worker have recently been recruited into a total 10wte positions. Approx. 35wte Pre Reg Nurses have recently taken up their positions throughout Sept/Oct 2022 with the next cohort of Pre Registered nurses (21 in total) having been interviewed in November 2023 in preparation for their registration in January/February 2023.

The international recruitment of nurses is currently underway with 39wte nurses deployed to the UK and another 21 nurses planned for deployment in January 2023. This will further support increasing the shift fill rate and reducing the overarching nursing vacancy level.

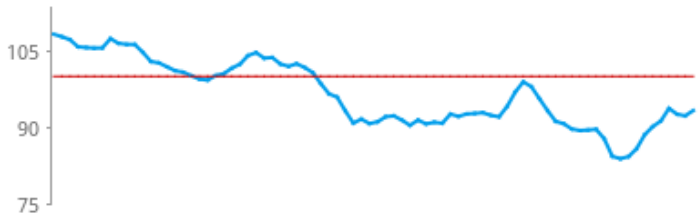
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Additional Detail Charts

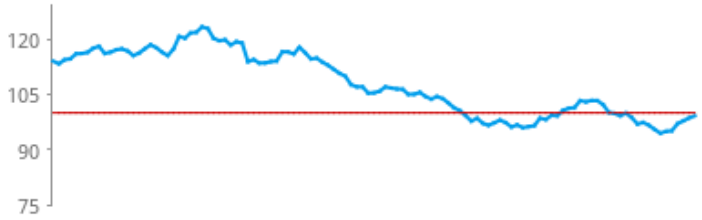
Hospital Standardised Mortality Ratio

Month	Performance
Nov 21 - Oct 22	93.28



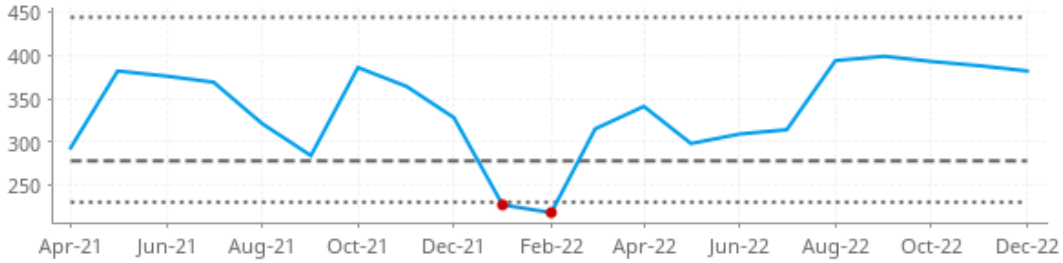
Summary Hospital-Level Mortality Indicator

Month	Performance
Aug 21 - Jul 22	99.19



Compliments

Month	Performance	Standard
Dec-22	382	278



Safety & Quality

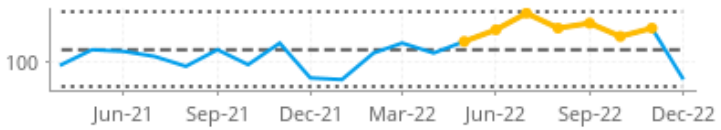
24

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

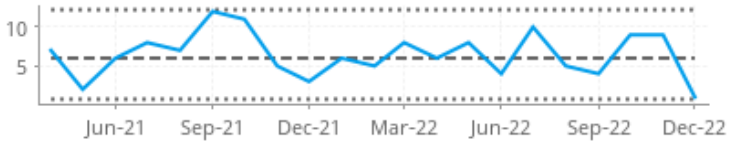
Stage 1 - Informal

	Month	Performance	Standard
✓	Dec-22	90	107



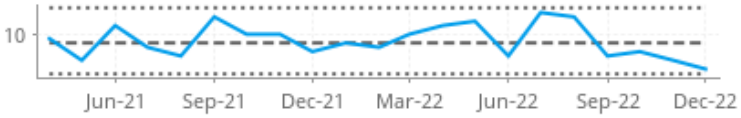
Stage 2 - Meeting

	Month	Performance	Standard
✓	Dec-22	1	6



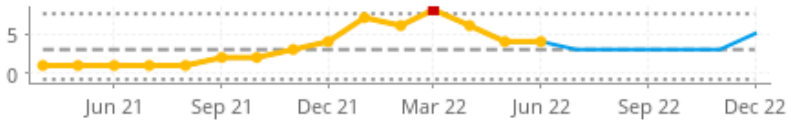
Stage 3 - Formal

	Month	Performance	Standard
✓	Dec-22	2	8



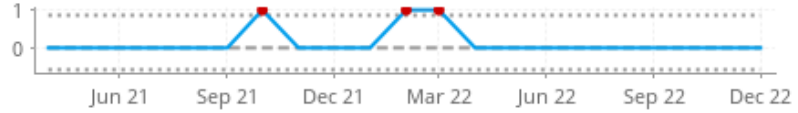
Red Risks

	Month	Performance	Standard
✗	Dec-22	5	4



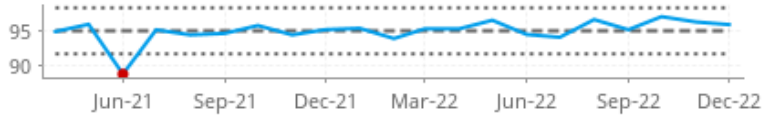
Never Events

	Month	Performance	Standard
✓	Dec-22	0	0



VTE %

	Month	Performance	Standard
✓	Dec-22	95.88%	95.00%



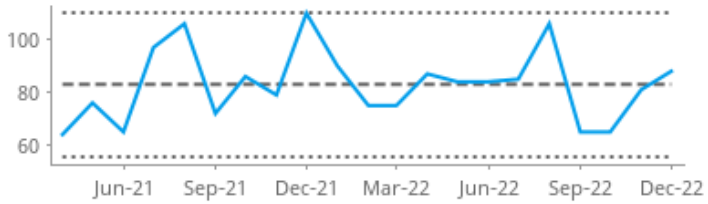
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

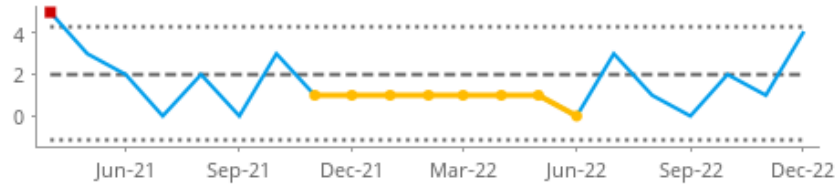
Fall No Harm

Month	Performance	Standard
Dec-22	88	83



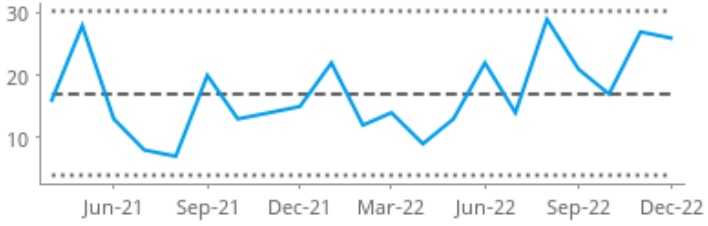
Fall Moderate Harm

Month	Performance	Standard
Dec-22	4	2



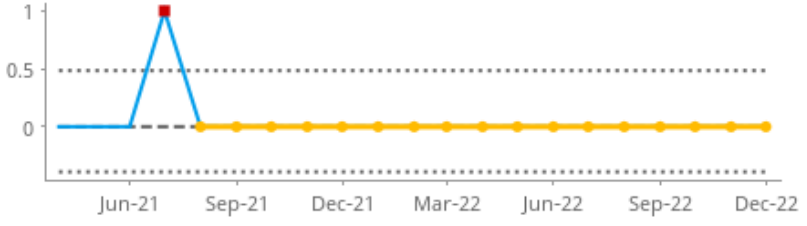
Fall Low Harm

Month	Performance	Standard
Dec-22	26	17



Fall Severe Harm

Month	Performance	Standard
Dec-22	0	0



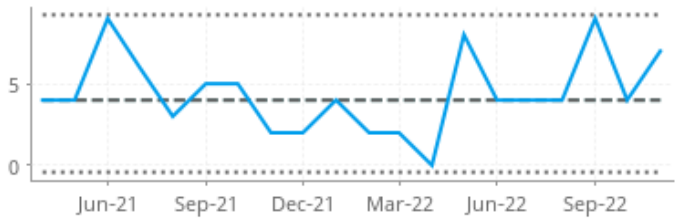
Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

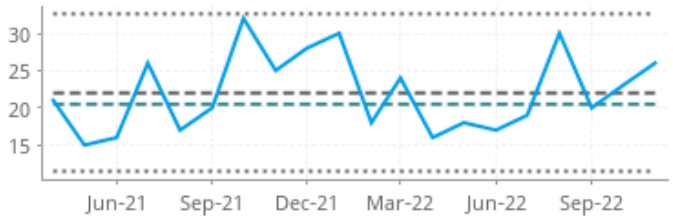
Pressure Ulcer Cat 1

Month	Performance	Standard
Nov-22	7	4



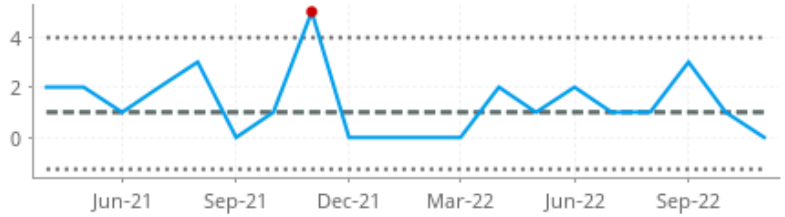
Pressure Ulcer Cat 2

Month	Performance	Standard
Nov-22	26	21



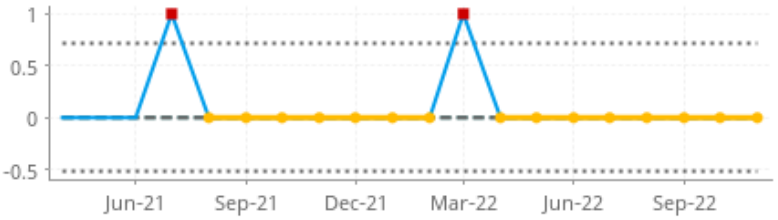
Pressure Ulcer Cat 3

Month	Performance	Standard
Nov-22	0	1



Pressure Ulcer Cat 4

Month	Performance	Standard
Nov-22	0	0



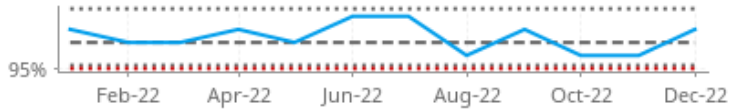
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

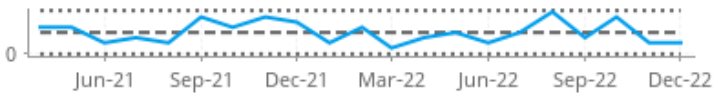
Hand Hygiene

Month	Performance	Standard
Dec-22	98%	95%



Cdiff

Month	Performance	Standard
Dec-22	2	5



MRSA

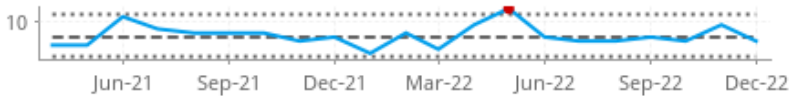
Month	Performance	Standard
Dec-22	1	0

MSSA

Month	Performance	Standard
Dec-22	7	3

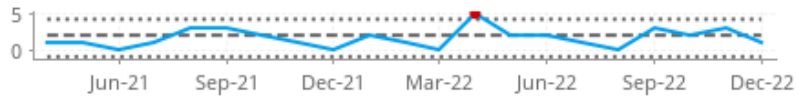
Ecoli

Month	Performance	Standard
Dec-22	5	6



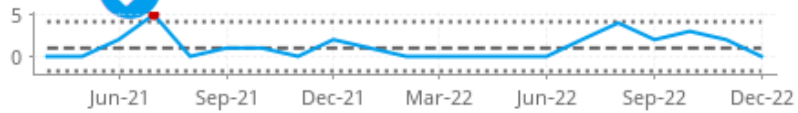
Klebsiella

Month	Performance	Standard
Dec-22	1	2



Pseudomonas

Month	Performance	Standard
Dec-22	0	1



CAUTI

Month	Performance	Standard
Dec-22	10	19

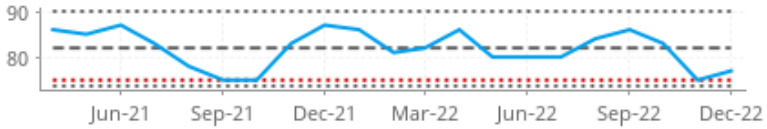
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SCP) Charts

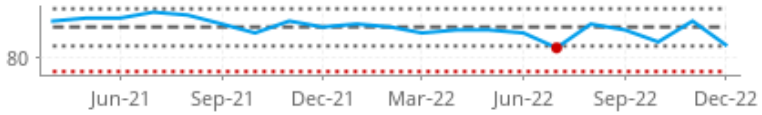
FFT Emergency Care

Month	Performance	Standard
Dec-22	77.00%	75.00%



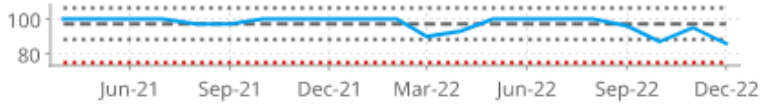
FFT Inpatient

Month	Performance	Standard
Dec-22	84.00%	75.00%



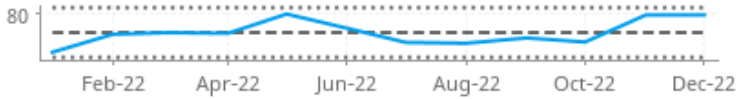
FFT Maternity

Month	Performance	Standard
Dec-22	86.00%	75.00%



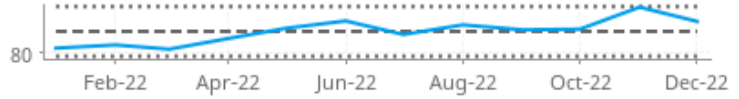
UNIFY RN Day

Month	Performance	Standard
Dec-22	79.87%	>=80% and <=109.99%



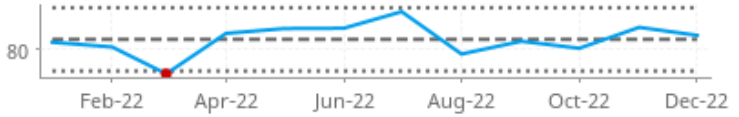
UNIFY RN Night

Month	Performance	Standard
Dec-22	90.06%	>=80% and <=109.99%



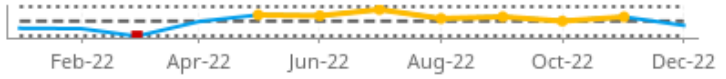
UNIFY HCA Day

Month	Performance	Standard
Dec-22	84.55%	>=80% and <=109.99%



UNIFY HCA Night

Month	Performance	Standard
Dec-22	119.66%	>=110% and <=125.99%



Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	*Performance*	*Standard*	*Trend*	
Sickness - Overall					The sickness absence rate saw a decrease in November 2022, to 6.05% from 6.17%. This was split by 5.37% non-COVID and 0.68% COVID related absence (Covid decreased from 0.72% in October 2022). Short term absences have decreased by 0.2% and make up 3.08% of the absence figure with long term absences making up 2.97%. Mental health conditions (stress / anxiety / depression) continued to be the most common reason for absence followed by chest and respiratory problems and musculoskeletal problems. The review of pathways for both short and long term absent management processes continues with some positive outcomes identified. A further review of the sickness absence policy is taking place with full engagement of senior clinical matrons and other stakeholders including staff side.
	Nov-22	6.05%	4.00%		
Sickness Breakdown					
Short Term	Nov-22	3.08%			
Long Term	Nov-22	2.97%			

Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Appraisals				
✖	Dec-22	84.92%	95.00%	
Turnover				
✖	Dec-22	10.21%	10.00%	
Mandatory Training				
✖	Dec-22	88.04%	90.00%	

Narrative

Appraisals -
The position for appraisal compliance from December's overall Trust RAG report stands at 84.92% which is a decrease from 85.86% in November 2022 (amber). The slight decline in appraisal rates during the month of December is not an unusual one, with this trend occurring in 2019, 2020 and 2021 and is a result of annual leave and winter pressures.

Staff Turnover -
There has been a further reduction in turnover in December from 10.55% to 10.21%, which is the closest to the target of 10% in more than a year and the ninth consecutive month seeing a move towards target. Feedback from staff is vital in addressing retention issues, both during employment as well as from people considering leaving employment. Actions from the engagement platform, through Clever Together, has provided valuable intelligence to ensure our recognition strategy is appropriate. The 2022 Staff Survey data has recently been released and is currently being analysed with expectation of action plans being developed locally to address any gaps and or concerns.

Mandatory Training –
Compliance increased from 86.94% in November 2022 to 88.04% in December 2022. Resuscitation training, Patient Safety (Level 1), Duty of Candour and Catheterisation training have the lowest compliance levels; with Safeguarding Children and Adults are also significantly below the expected target.

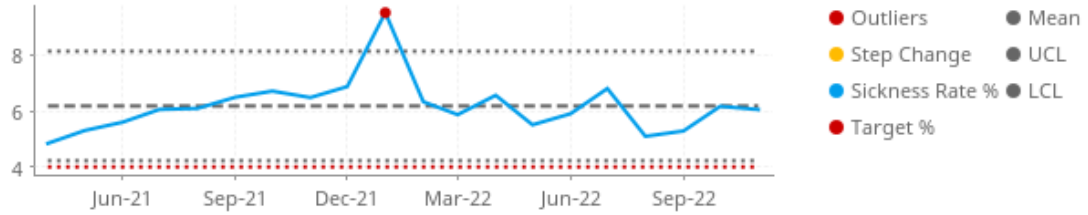
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

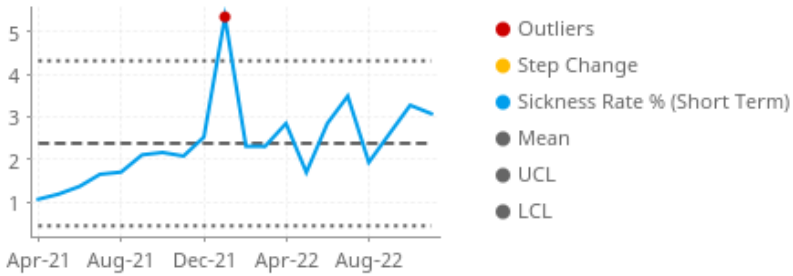
Sickness - Overall

Month	Performance	Standard
Nov-22	6.05%	4.00%



Short Term

Month	Performance
Nov-22	3.08%



Long Term

Month	Performance
Nov-22	2.97%

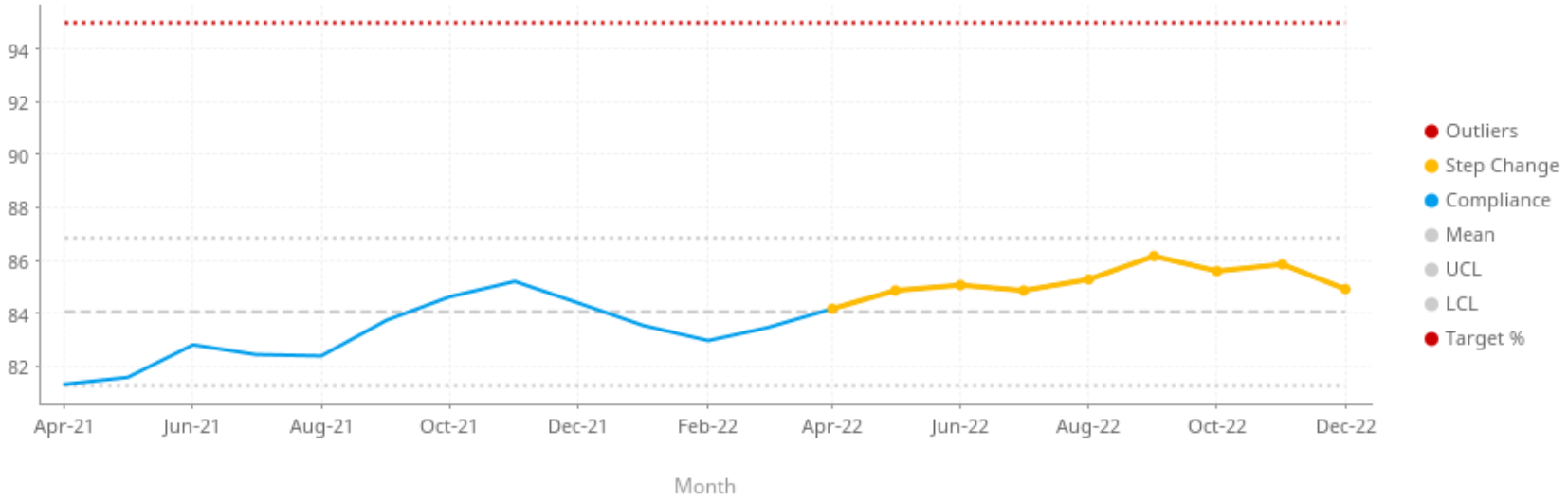
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Appraisal

Month	Performance	Standard
Dec-22	84.92%	95.00%



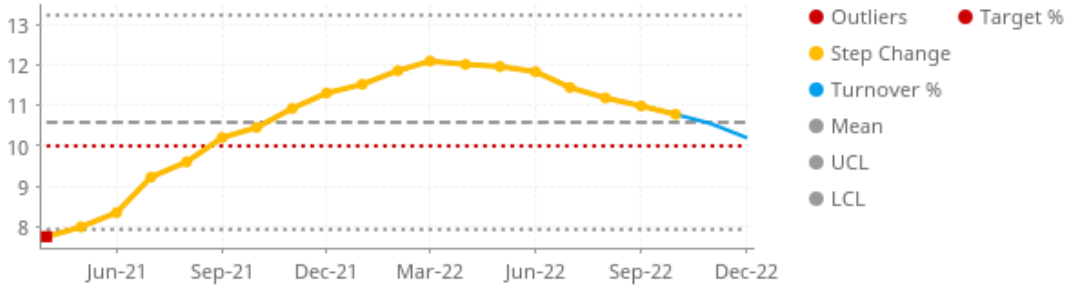
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

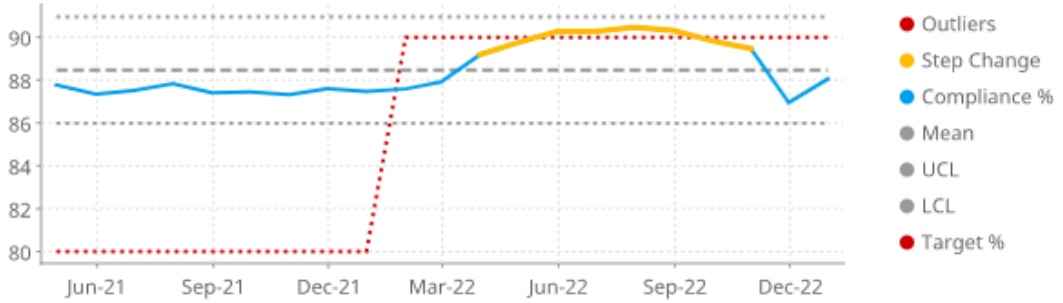
Turnover

Month	Performance	Standard
Dec-22	10.21%	10.00%



Mandatory Training

Month	Performance	Standard
Dec-22	88.04%	90.00%



Finance

34

NHS
North Tees and Hartlepool
NHS Foundation Trust

Finance Overview - Month 9

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	(2)	389	☺
Year to Date	4,742	5,484	☺

Balance Sheet

£m

Cash Actual	71.8
Cash Plan*	66.8

*Explained by an improvement in the 2021/22 cash position

Capital (*)

	Plan (£m)	Actual (£m)	
In Month	1,966	2,693	☺
Year to Date	8,949	9,658	☺

* Capital plan rephased to commence from 01 July 2022

NHS Oversight Framework (Issued 27 June 2022)

Financial Efficiency - Variance from Efficiency Plan	🟢	Achievement of Mental Health Investment Standard	NA
Financial Stability - Variance from Break-even	🟢	Agency Spending	🔴

NHS
North Tees and Hartlepool
NHS Foundation Trust

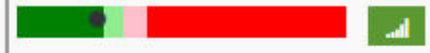
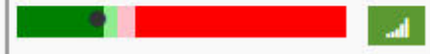
Appendix 1

RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT – November 22										
Incomplete Pathways waiting <18 weeks	60.1%		78.8%	76.4%	59.8%	72.1%	69.4%	82.9%	66.9%	63.9%
Half of incomplete patients wait less than	14		8	9	14	10	11	9	12	12
Half of admitted patients wait less than	12		9	18	21	14	12	12	9	7
19 out of 20 admitted patients wait less than	67		36	45	63	53	63	45	55	62
Half of Non admitted Pathways waited less than	9		5	8	10	5	7	8	5	9
19 out of 20 non admitted patients wait less than	54		33	33	50	38	41	36	32	38
Incomplete Pathways waiting >52 weeks	379316		40	108	764	95	4271	25	1466	2084

Cancer Waiting times Summary		S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals		93.07 (1410/1515)	81.72 (1198/1466)	86.28 (1038/1203)	68.98 (1743/2527)	92.48 (1686/1823)	65.93 (1229/1864)	89.54 (1139/1272)	77.19 (1689/2188)	80.33 (11132/13858)
Breast Symptomatic Referrals		0 (0/0)	72.6 (53/73)	89.74 (35/39)	53.09 (86/162)	95.12 (156/164)	88.89 (8/9)	89.77 (193/215)	78.17 (154/197)	79.74 (685/859)
31 Day First Treatments		99.53 (211/212)	92.73 (102/110)	100 (157/157)	80.49 (429/533)	96.93 (158/163)	91.44 (267/292)	95.97 (143/149)	89.7 (148/165)	90.68 (1615/1781)
31 Day Subsequent Treatments - Drugs		100 (123/123)	100 (3/3)	100 (59/59)	98.73 (233/236)	100 (43/43)	94.44 (68/72)	100 (65/65)	100 (4/4)	98.84 (598/605)
31 Day Subsequent Treatments - Radiotherapy		0 (0/0)	0 (0/0)	0 (0/0)	97.25 (460/473)	0 (0/0)	86.07 (173/201)	0 (0/0)	0 (0/0)	93.92 (633/674)
31 Day Subsequent Treatments - Surgery		94.74 (18/19)	66.67 (6/9)	100 (21/21)	67.86 (95/140)	83.33 (10/12)	91.67 (11/12)	100 (7/7)	78.26 (18/23)	76.54 (186/243)
62 Day Target - 2WW		66.55 (91.5/137.5)	51.63 (47.5/92)	64.9 (49/75.5)	49.88 (108/216.5)	73.15 (79/108)	58.62 (109.5/188.5)	64.63 (47.5/73.5)	72.73 (76/104.5)	61.14 (608/996)
62 Day Target -Screening		50 (0.5/1)	60 (3/5)	83.75 (33.5/40)	50 (22/44)	80 (4/5)	95.24 (10/10.5)	78.75 (31.5/40)	42.86 (3/7)	70.49 (107.5/152.5)
62 Day Target - Upgrade		84.78 (19.5/23)	95.65 (11/11.5)	0 (0/0.5)	61.64 (22.5/36.5)	68.42 (6.5/9.5)	81.16 (28/34.5)	87.5 (14/16)	70.37 (9.5/13.5)	76.55 (111/145)
28 Day Target - 2WW		71.71 (1019/1421)	66.08 (908/1374)	80.76 (873/1081)	76.59 (1688/2204)	72.62 (1260/1735)	76.9 (1062/1381)	83.38 (908/1089)	83.36 (1533/1839)	76.3 (9251/12124)
28 Day Target -Breast Symptomatic		0 (0/0)	83.33 (60/72)	100 (36/36)	92.81 (142/153)	94.55 (156/165)	100 (9/9)	98.6 (211/214)	95.81 (183/191)	94.88 (797/840)
28 Day Target - Screening		55.56 (5/9)	40 (2/5)	58.21 (78/134)	75.8 (119/157)	74.24 (49/66)	0 (0/1)	67.18 (131/195)	58.49 (31/53)	66.94 (415/620)
28 Day Target - Overall		71.61 (1024/1430)	66.85 (970/1451)	78.9 (987/1251)	77.53 (1949/2514)	74.52 (1465/1966)	76.99 (1071/1391)	83.44 (1250/1498)	83.87 (1747/2083)	77.02 (10463/13584)

Standard Indicator Set: Operational Efficiency	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2022)	8.46% (Oct 2021 - Sep 2022)	8.48% (Sep 2021 - Aug 2022)	-0.02 ↓	7.36%	7.09%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2022)	1.91% (Oct 2021 - Sep 2022)	1.89% (Sep 2021 - Aug 2022)	0.02 ↑	2.26%	1.90%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2022)	4.43% (Oct 2021 - Sep 2022)	4.43% (Sep 2021 - Aug 2022)	No Change	4.89%	4.10%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2022)	6.82% (Oct 2021 - Sep 2022)	6.85% (Sep 2021 - Aug 2022)	-0.03 ↓	6.96%	5.82%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2022)	9.72% (Oct 2021 - Sep 2022)	9.75% (Sep 2021 - Aug 2022)	-0.03 ↓	9.45%	7.90%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Dec 2022)	8.45% (Nov 2021 - Oct 2022)	8.47% (Oct 2021 - Sep 2022)	-0.02 ↓	8.61%	7.83%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Dec 2022)	2.53 (Nov 2021 - Oct 2022)	2.53 (Oct 2021 - Sep 2022)	No Change	2.32	2.14	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Dec 2022)	0.00% (Nov 2021 - Oct 2022)	0.00% (Oct 2021 - Sep 2022)	No Change	9.08%	9.81%	
Rate of telephone or Telemedicine consultations (12 mth rolling) HES Outpatients (Dec 2022)	20.39% (Nov 2021 - Oct 2022)	20.58% (Oct 2021 - Sep 2022)	-0.19 ↓	18.55%	20.69%	
Rate of telephone or Telemedicine consultations for followup consultation (12 mth rolling) HES Outpatients (Dec 2022)	21.30% (Nov 2021 - Oct 2022)	21.45% (Oct 2021 - Sep 2022)	-0.15 ↓	19.97%	23.21%	
Rate of telephone or Telemedicine consultations for first consultation (12 mth rolling) HES Outpatients (Dec 2022)	18.08% (Nov 2021 - Oct 2022)	18.40% (Oct 2021 - Sep 2022)	-0.32 ↓	15.25%	15.44%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Dec 2022)	86.24% (Nov 2021 - Oct 2022)	86.58% (Oct 2021 - Sep 2022)	-0.34 ↓	78.44%	77.23%	
Cancer waiting times - 28-day Faster Diagnosis Standard (12 mth rolling) Cancer Waiting Times (Dec 2022)	80.39% (Nov 2021 - Oct 2022)	80.51% (Oct 2021 - Sep 2022)	-0.12 ↓	76.61%	70.11%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Dec 2022)	96.26% (Nov 2021 - Oct 2022)	96.61% (Oct 2021 - Sep 2022)	-0.35 ↓	90.52%	92.30%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Dec 2022)	63.02% (Nov 2021 - Oct 2022)	64.82% (Oct 2021 - Sep 2022)	-1.80 ↓	64.26%	63.05%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Dec 2022)	76.09% (Nov 2021 - Oct 2022)	76.21% (Oct 2021 - Sep 2022)	-0.12 ↓	66.06%	61.25%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Dec 2022)	83.55% (Nov 2021 - Oct 2022)	84.59% (Oct 2021 - Sep 2022)	-1.04 ↓	82.88%	73.44%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Dec 2022)	81.33% (Nov 2021 - Oct 2022)	82.00% (Oct 2021 - Sep 2022)	-0.67 ↓	71.85%	58.14%	
Day case realisation rate (12 mth rolling) HES Inpatients (Dec 2022)	96.95% (Nov 2021 - Oct 2022)	96.85% (Oct 2021 - Sep 2022)	0.10 ↑	96.72%	96.69%	

Day case rate (12 mth rolling) HES Inpatients (Dec 2022)	85.38% (Nov 2021 - Oct 2022)	85.28% (Oct 2021 - Sep 2022)	0.10 ↑	85.04%	73.07%	
Average excess length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.15 (Nov 2021 - Oct 2022)	0.11 (Oct 2021 - Sep 2022)	0.04 ↑	0.42	0.60	
Average length of stay (12 mth rolling) HES Inpatients (Dec 2022)	3.27 (Nov 2021 - Oct 2022)	3.24 (Oct 2021 - Sep 2022)	0.03 ↑	4.02	4.85	
Average elective length of stay (12 mth rolling) HES Inpatients (Dec 2022)	1.87 (Nov 2021 - Oct 2022)	1.82 (Oct 2021 - Sep 2022)	0.05 ↑	3.27	4.56	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Dec 2022)	3.43 (Nov 2021 - Oct 2022)	3.40 (Oct 2021 - Sep 2022)	0.03 ↑	4.14	4.87	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.21 (Nov 2021 - Oct 2022)	0.21 (Oct 2021 - Sep 2022)	No Change	0.22	0.24	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.01 (Nov 2021 - Oct 2022)	0.01 (Oct 2021 - Sep 2022)	No Change	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.37 (Nov 2021 - Oct 2022)	0.37 (Oct 2021 - Sep 2022)	No Change	0.42	0.49	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.82 (Nov 2021 - Oct 2022)	0.83 (Oct 2021 - Sep 2022)	-0.01 ↓	1.02	0.97	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	0.20 (Nov 2021 - Oct 2022)	0.20 (Oct 2021 - Sep 2022)	No Change	0.31	0.26	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2022)	1.29 (Nov 2021 - Oct 2022)	1.30 (Oct 2021 - Sep 2022)	-0.01 ↓	1.76	1.85	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Dec 2022)	36.03% (Nov 2021 - Oct 2022)	36.06% (Oct 2021 - Sep 2022)	-0.03 ↓	40.37%	34.74%	
Elective stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Dec 2022)	5.14% (Nov 2021 - Oct 2022)	5.10% (Oct 2021 - Sep 2022)	0.04 ↑	11.20%	12.36%	
Emergency stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Dec 2022)	17.14% (Nov 2021 - Oct 2022)	17.06% (Oct 2021 - Sep 2022)	0.08 ↑	18.32%	21.80%	
Elective super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Dec 2022)	0.58% (Nov 2021 - Oct 2022)	0.56% (Oct 2021 - Sep 2022)	0.02 ↑	2.11%	3.17%	
Emergency super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Dec 2022)	3.10% (Nov 2021 - Oct 2022)	3.06% (Oct 2021 - Sep 2022)	0.04 ↑	5.06%	6.21%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Dec 2022)	88.81% (Nov 2021 - Oct 2022)	91.42% (Oct 2021 - Sep 2022)	-2.61 ↓	72.84%	77.77%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Dec 2022)	0.31% (Nov 2021 - Oct 2022)	0.29% (Oct 2021 - Sep 2022)	0.02 ↑	0.90%	0.89%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Dec 2022)	82.67 (Nov 2021 - Oct 2022)	82.15 (Oct 2021 - Sep 2022)	0.52 ↑	98.84	101.02	Very low (>99.8%)

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Capital Programme Performance Q3 – 2022/23										
Date:	26th January 2023										
Prepared by:	Steven Taylor, Assistant Director of Estates and Capital NT&HS LLP										
Executive sponsor:	Neil Atkinson, Director of Finance										
Purpose of the report	The purpose of this report is to provide the Board of Directors with an update as of 31 December 2022 (Quarter 3) on the progress of delivering the 2022/23 capital programme, along with the current forecast position, highlighting any risks in delivery.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

<u>Capital Programme Delivery 2022/23</u>

The Trust's overall capital programme plan at month 9 is £21.983m of which:

- CDEL amounts to £21.584m (this includes internally funded schemes, IFRS16 new leases and PDC expected in year), and;
- Donated/grant funded assets are £0.399m

The capital programme demonstrates a continued commitment and investment to reducing the estates backlog, medical equipment, IT developments and supporting the Pathology collaboration. There is also a prudent contingency of £1.5m for emerging capital issues and business cases.

The annual capital plan for 2022/23 (detailed by scheme) was presented and approved at the Capital and Revenue Management Group on 29th July 2022.

Capital Spend Phasing

The annual phasing of the capital plan is 14% from July to September, 28% from October to December and 58% from January to March.

Month 9 Position

As at month 9, the Trust has spent £9.7m, against a year-to-date CDEL plan of £9.0m.

Slippage

There is identified slippage relating to pathology collaboration and robot enabling works. Capital Managers continue to present plans at monthly CRMG meetings to support overall delivery.

Forecast

The Trust has a strong track record of delivery of its capital programme. Due to identified delays relating to pathology collaboration and robot enabling works, there is a forecasted underspend of

£2m. The capital programme is underpinned by the capital performance framework which is reported to the Capital & Revenue Management Group each month. Full details of capital programme delivery is contained in the attached report.
How this report impacts on current risks or highlights new risks:
This report doesn't highlight any new risks.

Committees/groups where this item has been discussed	Capital and Revenue Management Group
Recommendation	The Board is asked to; • Note the contents of this report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26 January 2023

Capital Programme Performance Q3 2022/23

Report of the Director of Finance

Strategic Aim

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

Transforming our Services

1. Introduction / Background

1.1 The purpose of this paper is to provide an update as of 31 December 2022 (Quarter 3) on the progress of delivering the 2022/23 capital programme and also provide an update on any recent changes that have been announced nationally and regionally that will impact on the Trust's programme.

1.2 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.

2. Main content of report

2.1 The Trust's overall capital programme plan at month 9 is £21.983m and is broken down as follows;

- CDEL is £21.584m (this includes internally funded schemes, IFRS16 new leases and PDC expected in year), and;
- Donated/grant funded assets are £0.399m

The plan demonstrates a continued commitment and investment to reducing the estates backlog, medical equipment, IT developments and supporting the Pathology collaboration. There is also a prudent contingency of £1.5m for emerging capital issues and business cases.

The annual capital plan for 2022/23 (detailed by scheme) was presented and approved at Capital and Revenue Management Group on 29th July 2022.

As at month 9, the Trust has spent £9.7m against a year-to-date plan (CDEL) of £9.0m.

Please note that the current month plan for January, February and March is £4m per month, so there is significant pressure on the capital programme in quarter 4.

2.2 **Estates**

Total expenditure on Estates schemes is £7.0m at the end of December 2022 against a year to date budget of £4.5m, so ahead of plan by £2.5m. Estates schemes include backlog, hospital re-development (SOC/OBC), robot enabling works and pathology collaboration.

2.3 **Medical Equipment**

Total expenditure on Medical Equipment schemes is £1.4m at the end of December 2022, against a year to date budget of £0.5m, so is ahead of plan by £0.9m.

2.4 **Information and Technology Services and Digital Strategy**

Total expenditure on IT&S schemes is £1.2m at the end of December 2022, against a year to date budget of £1.1m, so ahead of plan by £0.1m.

2.5 **Contingency**

Total expenditure on contingency schemes is £0.0m against a plan of £2.8m so behind plan by £2.8m.

2.6 **Forecast 2022/23**

The capital forecast for the year at December 2022 includes £2.0m slippage on the capital programme which is due to delays in spend on the pathology collaboration, robot enabling works and the hospital re-development, offset by estates backlog and medical equipment brought forward from future years.

2.7 The overall detailed work-stream reports for Q3 are presented in **Appendix 1**.

2.8 The overall financial summary for the period to 31 December 2022 is presented at **Appendix 2**.

3. Recommendation

3.1 The Board is requested to receive this report and note the position on capital schemes up to 31 December 2022.

3.2 The Board are also asked to acknowledge the £2m forecast underspend against the 22/23 plan of £22m.

Neil Atkinson
Director of Finance

Gillian Colquhoun
Interim Chief Information and Technology Officer/SIRO

Appendix 1 - Work Stream Reports

1. Estates Backlog Maintenance Programme

The 2022/23 backlog maintenance capital allocation was broken down into categories and specific projects to target high and significant risk backlog issues. CIR is currently £19.6m out of overall Trust backlog of £49.2m. An overall programme covering all backlog projects was developed and project managers assigned for each project.

A detailed spend profile project by project was developed. This allows for monthly reporting against time and cost for the overall programme (as required by NHSE). £11.14m has been allocated to Backlog Maintenance which includes £1.658m of pre-commitments carried forward from FY2021/22. £2.12m has been allocated for service developments.

Lift Replacement UHH: Replacement of the 3 ageing lifts in the acute block at UHH. Two lifts have been completed including one with a bed evacuation capability. Work is planned to be completed on the final lift by end of Q4.

DDA Audit: The draft final access audit report has been reviewed and additional surveys requested with final report being provided in Q4. Any areas of concern deemed urgent will be picked up in FY23/24 capital programme.

Roofing Repairs UHH: Phase 2 works planned for FY22/23 have now been completed. Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

Intrusive Structural Surveys – UHNT: In response to concerns raised by Faithful and Gould/WS Atkins in the 6 Facet Survey further more detailed intrusive surveys were carried out to assess the extent of any additional remedial works to ensure the building remains safe and operational for the remainder of its 9 year life.

The works have now been fully costed and commenced on the 10th October for 26 weeks with completion this financial year.

South Wing: The removal and replacement of all the existing mastic to prevent any further corrosion and carry out local repairs as needed. Some panels have significant cracks and need to be replaced. Mullions on the South Wing have previously been covered with sheeting without any remedial work being carried out and this is being rectified now with anticipated completion by end of Q4.

Tower Block: Above ground level there is evidence of cavity wall ties installed both during construction and also retrospectively. The outer and inner leaves are not cross bonded and there is no significant cavity between the two leaves. The retrospective ties are M10 Stainless Steel rod drilled and resin anchored into the ring beam and outer leaf (inner leaf is built from the top of the ring beam).

Works to Tower Block commenced at the end of October and includes additional wall ties and pigeon spikes. Anticipated completion by end of Q4.

Hospital Streets: There is evidence of the primary support steelwork starting to fail due to water ingress. There is also signs of corrosion to the primary pipework in the locations of the supports.

Removal of the redundant gas pipe and fitting of additional support brackets has been completed. NTH Solutions are conducting significant engagement with the clinical teams in the impacted areas to minimise disruption.

Fire Door Replacement UHNT / UHH: The fire door replacement programme is ongoing with fire doors being repaired / replaced / upgraded due to operational damage and change of use over the life of the buildings. Fire doors have been replaced for high risk areas including main staircase and the main circulation corridors around the lower ground floor and ground floor.

The replacement works will continue on both main sites into FY2022/23. West Wing remains a high priority for FY2022/23 and 2023/24.

West Wing Fire Precautions: Initial remedial works were carried out and the alignment of the fire compartmentation started mid July 2022 on the first floor and within the roof space. A lift has been upgraded to a patient evacuation lift by Kone. The estates work in the roof void have been completed and the Fire Officer has inspected and is satisfied. The changes to the fire strategy have been approved and implemented. Additional works are planned for FY23/24 but are subject to a ward decant (planned for spring/summer 23).

Fire Alarm Replacement UHH: The business case was approved in May 2020. Following an OJEU procurement tender, the project was awarded to TFS. The overall project cost is £1m, with £50K of spend in FY21/22 and the remaining spend in FY22/23. The project team has consistently worked closely with the clinical teams to arrange access to clinical areas and using installation methods agreed with Infection Prevention and Control. The installation, soak testing and changeover date were all completed by the end of Q3 22/23. The new system is now fully operational.

Replacement of the Combined Heat and Power Unit (CHP) UHH: Work has been undertaken to scope and size the replacement of the end of life CHP unit on the UHH site. The CHP generates the electricity for the site and the waste heat from the engine is used to heat the hot water and heating requirement for site whilst reducing the energy bill for the Trust. As the challenge to achieve net zero carbon gathers pace, the unit will be designed to use a blend of hydrogen and natural gas to reduce carbon emissions when the gas network is capable of a blended supply. The plant will also form the resilient backup and provide flexibility to support future renewable energy plant, such as solar PV and ground source heat pumps (which cannot provide consistent energy 24/7).

The new CHP will ensure energy is provided consistently when required on site. The CHP will be a part of the sites future energy mix to deliver net zero carbon. The procurement stage has now been completed with Veolia being the successful bidder, the order has been placed and installation has commenced. Approval obtained from Environment Agency. Discussions underway with Northern Power Grid to finalise connection date in Q4.

The cost of the replacement CHP is £640k and is planned to payback in energy cost savings to the Trust in 4-5 years. The plant has a 10 year lifespan and is planned to be completed by Q4 of FY2022/23.

2. Other Estates Capital Developments

Community Diagnostic Hubs: Collaborative planning continues to deliver the Tees Valley element of the national plan to develop hub and spoke arrangements for diagnostic facilities outside of acute settings and within the community. Plans have been developed for the spokes at UHH, Stockton (Lawson Street) and Redcar (South Tees). The spoke delivering additional MRI scanning capability became operational on the UHH site at the end of September with Respiratory and CT scanning services operational in Q1 FY2022/23.

Works associated with Cardiology services at Lawson Street were completed by the end of March 2022.

An independent option appraisal was carried out by P+HS Architects to determine the location of the main hub (Stockton or Middlesbrough). The Waterfront development in Stockton is the recommended location and this will feed into the business case seeking capital funding approval. The CDC Estates Project Group, which includes representatives from North Tees, CCG, NHS PS and South Tees

supported the recommendation.

PA Consulting have been appointed to support development of the 2022/23 business case for design and development of the main hub.

There have been ongoing issues with regards Virgin Media installing the required fibre link between North Tees and South Tees and Lawson Street to North Tees (Trust order raised in February 22). The project team has raised formal complaint with Virgin Media CEO and CISAS (Ombudsman). The installation for the North and South Tees link has been completed. The Lawson Street works are scheduled to be completed by mid-January 2023.

Pathology Collaboration: The project team has been established and external design team appointed. Work to develop the 1:100 drawing for the new cellular pathology has been agreed and signed off by pathology stakeholders from North Tees and South Tees. The overall estate plan was for microbiology to be vacated and works to commence in November with completion by Q1 of 23/24. This has been delayed due to the appropriate staff consultation process.

Training Academy (Ward 10 UHH): Hartlepool Borough Council were successful in securing a £25million pound bid from the Towns Fund. This included a £1.2 million pound project to develop a medical training academy on Ward 10 at UHH. The funding is via Hartlepool Borough Council, however, the Trust agreed to fund the first £50,000 for the initial design in FY21/22 which has now been fully expended.

Theatre Robots: Forming part of the wider clinical strategy, split over two key phases, for the development of perioperative services over the coming years. The purpose of this perioperative services strategy is to support the delivery of the Trusts business and dovetail the south ICP clinical services strategy.

Phase 1 additional (larger) theatre to facilitate robotic surgery in location of current storage and changing facilities. Relocation of displaced storage and changing facilities. Refurbishment and structural upgrade to theatre 1 and transformation into an integrated theatre.

Phase 2 of the theatre estate development plan concentrates on theatres 9 & 10, and the potential for development steered by the needs of the ICS.

Trust has approved the Theatre Robot project can proceed. Design will progress until end of FY22/23.

Strategic Outline Case: The SOC has been completed and went to Transformation Committee on 18th August 2022 and is provisionally going to Trust Board in January 23.

The Trust are progressing preparatory work in conjunction with the external advisors (P&HS, Driver Group and PA Consulting). 4 key work streams have been identified (Estates and Commercial, Finance, Clinical and PMO/Strategic) and groups formed to provide input to establish the key OBC requirements. Programme dates to be reviewed following decision by Trust Board regarding the SOC.

Carbon Reduction UHNT: The advice received from our external advisors (Veolia) is that the North Tees site is unlikely to receive grant funding due to the new energy centre development. The schemes being proposed for North Tees therefore requested internal capital funding (£1.4m FY22/23).

The following investment was approved at CRMG in July:-

- £1.1m - Solar PV: A proposal has been made for 480kWp -600kWp of solar arrays for the roof spaces (avoiding roofs with 10 year life spans). Based on Capital investment of £1.1M, and newer technology would suggest a ROI of nearer 5-6 years. Potential savings of £150,000 to £200,000 per year (225TonnesCO2e).

- LED Lighting: 70% of existing lights within the Trust are now LED. A value of £150,000 this FY would be a significant step towards 100% LED lighting. From previous LED lighting schemes, the Trust can evidence that a ROI in 2-3 years is achievable, so saving of £50,000 to £75,000 per year (125TonnesCO2e) are realistic and prudent.

The approved funding will be spent in 2022/23.

Carbon Reduction UHH: The Trust have applied for external grant funding for UHH, which satisfies the qualifying requirements of the government's Public Service Decarbonisation Scheme (PSDS) funding. The grant funding application process (controlled by Salix) went live on 12th October 2022 and organisations are required to fund 12% of the overall cost over the next 2 financial years. The bid is for £14.1m so requires Trust funding for circa £2.2m.

At Capital Revenue Management Group on 26th August 2022 approval was received for NTH Solutions to submit the bid on behalf of the Trust. A decision is expected by the end of January with funding release by Salix to successful bidders in April 2023. This is a 2 year programme so would be completed by end of March 2025 and Trust funding could be spread over 2 FY's. (23/24 and 24/25).

3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against an initial allocation of £2.65m plus a further allocation of £2.1m, a total of £4.75m. The total value of orders placed by the Trust is £3.39m. The Trust has taken delivery of the following equipment;

Endoscopy equipment

- A duodenoscope to allow direct access to bile or pancreatic ducts.
- Balloon Enteroscope for small intestine assessment
- Argon diathermy for Endoscopic procedures
- 2 x Gastroscopy scopes for examination of the stomach
- 2 x Colonoscopy scopes for examination of the colon and rectum

Ultrasound equipment

- 5 x Ultrasoound scanners for various locations in Breast screening and Radiology
- 1 x Ultrasound for fluoroscopy at North Tees
- 1 x Ultrasound for Lawson street

QC Laboratory equipment

- Photometer for A photometer measuring the strength of electromagnetic radiation in the range from ultraviolet to infrared and including the visible spectrum.
- Phocheck VOC Gas detector

Paediatrics

- 7 x Vital signs monitors

Audiology

- 3 x Audiometers for hearing assessment

Respiratory

- Ward based spirometer for lung function testing
- Overnight oximeters for measurement of blood oxygen saturation during a night of rest
- Embletta sleep study device
- 4 x Uninterruptable Power supplies for use with high flow ventilation for patient transfers

Theatres

- Lead aprons for X Ray personal protection
- 2 x Spinal operating tables
- 2 x |Diathermy for electrosurgery

Items currently in progress are;

- Ultradymics equipment for Urinary studies
- 5 x examination couched for UHH outpatients
- Endotoxin meter for detection of bacterial endotoxins
- Medical Gas analyser to test the quality of hospital medical gases
- X ray equipment for Room 1 Orthopaedics
- X Ray equipment for Fluoroscopy
- Image intensifier X Ray for Theatres
- Phlebotomy Chairs and Trolleys
- 2 x incubators for Pathology
- Paediatric Ventilator for A&E
- Ultrasound for Breast screening
- Surgical Power tools for Theatres
- General operating table for Theatres
- 5 x Oxylog portable ventilators to replace obsolete units on ITU and A&E
- 2 x Echo machines –Ultrasound for Cardiology
- Pain management infusion pumps
- ECG recorder for Ward 4 UHH
- Vital signs monitors for Rutherford Morrison unit UHH
- 2 x Ultrasound for Theatres and ITU
- Resuscitaires for routine warming and emergency respiratory intervention on new babies

4. Information and Technology Services (I&TS)

The current I&TS capital plan incorporates elements of the Trust's Information and Communications Technology (ICT) and broader Digital Programmes capital projects.

CISCO Network Upgrade: a full upgrade of the wired network to the latest technology and replacement of the wireless network to support Trust wide projects. Cisco 5-year finance lease ended July 2022 – work now complete.

Desktop PC replacements: A three-year contractual payment plan to replace aging desktop computers to allow migration to Windows 10 – now complete.

TrakCare Hardware refresh: to replace the Infrastructure on which TrakCare system runs to ensure continual reliability of the system and support – work complete.

Out of Hospital Services tablet replacement: To replace Out of Hospital services equipment. 30 x13Yoga Think Pads have been ordered and are expected to be received January 23.

Laptop replacement: This is an on-going scheme to replace laptops within the Trust on a rolling basis.

Networking Hardware / Infrastructure:

- **Network switch replacement** – Ongoing scheme to upgrade and replace end of life hardware. Hartlepool core network to be upgraded from 4Tbps (Terabits per second) backbone speed to 12Tbps with supervisor 6T cards. Work complete as scheduled in July 2022.

- Fibre Cable replacement –to replace the remaining legacy fibre cabling for both (North Tees and Hartlepool) data networks. New cabling will support higher data transfer rates of up to 10Gbps (Gigabits per second). Current work is being carried out to complete the old residences blocks. This work is now complete.
- Firewall Switch replacement – Upgrade and replace end of life firewall hardware. Quantum appliance required to upgrade the Digital Pathology firewall that will also be utilised for Community Diagnostics. Appliance will provide greater port density and include 10Gbps connectivity – work now complete.
- Cyber Security – Vectra AI (Artificial intelligence) appliance to be upgraded at Hartlepool. Vectra AI is used to listen and monitor for network threats on all devices throughout the network – expected completion end of Q4.

Servers & Storage

- **Server replacement** – Ongoing scheme to replace end of life server hardware services including:
    - Horizon VDI expansion – Virtual desktop technology to be increased from 100 to 200 desktops enabling a more seamless remote access solution for system access outside of the Trust. Hardware nodes now installed with system level setup now complete.
    - OPSWat –NAC (Network Access Control) for Internet access to Horizon. Cloud based posture assessment that evaluates the security states of the connecting system. Delays due additional blade hardware requiring additional memory and CPU. Hardware to be upgraded by March 31st. Deployment of OPSWat to follow from April onwards.
- Additional Dell Blade Centre
    - New Dell Blade Centre to be installed in the A&E server room in order to provide resilience for existing virtual environment (currently in lower ground server room). Solution will provide resilience and allow us to relocate duplicate servers (where they exist) which will allow us to maintain service during any future outages. Expected completion by the end of Q4.
- File Storage – Dell / EMC Cyber Sense which is an off line cloud based backup storage service which enables the secure off site storage of data –Now installed, fully commissioned and complete.
- Data Protection suite and Residency days for Dell / EMC Cyber Sense – sign off complete. Phase 1 implementation work completed during July. Phase 2 work to begin week commencing 17th October 2022. Expected completion by the end of Q3, this work is now complete.

Telecomms

- **VC expansion** – Additional video conference facilities to support both Microsoft Teams and CMS (Cisco Meeting Service) collaboration. Expected competition Q3.

Office Facilities

- **Switchboard Infrastructure** – Revamp of switchboard facilities to create additional space. Removal of disabled toilet and improved breakout area. Minor works raised in June circa £20k – this work is now complete.

- ***ICT Office*** – Infrastructure – reconfiguration of ICT office to support a better working environment – complete.

5. Digital Strategy – Progress on developments

FY 2022/23 capital funding allocation is £0.805m, this will enable the Trust to digitise all nursing admission documentation (NAD) into TrakCare EPR and also enable the full potential of an integrated patient record to be fully realised within Critical Care.

Below is a brief overview and update on schemes within the digital programme:

Nurse Admission Documentation (NAD) – Work to re-align the Nursing Admissions project plan with the TrakCare T2022.6 Upgrade plan has now been complete. Key milestones from the TrakCare T2022 Upgrade project plan are being reviewed and detailed interdependencies across the various projects are being highlighted. Clinical "show & tell" validation sessions have commenced in January 2023. Full user acceptance testing is planned to take place during February, with training scheduled to take place during March. Both user acceptance testing and training elements are critically dependent on delivery of milestones within the TrakCare Upgrade plan, which is to be monitored closely. Early deployment of laptops and carts (20 in total) has commenced in advance of project go live, to allow nursing teams to utilise the equipment to alleviate existing equipment pressures. Handover of the Project Manager role is now complete with the interim PM leading the project from mid-December onwards.

ITU - The PID, plan and Solution Proposal submitted to DPSG for formal approval to proceed. The ITU module Change Control Note has now been signed. ITU requested a reassessment with Parity around the placement of equipment to ensure it will be ergonomically safe. A session with some alternative equipment is arranged for 16th December for staff to test and provide feedback. The Mindray equipment was installed week commencing 5th December. Training is being provided by the supplier on the unit prior to and during install. Interface specifications for Mindray and Medicus are finalised. Configuration of the ITU flowsheet continues with ISC along with cross referencing paper processes to reduce duplication and improve efficiency. Work has also commenced on data gathering for ITU ePMA workflows.

My 'GNCR' aka PEP (Patient Engagement Platform) – To provide a secure portal to allow patients to take control of aspects of their care, by providing electronic access to elements of their own health records. The project plan is currently under review; targeting key milestones for (a) Technical Go-Live, (b) Soft Launch, (c) 1 Trust, and (d) roll out further trusts (North Tees and Gateshead are both progressing to being the first Trusts to connect). As part of the national Wayfinder initiative, funding was allocated for Greenfield Sites, this initially excluded GNCR. Subsequently, approval is now progressing to provide £2m allocation to GNCR programme to support the run costs associated with PEP with funding needing spent by 31 March 23. A Project Manager from NTH has been assigned to start building the case for change, this is expected to be finalised in February 23.

The proposal supports and enhances the regional strategy to link the pathways currently available through Health Call to the GNCR PEP providing a single integrated solution. The integration with the NHS App will provide a consistent patient user experience across all available pathways. In the first phase of rollout patients will be able to use their NHS App to:

1. View secondary care appointments in a single place
2. Access to relevant, locally curated information for appointments
3. View a single point of contact within their secondary care organisation
4. Book, change and cancel secondary care appointments (where functionality is already in place)

Prostate Cancer Stratified Follow Up – HealthCall have provided a copy of the overarching contract between HealthCall and the Academic Health Science Networks (AHSN), there are some ooutstanding queries from IG on the DPIA that NHS England are providing a regional perspective on for resolution.

COVID Virtual Ward (Oximitry@Home), DPIA still to be signed off to include the use of Bluetooth devices. Some further changes were needed following the initial testing that was undertaken, this additional development is underway.

BadgerNet - The Digital Midwife appointed and will be in post early January. The task list for the Digital Midwife is extensive and any further delays to this work will most certainly impact on the timescales for delivery. The service is currently looking at releasing a number of 'subject matter experts' from each of the departments to work on the current 'AS IS' processes required throughout community, antenatal, delivery and postnatal.

The Technical Team is assembled and work has begun on the interface specifications for TrakCare and 'Smart Pulse', the trusts imaging solution. A survey of CTG devices, the level of specification and additional infrastructure is being gathered by ICT to inform any further capital requirements.

EPMA Phase 2 (includes Infusions and will remove all remaining cardex) - The Warfarin change will be progressed in following the change freeze in place for the ECDS update Jan/Feb. Testing, training and communications are being prepared to support the change in process.

Insulin – the 'to be' (future state) process maps have been finalised, seeking final sign off. Risk assessments for four concerns have been produced and reviewed with the Clinical Safety Officer and proposed mitigation accepted. The charts will be progressing in line with the warfarin configuration. Once Adult Insulin is signed off, efforts will move to looking at Paediatric Insulin, however this is a more complex process. The team continue to contact other Trusts to see how this is being managed by other systems.

GMAWS (Alcohol Withdrawal) – the cconfiguration tested and signed off, ready to be progressed through change control into LIVE, once Health Records Committee approve the form for use.

Approval by the Steering Group given to progress the Set Cumulative Doses and Frequency Interval Percentage Warning changes. Testing, training and communications are all being prepared for and the change will be progressed once the soft change freeze in place for ECDS is lifted.

EDM2 –The work to complete the outstanding technical milestones has now been scheduled; backup and recovery testing will complete 16th December, work to finalise the 500 patient records that failed to migrate from NHTop will complete early January (enabling the Trust to decommission NHTop and Documentum), and the build to enable full physical separation of servers for failover will be complete by end January 2023.

The rollout of MediViewer continues in Obstetrics and Gynaecology, with training for midwifery teams underway and a pre-go live workshop for the Obstetrics day forward scanning process held on 7th December. A successful proof of concept for Gynaecology MDTs with digitised records was also held on 7th December, with the service helping to design a process for MDTs where outcomes are currently recorded on paper. There have been ongoing issues raised with the availability of consent forms at the point of procedure by Gynaecology clinicians. The record flow between OPD, pre-assessment and access lounge has been further reviewed and controls put in place by the Trust Admin Manager/admin leads, and a paper with options for the way forward has been presented to the pilot clinicians.

The Trust continue to closely monitor planned episodes of care in other specialties where the record has been scanned ahead of a Gynaecology encounter; communications to service managers and Trust wide communications have been issued to outline the training and support offered by the project team.

CareScan+ Discussions held with Endoscopy Dept. and a demo arranged for Tuesday 13th December. It is anticipated that the Trust will be able to quickly implement CareScan+ into Endoscopy on both sites by January 2023. This will then allow focus on a CareScan+ implementation within

South Tees Endoscopy by the 31st March 2023.

Discussion held with colleagues at Derby and Burton NHS Foundation Trust (UHDB) who are still keen to progress a pilot/proof of concept by the 31st March 2023. A further discussion around potential project timescales is scheduled for January.

Northern Lincolnshire and Goole NHS Foundation Trust - a demo of CareScan+ was provided on 15th December 2023. They are keen to implement the Patient Care functionality throughout their Theatres.

The Wheelchair Service colleagues were very enthused by the Stock Take and Asset Tracking functionality and have requested CareScan+ Stock Take module is implemented into the Wheelchair & Orthotics Service ASAP, with a view of staging the other modules (Asset Tracking, Patient Care) over the next few months.

CareScan+ Clinical Lead has been appointed to Ish Ahmed. Ish is a Consultant in Upper GI and has a wealth of experience and knowledge around the Trusts Digital transformation agenda. Ish will provide 1PA support per week to the Project Team.

Appendix 2 – Capital Programme Financial Position as at 31st December 2022

Capital Plan, Actual and Commitments

Reporting period: 1st April 2022 to 31st December 2022

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Commitments 2022/23 £'000
CAPITAL PROGRAMME					
Estates Backlog					
Building Sub Structure	1,453	1,079	1,097	(18)	1,033
Compliance	2,019	1,582	2,743	(1,161)	600
Energy Conservation	1,867	457	481	(24)	132
Patient Environment	716	718	1,711	(993)	321
Service Developments	6,317	427	362	65	67
Estates Backlog Total	**12,372**	**4,265**	**6,395**	**(2,131)**	**2,152**
New Hospital support					
New Hospital Support	250	114	99	15	18
New Hospital Support Total	**250**	**114**	**99**	**15**	**18**
Robot Enabling Works					
Robot Enabling Works	150	29	52	(23)	192
Robot Enabling Works Total	**150**	**29**	**52**	**(23)**	**192**
Pathology Callaboration					
Pathology Callaboration	1,000	74	462	(388)	538
Pathology Callaboration Total	**1,000**	**74**	**462**	**(388)**	**538**
Medical Equipment					
Medical Equipment	3,326	482	1,400	(918)	1,662
Medical Equipment Total	**3,326**	**482**	**1,400**	**(918)**	**1,662**
IT					
ICT	1,650	1,114	754	359	178
IT Total	**1,650**	**1,114**	**754**	**359**	**178**
GDEFF					
GDEFF	0	0	1	(1)	8
GDEFF Total	**0**	**0**	**1**	**(1)**	**8**
Service Developments					
Contingency	1,654	2,871	34	2,837	0
Nurse Admission Hardware	141	0	80	(80)	0
TrakCare ITU Module	515	0	375	(375)	85
Service Developments Total	**2,310**	**2,871**	**489**	**2,382**	**85**
Tech Capital Funding					
Tech Capital Funding	350	0	0	0	0
Tech Capital Funding Total	**350**	**0**	**0**	**0**	**0**
IFRS16					
IFRS16	176	0	0	0	0
IFRS16 Total	**176**	**0**	**0**	**0**	**0**
Community Diagnostic Hub					
Community Diagnostic Hub - North Tees	0	0	(1)	1	32
Community Diagnostic Hub - South Tees	0	0	(0)	0	0
Community Diagnostic Hub Total	**0**	**0**	**(1)**	**1**	**32**
Targeted Investment Fund					
TIF	0	0	5	(5)	21
Targeted Investment Fund Total	**0**	**0**	**5**	**(5)**	**21**
TOTAL CDEL	**21,584**	**8,949**	**9,658**	**(709)**	**4,886**
TOTAL CDEL	**21,584**	**8,949**	**9,658**	**(709)**	**4,886**
DONATED ASSETS					
Donated					
Donated	399	297	116	181	9
Donated Total	**399**	**297**	**116**	**181**	**9**
Digital Pathology					
Digital Pathology	0	0	(51)	51	0
Digital Pathology Total	**0**	**0**	**(51)**	**51**	**0**
DONATED ASSETS TOTAL	**399**	**297**	**65**	**232**	**9**
GRAND TOTAL	**21,983**	**9,246**	**9,722**	**(476)**	**4,895**

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Elective Recovery Update								
Date:	26 January 2023								
Prepared by:	Alison Coates, Care Group Manager Rowena Dean, Care Group Director								
Executive sponsor:	Levi Buckley, Chief Operating Officer								
Purpose of the report	The purpose of this paper is to provide the Board of Directors with an update on the delivery of the 2022/23 elective recovery plans within the Trust including RTT waiting times, improvement work streams and the planning for a continued focus on recovery planning in 2023/24.								
Action required:	Approve		Assurance	✓	Discuss		Information	✓	
Strategic Objectives supported by this paper:	Putting our Population First	✓	Valuing our People	✓	Transforming our Services	✓	Health and Wellbeing	✓	
Which CQC Standards apply to this report	Safe		Caring		Effective	✓	Responsive	✓	Well Led ✓

Executive Summary and the key issues for consideration/ decision:

This paper seeks to provide assurance to the Board that the organisation is focused on:

- the patient level detail of current elective waits: (>104/78/52 and >40 week waiters)
- the growth required to continue to deliver the 104% activity target within funded establishment including workforce issues.
- plans to ensure all necessary arrangements are in place to protect capacity during the 22/23 winter period
- all associated risks, including financial, faced by the Trust in achieving the elective recovery plans including the provision of mutual aid for long waters within the wider Tees Valley and NENC ICB

Sustained pressures throughout the year peaked in November and December with significant impacts across the system. This has had a particular impact in UEC and medical services with all departments supporting at times of particular pressure. Against this backdrop and alongside further waves of covid and influenza infections the Trust has continued to focus on delivering safe and timely care for patients.

The Trust has zero patients waiting over 78/104 weeks for surgery and continues to support the wider system in driving these number down across the ICS. Further work is underway to model the waiting list shape and size through to March 2023 to ensure that the Trust can maintain a zero >78 and zero >104 week wait position.

As at 12 January, 37 patients were waiting more than 52 weeks. This equates to 7 on an inpatient pathway, of which 5 (71%) have a booked date, with the longest wait at 66 weeks. Of the 30 patients

on an outpatient pathway, 2 are awaiting diagnostic tests results. The remainder all have a booked appointment, with the longest wait at 77 weeks (booked date 19/01/2023) The health and wellbeing of the staff is paramount to the Care Group and the wider Trust. However, in the interim, there are additional enhanced overtime shifts offered to help bridge the workforce gaps. The Trust continues a focused programme of work to improve efficiency and productivity and is engaged in national programmes, including GIRFT and IECCPP, to identify and deliver improvements. This work is also in collaboration with system partners with the Trust continuing to provide activity to support partners.	
How this report impacts on current risks or highlights new risks:	
This report addresses risks identified within the Board Assurance Framework. Specifically Performance and Compliance (BAF 1C) and Transforming Our Services (BAF 3B)	
Committees/groups where this item has been discussed	Care Group Senior Management Team Business Team Meeting Executive Management Team
Recommendation	The Board of Directors is asked to note: • the strong year to date performance including the provision of capacity for the wider Tees valley • the detailed planning for 2022/23 to deliver the national elective trajectories of 104% of baseline activity • the analysis of current risk and mitigation plans including continued modelling of planning and finical risks • The opportunity to scope and implement sustainable infrastructure and growth of service provision through the scoping and implementation of the aligned payment incentive arrangements detailed in the Planning and Priorities 2023 /24 guidance. • the regular monitoring of the elective recovery trajectories through the Executive Management Team

North Tees and Hartlepool NHS Foundation Trust

Board of Directors Meeting

26 January 2023

Elective Recovery Update

1. Introduction

The purpose of this paper is to provide the Board of Directors with an update on the delivery of the 2022/23 elective recovery plans within the Trust.

The Trust's vision has always been one of collaboration and growth with a commitment to deliver, or exceed, the national target of 104% of 2019/202 baseline activity through the sustainable growth of services both locally and across the wider system with neighbouring organisations. This paper seeks to provide assurance to the Board that the organisation is focused on:

- the patient level detail of current elective waits: (>104/78/52 and >40 week waiters)
- the growth required to continue to deliver the 104% activity target within funded establishment
- the workforce required to ensure sustainable delivery
- the associated workforce and recruitment trajectories
- the short, medium and long term requirements to achieve these targets
- plans to ensure all necessary arrangements are in place to protect elective capacity during the 22/23 winter period
- all associated risks, including financial, faced by the Trust in achieving the elective recovery plans including the provision of mutual aid for long waters within the wider Tees Valley and NENC ICB

2. Current Position

The Trust remains one of the top performing organisations both within the NENC system and nationally. As previously reported to the Board of Directors the Trust commenced recovery planning during the first wave of the covid pandemic. In spite of further waves of covid the organisation remains the top performer in the NENC against the Elective Recovery Fund (ERF) attracting £6.964 million income during 2021/22 and a 2022/23 year to date (M9) total of £5.45 million. This has supported the organisation in undertaking additional activity both internally and as system support for >78 and>104 week waiters.

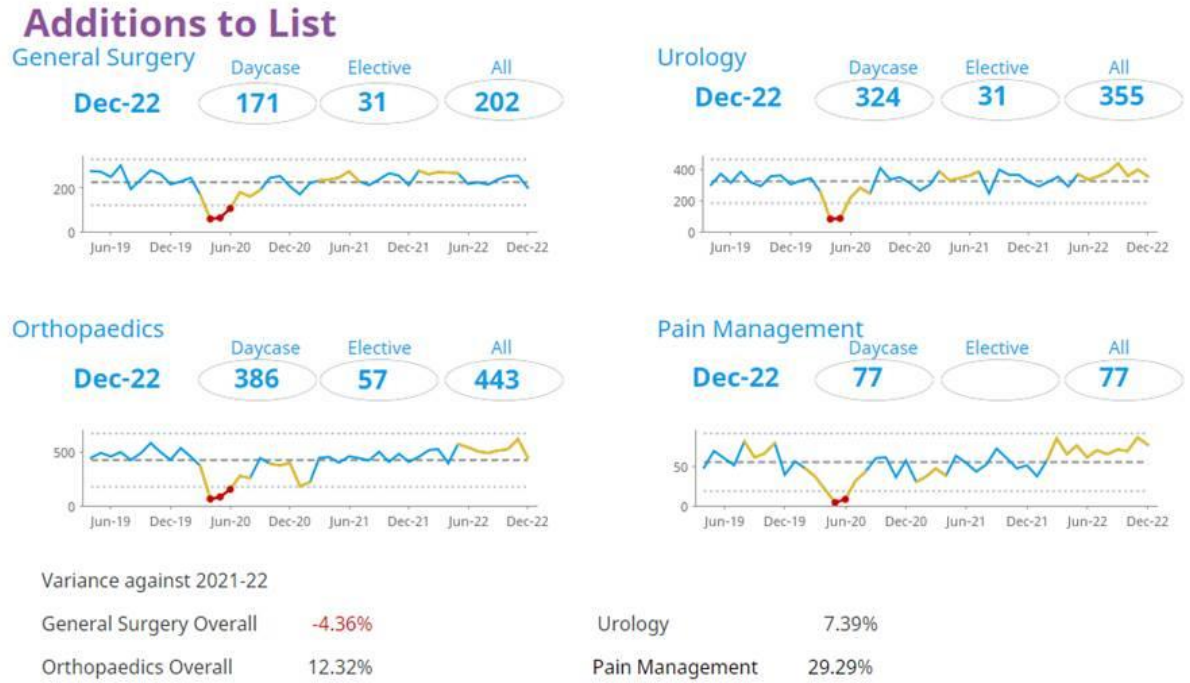
Table 1 below illustrates the comparative performance across the NENC ICS in respect of Referral to Treatment (RTT) incomplete pathways, i.e. over 18 weeks from referral to treatment. The data identifies the Trust is the fifth highest performer nationally and the second highest performer within the NENC ICS. Recovery plans for the remainder of quarter 4 2022/23 are focussed on further reductions of incomplete pathways and >40 week waits.

Provider Name (FT)	Incomplete Pathways			
	Within 18 weeks	Total	%	Rank (National)
Northumbria Healthcare	27,253	32,871	82.90%	1
North Tees and Hartlepool	**15,609**	**20,051**	**77.80%**	**5**
South Tyneside and Sunderland	43,700	57,240	76.30%	6
Gateshead Health	9,420	12,837	73.40%	9
The Newcastle Upon Tyne Hospitals	70,752	101,392	69.80%	19
South Tees Hospitals	31,163	46,747	66.70%	30
County Durham and Darlington	28,522	43,618	65.40%	37
North Cumbria Integrated Care	22,661	37,530	60.40%	65

Table 1: Incomplete pathways RTT over 18 weeks, NENC ICS providers ranked nationally. (from national GIRFT data 01/2023)

2.1 Inpatient waiting list growth 2019 – 2022

During 2022/23 the Trust has seen a continued increase in referrals. This has resulted in an increase in additions to lists for a number of sub-specialties as illustrated in graph 1 below.



Graph 1: Additions to waiting lists – data to December 2022 (dashboard from Yellowfin BI tool)

2.2 Progress to date

Graph 2 below describes the elective recovery month on month progress to date. The graph describes the elective recovery percentage against the national trajectory of 104% and is inclusive of the full M9 position. Quarter 3 (Sep 2022 - Dec 2022) saw significant increases in both elective and non-elective activity and further impact from increased covid and flu

admissions. This also affected late notice cancellations of activity due to patients being unfit for procedures and staff unavailability due to sickness. This impact has been reflected locally and nationally with excessive pressures continuing into January 2023. It should also be noted that elective surgery at Hartlepool site was reduced during the festive period in December on a planned basis as part of the overall winter planning arrangements. In spite of these challenges the Trust has continued to reduce long waits for elective procedures with significant increase in activity against 2019/20 baselines.

Month on month % variance from plan

Admissions % of trajectory		Month									
Care Group	Group	1	2	3	4	5	6	7	8	9	Total
Care Group 1	Day Cases	151%	117%	109%	125%	108%	115%	112%	97%	106%	115%
	Elective	107%	153%	143%	91%	194%	156%	149%	113%	113%	135%
Care Group 2	Day Cases	108%	88%	88%	99%	92%	101%	97%	97%	102%	97%
	Elective	89%	238%	306%	245%	405%	94%	88%	103%	116%	187%
Care Group 3	Day Cases	104%	98%	105%	105%	99%	117%	101%	115%	124%	108%
	Elective	107%	102%	96%	76%	125%	106%	113%	96%	93%	102%

Graph 2: Elective recovery – (dashboard from Yellowfin BI tool)

2.3 NE&NC Performance.

The Trust remains a high performer within the wider system including the provision of capacity for the wider Tees Valley. Table 2 below illustrates the relative performance across the NENC ICS in respect of >52 week waiting times. The Trust has zero patients waiting over 78/104 weeks for surgery and continues to support the wider system in driving these number down across the ICS. Further work is underway to model the waiting list shape and size through to March 2023 to ensure that the Trust can maintain a zero >78 and zero >104 week wait position. The impact of the NEAS strike (21st December 2022 and escalation of winter pressures at the beginning of January 2023 is currently being factored into a revised trajectory.

As Table 2 illustrates, at 1 January 2023 the Trust had 33 patients waiting over 52 weeks. 29 of these patients (88%) have a To Come In (tci) date. The Trust is currently forecasting 20 over 52 week admitted patient care waits by the end of March 2023. Work continues to reduce this to the minimum amount possible with patient choice as the key factor in delayed treatment.

52+ Week Waiters	WE 27 Nov 22	WE 04 Dec 22	WE 11 Dec 22	WE 18 Dec 22	WE 25 Dec 22	WE 01 Jan 23	% with TCI or appt	Jan 23 Plan	Change from previous week	Avge volume change per week (based on latest 4 weeks)
GATESHEAD HEALTH NHS FOUNDATION TRUST	86	98	99	101	103	101	76%	*5*	-2	1
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	30	25	32	30	30	24	50%	*0*	-6	-0
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	4,380	4,357	4,337	4,375	4,408	4,311	18%	*2,029*	-97	-12
NORTH ICP	4,496	4,480	4,468	4,506	4,541	4,436		*2,034*	-105	-11
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	2,157	2,135	2,160	2,130	2,097	2,091	32%	*590*	-6	-11
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	114	112	104	120	126	127	47%	*100*	1	4
CENTRAL ICP	2,271	2,247	2,264	2,250	2,223	2,218		*690*	-5	-7
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	44	40	34	33	35	33	88%	*0*	-2	-2
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1,708	1,864	1,766	1,751	1,829	1,830	41%	*927*	1	-9
SOUTH ICP	1,752	1,904	1,800	1,784	1,864	1,863		*927*	-1	-10
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	838	820	840	860	860	873	23%	*580*	13	13
NORTH EAST & NORTH CUMBRIA	**9,357**	**9,451**	**9,372**	**9,400**	**9,488**	**9,390**	27%	*4,231*	**-98**	**-15**

Table 2: Weekly ICS Recovery Report

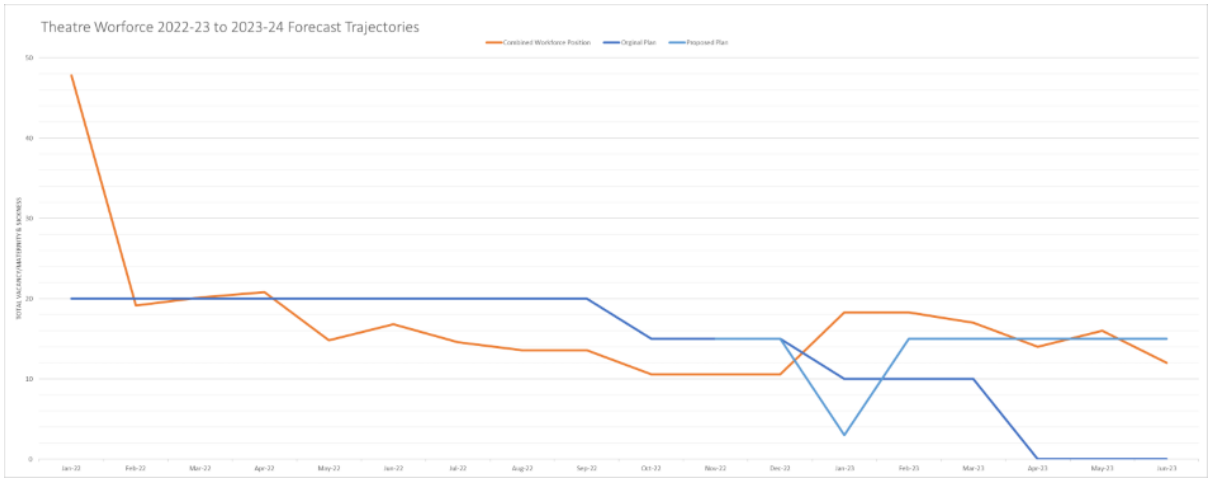
3. Theatre workforce mapped against proposed insourcing activity

Workforce pressures remains a key constraint within both the Trust and the wider system. The Care Group has maintained effective internal processes to manage this against both short and

long term activity trajectories. Internal and overseas recruitment has, and continues to, take place. Graph 3 below highlights the current position of the combined impact of all theatre workforce including absenteeism, vacancies and maternity leave over the next 6 months. Whilst the Care Group acknowledges that this remains a forecasted position it is based on current and planned appointments. It is anticipated that the Care Group will start to see the impact of these recruitment drives during Q4 with a more resilient workforce position at the beginning of Q1 2023.

The health and wellbeing of the staff is paramount to the Care Group and the wider Trust. However, in the interim, there are additional enhanced overtime shifts offered to help bridge the workforce gaps. In addition to the recruitment described above the Trust will continue with both insourcing as well as internal waiting list initiatives.

The graph demonstrates the Care Group workforce current position which, despite recruitment and retention, shows the current benefit in supporting additional activity through insourcing and waiting list initiatives. The Trust will use this forecasting to inform the level of continued use of additional activity into quarter four depending on how the additional activity is reported i.e. monthly, quarterly or annualised. It is important to note that the additional workforce associated within current business cases required to deliver the 104% target are included within the workforce trajectories.



Graph 3: Theatre workforce forecast trajectory

4. Winter Planning

In terms of winter planning the Collaborative Care Group has a proven track record of managing and delivering the elective programme during times of escalation and surge. It is acknowledged that the system has seen significant pressures over and above the normal winter escalation, which resulted in additional beds being opened to support the elective programme above what was anticipated within the month of December.

5. Improving Elective Care Coordination for Patients Programme

The Trust has recently agreed to participate in the externally funded NHSE programme to introduce “Improving Elective Care Coordination for Patients Programme” (IECCPP).

This is a digital solution which is designed to help Trust teams’ better plan, schedule and manage patients through the elective pathway. The solution does not replace existing systems but sits as a layer above Trust applications, bringing together the information currently held in different Trust systems into a single place.

At a local level the digital solution is currently being implemented at South Tees FT and will have the potential opportunity to support sharing of waiting list information / scheduling of theatre sessions as the Trusts work closer together at an operational level to support waiting times. This will support the further provision of spinal service capacity and act as an enabler to improved coordination of urology pathways across the Tees Valley.

6. GIRFT High Volume Low Complexity Guidance (HVLC)

Getting It Right First Time (GIRFT) High Volume Low complexity programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways.

The Trust is actively using the metrics produced to improve its efficiency and productivity across its elective procedures. The Trust performs well in a number of key metrics including HVLC elective activity as a percentage of BAU (Activity vs baseline high at 127.48% of baseline), however the Trust acknowledges that it's Basket of Day Case Rates can be improved with performance below 75% in some specific specialities. There is a specific day case procedure group within the care group to address this opportunity and improve day case rate performance. The Trust also has a peri-operative group that has reviewed all theatre utilisation metrics to identify pathway, process and practitioner improvement opportunities.

The care group remains committed to eliminating waiting list initiatives through maximising productivity and efficiency.

7. NHS England guidance

NHS England (NHSE) issued a letter to providers on 12 January outlining the NHS and government elective recovery plan commits to eliminating 78 week waits by March. This includes outpatient pathways and the Trusts plans are in place to meet this requirement with tci dates identified for all patients unless delayed due to patient choice.

The NHSE letter describes other 'required actions' including the requirement that any patient waiting over 52 weeks on a RTT pathway (at 31st March 2023) should have their care clinically validated within 12 weeks. There are further requirements to review waiting list validation, which the current internal waiting list validation processes and the IECCPP work programme described above will support.

8. Risks and Mitigations

Risk	Mitigation
Continuation of gap in theatre workforce into quarter four due to a combination of sickness and the ability to recruit to vacancies.	Continued phased plan and adaptation of support through GutCare and planned international recruitment and training.
Negative impact on morale of theatre staff when using GutCare to provide additional capacity.	The Care Group regularly links in with the unions and staff side representatives. The use of insourcing is a short term solution with a long term approach to ensure sustainable workforce through substantive recruitment.
The 104% activity target assumes that the wider system activity carried out within the	Work towards agreement with regards to funding flows which support system

Trust is counted towards the Trusts activity increase and is funded accordingly.	cooperation and collaboration. Supported through DoF system discussions. Opportunities for 2023/24 for the care group based upon the Aligned Payment and Incentive (API) arrangements recently published in the Planning and Priorities guidance 2023/24.
Activity increase includes system activity which requires shared administration structures and processes across organisations.	External funding through NHSE to introduce Improving elective care coordination for patients programme (IECCPP). At a local level the digital solution is also currently being implemented at South Tees FT and will have the potential opportunity to support sharing of waiting list information / scheduling of theatre sessions as the Trusts work closer together at an operational level to support waiting times. For example spinal services and urology.
These proposals establishes the collaborative care trajectories, however, further work needs to be undertaken to include other elective activity to ensure delivery of the 104% across all areas e.g. endoscopy.	Further work is taking place with the other care groups who deliver aspects of the elective workload at all points of delivery. Monitored through Recovery Group.
Consultants' willingness to undertake additionally at weekends etc. due to concerns over pension tax implications.	Full Business Case being developed to inform the Trusts planning and priorities in 2023/24 to deliver a sustainable cost effective approach to delivery of the 104% activity which also improves the Care Groups run rate. i.e. Full recruitment to reduce reliance on additional sessions..
Elective Recovery Funding (ERF) is currently non-recurring and therefore any recurrent permanent recruitment is at risk to not be funded 2023/24 onwards..	Proactively manage succession planning and exit strategies if activity reduces in the longer term. Scope the impact of the Aligned Payment and Incentive (API) arrangements and the two year funding agreement as detailed in the planning and priorities guidance recently published. Continues DoF/commissioner discussions on system approach to funding over-performance against ERF trajectories for 2022/23
A further wave of Covid / Flu pandemic which significantly compromises staffing / elective capacity.	Ensure workforce is sustainable through recurring recruitment and continuation of insourcing available if required as demonstrated in this paper.
The national NHSE approach to addressing over 78 and over 104 week waits is likely to result in request for additional mutual aid. At North East and Yorkshire pilots are currently being undertaken in dermatology and ophthalmology, which does not impact	Continued monitoring of internal sub specialty waiting list at Care Group level, monitored through the Trust Recovery Group. Attendance at NENC Elective Recovery Group to support system planning in response to mutual aid

on the Trust however, this could be extended to other challenged specialities going forward. For example, Orthopaedics. and	requests. The Trust has also signed up to the Digital Mutual Aid System (DMAS). Which allows Trusts to offer and receive help from other providers for patients who are willing to go to other providers for their procedure.
Increasing waiting list due to high levels of primary care referrals in throughout the financial year (109%) This will result in additional activity in some specialities especially gynaecology and cancer pathways.	Collaborative work across Care Groups and with primary care colleagues to model the impact of increased referrals. Weekly Care Group reviews of waiting list positions to model future waiting list impact.

9. Summary

The Trust remains in a strong position in terms of elective recovery and will continue to deliver and build on the elective recovery trajectories in line with the current local and national targets. The Care Group will continue to monitor, review and refine all demand and capacity planning during the winter period with regular recovery updates reported to the Executive Management Team. All decision making relating to elective recovery will continue to be informed, measured and considered in an effort to ensure the Trust remains a top performing hospital of choice for our local population. The organisation remains committed to collaboration to increase capacity and support to the wider system with continued service provision for the Tees Valley.

The care group has identified risks to delivery of the recovery plans with appropriate mitigations identified. This is complemented by a programme of productivity and efficiency with supported programmes of improvement aligned to national GIRFT work streams and the improvement of theatre utilisation.

Further analysis and modelling of the implications of a return to block contracts and payment By Results (PBR) will require regular review of activity plans to balance the financial and performance implications with the imperative to provide timely care for the local population.

10. Recommendations

The Board of Directors is asked to note:

- the strong year to date performance including the provision of capacity for the wider Tees valley
- the detailed planning for 2022/23 to deliver the national elective trajectories of 104% of baseline activity
- the analysis of current risk and mitigation plans including continued modelling of planning and finical risks
- The opportunity to scope and implement sustainable infrastructure and growth of service provision through the scoping and implementation of the aligned payment incentive arrangements detailed in the Planning and Priorities 2023 /24 guidance.
- the regular monitoring of the elective recovery trajectories through the Executive Management Team

Levi Buckley
Chief Operating Officer

Board of Directors Meeting

Title of report:	Monthly Registered Nursing and Midwifery Workforce Report and Bi-annual Workforce Review										
Date:	26 January 2023										
Prepared by:	Emma Roberts, Associate Director of Nursing and Professional Workforce										
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality										
Purpose of the report	This report provides the Board of Directors with the annual position of the Registered Nursing and Midwifery workforce. The National Quality Board (2016) articulated the requirement to undertake Nursing and Midwifery workforce reviews annually with an update on actions highlighted to the Board on a six monthly basis. This report provides the **annual** review for 2022 including updates from the last bi-annual review produced January 2022. Both the monthly and the bi-annual workforce reviews focus on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It is vital to understand the nature of workforce pressures and actions to address, both in the long and short term.										
Action required:	Approve		Assurance	x	Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing our People	x	Transforming our Services	x	Health and Wellbeing				
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	
Executive Summary and the key issues for consideration/ decision:											
Summary	**Section 1** introduces the report to provide the Board of Directors with an update on the Nursing and Midwifery workforce position for November 2022 and the recommendations presented within the annual Professional Workforce Review of 2022. **Section 2** provides an update on **vacancies**. The Registered Nurse vacancy position for November 2022 is 53.57 (3.9%) and continues to reduce month on month. Registered Midwifery vacancies in November 2022 is 16.49wte (15.78%). **Section 3** provides an update on **sickness and absence** for November 2022. There has been an increase in non-covid sickness with a reduction in covid sickness. Maternity leave across registered and unregistered N&M workforce was 3.42%.										

Section 4 indicates that maternity has seen an increase in **Turnover** during November 2022.

Section 5 provides an update on **Temporary Staffing** usage during November 2022. There has been an increase in N&M fill rates following the implementation of an incentivised scheme. To mitigate the RN vacancy risk the Trust continues to use block bookings via nursing agencies that are part of our current agency cascade.

Section 6 identifies the compliance with **Safe Care Live and Birth Rate Plus.** All above the recommended compliance for November 2022 with exception of the Pre and Post Natal ward which was slightly lower.

Section 7 highlights the **Patient Safety and Quality Outcomes during November 2022.** Seven red flags were raised in relation to shortfalls in registered nurse time. The RESET tool was used 71 times across a number of wards. Further work has been identified in the use of this tool. Focused work has been undertaken to improve the level of compliance of Birth Rate plus, ensuring that all red flags raised are validated.

Section 8 provides the Nursing and Midwifery **Bi-annual Workforce Review.** Key points to note:

- The Nursing and Midwifery workforce position has been presented to the Executive Team on a monthly basis and this will extend to Trust Board on a monthly basis to provide oversight and assurance of safer staffing
- There are clear and robust escalation processes in place to identify daily risk associated with staffing shortfalls and ensuring robust mitigation is in place and monitored to ensure that the ability to deliver the right care, in the right place at the right time is in place.
- It has been identified through this review that 3 in-patient areas require further review including alternative workforce modelling and current established budget. There is assurance that with the robust processes in place in relation to patient experience and quality of care, we are already sighted on these areas, providing enhanced support on a daily basis and developing an appropriate workforce to meet the changing needs of the patients.
- Registered Maternity vacancy is currently higher than the regional average. Work has been undertaken to ensure risk in relation to vacancy has been mitigated and action to support this include top of pay band for NHSP shift and an incentivised scheme. In addition, for a short period of time Matrons have been working half of their time clinical.
- Focused work continues via the strategic workforce action groups which are aligned to the Nursing and Midwifery Workforce Strategy
- There is a continued commitment to maximising the Trusts recruitment and retention position by investing in both domestic and international recruitment.

Section 9 includes information on the **Evidence Based Establishment Setting Methodology** and the **Acuity and Dependency Tools**

	Section 10 presents the **Workforce Metrics** used for the annual review which include: • Care Hours per Patient Day (CHPPD) • Vacancies • Turnover • Sickness and Absence • Planned and Actual Staffing • Temporary Staffing Usage • Outcome of the SNCT Data Review **Section 11** highlights the **recommended actions and updates** from the Workforce Review Panels for Emergency Services, Maternity Gastroenterology, Medical Wards (wards 36, 40 and 42) and the Stroke Service. **Section 12** presents the **Patient Safety and Quality Outcomes** including information on: • Falls – 84% resulted in no patient harm, 16% low harm and 0% severe harm • Pressure ulcers – the highest level being Category 1 and 2 across both hospital and community services • Red flags and Datix – 98 red flags reported, 42% due to shortfalls in registered nurse time **Section 13** provides an update on the **Professional Workforce Strategy** with a focus on the key strategic workforce action groups to support the delivery of the overall strategy which include: • Recruitment and retention • Training and development • National preceptorship framework • Data and systems • Surge and escalation planning • Alternative workforce planning • Routes into care **Section 14** provides a **conclusion** to the report by providing assurance in relation to the ongoing work and actions identified within this report **Section 15** summarises the **Recommended Actions** following the completion of the annual professional workforce establishment review.
Actions	As within **Section 16** of the report the following actions are recommended: • Review of the patient criteria, workforce establishments and alternative workforce modelling of wards 40, 42 and 36 to be undertaken by Responsive Care with support from but not exclusive to the Associate Director of Nursing and Professional Workforce and Workforce Business Partners. • Review of the Critical Care workforce model following this workforce review to support the validation of the SNCT recommendations. • Receive the outcome of the 3yr Birth Rate Plus establishment review

	across the Maternity in patient wards with the national Birth Rate Plus team with recommendations included in the next bi-annual report. • Continue to monitor and support the compliance with Birth Rate plus to ensure validation of collected data. • Continue with the recruitment of both domestic and international nurses • For recommended actions in this report to be included in Care Groups annual workforce business planning process and to realign establishments in line with current budgets. • To review the workforce models where alternative workforce modelling opportunities have been identified • For a full update on the recommended actions from this report to be presented in the Bi-annual 6-month review in April 2023.
Recommendations	The Board of Directors is asked to; – Receive and review the monthly update and the bi-annual Registered Nursing and Midwifery workforce review for 2022. – Consider the approach taken in line with national guidance and recommendations. – Acknowledge and comment accordingly on actions outlines within the report. – Consider the revised approach to reporting the Nursing and Maternity workforce position on a monthly basis. – Note the significant assurance provided within this report in relation to safe Registered Nursing and Midwifery staffing.

How this report impacts on current risks or highlights new risks:

This report describes the nursing annual workforce establishment review process which has been completed in accordance with national guidance and awaits the formal establishment review of the Maternity Services. It highlights the on-going challenges presented in managing safer staffing across all services. There are some areas highlighted within this report which require further work to assure that their establishments are able to safely deliver the needs of their services. Recommended actions to achieve this assurance are outlined within this report.

There are naturally challenges associated with balancing establishment design with safer staffing and financial efficiency which will require mitigation through the robust governance processes that are already in place. Proactive workforce planning, alternative workforce design and strong working relationships across all teams and across the region will support the delivery of this work to ensure that patient and staff safety remains at the centre of all decisions, plans and actions associated with the safe staffing of all ward/departments and services.

Corporate moderate risk remains on the Trust wide risk register (6400) relating to safe staffing and escalation; this was last reviewed and updated early September 2022, this risk is due for review in January 2023.

No new risks have been identified

Committees/groups where this item has been discussed	• Business Team • Executive Team

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26 January 2023

Monthly Nursing and Midwifery Workforce Report and Bi-annual Workforce Review

Report of the Chief Nurse/Director of Patient Safety and Quality

1. Introduction

This paper provides the Board of Directors with an update on the Nursing and Midwifery workforce position for November 2022 and the recommendations presented within the annual Professional Workforce Review of 2022. The report provides assurance that arrangements are in place to staff our services with the right skills in in the right place to provide safe, sustainable and productive staffing.

2. Vacancies

- The recruitment and retention strategic workforce action group continue to focus on improving the vacancy position and turnover across the Nursing and Midwifery roles.
- The RN vacancy position for November 2022 is 53.57 (3.9%) and continues to reduce month on month with a forecasted position for end January 2023 of 17.12wte (1.24%).
- Registered Maternity (clinical bands 5 and 6) vacancy in November 2022 is 16.49wte (15.78%) with a planned service wide vacancy of 20.56wte (19.77%). Recent work has supported exploring immediate actions to stabalise the Maternity services focused upon Labour Ward, which have included a review of all specialist and Ward Matron roles to enable a contribution to clinical practice throughout November and December 2022.

3 Sickness and Absence

- There has been an overall increase in non-covid sickness absence in November 2022.
- There has been an overall reduction in covid sickness in November 2022.
- Total maternity leave across registered and unregistered nursing and midwifery staff (N&M) was 3.42% in November 2022.

4. Turnover

- The Maternity workforce has seen an increase in leavers, which is higher than those planned to start.

5. Temporary Staffing Usage

- A pay incentive was agreed and commenced in November 2022, consequently the RN fill rate has increased to 39.3% (62.3wte)
- Delivery Suite Registered Midwifery fill for November 2022 increased to 79.6% (4.7wte)
- Ward 22 Registered Midwifery fill for November 2022 increased to 67.6% (2.8wte)
- To mitigate the RN vacancy risk the Trust continues to use block bookings via nursing agencies that are part of our current agency cascade. There are currently 8wte block bookings still in place and are allocated to EAU and wards 24, 25, 26 and 33.
- A further 12wte block booked registered nurses are in place to support staffing the additional capacity opened up on ward 37.

6. Safe Care Live and Birth Rate Plus compliance

- Safe Care Live compliance for November 2022 was above the recommended compliance of 80%.
- Birth-rate Plus compliance for the Pre and Post Natal ward in November 2022 was slightly lower than the recommended compliance of 85%.
- Birth Rate Plus compliance for the Delivery Suite in November 2022 was above the recommended compliance of 85%.

7. Patient Safety and Quality Outcomes

- Seven red flags were raised in relation to safe nurse staffing in November 2022 based on the professional judgement of the nurse in charge to raise the concern of shortfalls in registered nurse time.

- The RESET tool was used 71 times throughout November 2022 mostly across wards 26, 27, 32, 36, 40, 41 and 42 and ACU. The Heads of Nursing have recently reviewed the criteria to trigger to a RESET and have provided further education to support the use of the tool with Senior Clinical Matrons.

- Focused work has been undertaken to improve the level of compliance of Birth Rate plus, ensuring that all red flags raised are validated. Raised red flags will now be reported to the Board of Directors in a monthly report that will address the confirmed validated position.

8. Nursing and Midwifery Bi-annual Workforce Review

8.1 Executive Summary

The purpose of this report is to provide the Trust Board with an overview of the Nursing and Midwifery annual workforce review of staffing, governance processes and compliance with national guidance, a requirement set out by the National Quality Board (2016).

This report will present an overview of the analysis of the 2022 Nursing and Midwifery workforce reviews including the Safer Nursing Care Tool (SNCT) reviews completed

for all adult and Paediatric in-patient wards and departments. Findings from the reviews and subsequent recommendations for on-going work and actions are presented in this report.

The purpose of this report is to provide assurance that the Trust is compliant with the national guidance in relation to safer staffing and to highlight where there are any risks, issues or concerns.

Future reporting to Board will now move to monthly with a bi-annual Nursing and midwifery workforce review every 6 months.

8.2 Key points to note

1. The Nursing and Midwifery workforce position has been presented to the Executive Team on a monthly basis and this will extend to Trust Board on a monthly basis to provide oversight and assurance of safer staffing
2. There are clear and robust escalation processes in place to identify daily risk associated with staffing shortfalls and ensuring robust mitigation is in place and monitored to ensure that the ability to deliver the right care, in the right place at the right time is in place.
3. It has been identified through this review that 3 in-patient areas require further review including alternative workforce modelling and current established budget. There is assurance that with the robust processes in place in relation to patient experience and quality of care, we are already sighted on these areas, providing enhanced support on a daily basis and developing an appropriate workforce to meet the changing needs of the patients.
4. Registered Maternity vacancy is currently higher than the regional average. Work has been undertaken to ensure risk in relation to vacancy has been mitigated and action to support this include top of pay band for NHSP shift and an incentivised scheme. In addition, for a short period of time Matrons have been working half of their time clinical.
5. Focused work continues via the strategic workforce action groups which are aligned to the Nursing and Midwifery Workforce Strategy.
6. There is a continued commitment to maximising the Trusts recruitment and retention position by investing in both domestic and international recruitment.

8.3 Introduction

The National Quality Board (2016) articulates the requirement to undertake a Nursing and Midwifery workforce review annually with an update on actions highlighted to the Board on a six monthly basis. The Developing Workforce Safeguards (DWS) (NHSI 2018) reinforces the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing.

The guidance recommends that establishment setting should be undertaken annually, with a mid-year review and this process should consider the following:

- Patient acuity and dependency
- Activity levels & occupancy
- Seasonal variation in demand
- Service developments/changes and commissioning
- Staff supply and experience

- The use of temporary staffing above the set establishment
- Patient outcome measures

The purpose of this annual report is to assure the Board of Directors of safe staffing by providing an overview of the current Nursing and Midwifery workforce position across the Trust. To provide assurance of compliance with the national guidance in relation to safer staffing and to highlight where there are any risks, issues or concerns.

This report contains all required information for board reporting as set out by the Chief Nursing Officer (CNO), which includes:

- Progress to date relating to actions identified in the six month review, January 2022
- Vacancy, recruitment and retention position for Nursing
- The use of temporary bank and agency staff for Nursing
- A Trust wide summary of the Nursing workforce data analysis completed in September 2022 using evidence based safe staffing tools where recommended
- Assurance that workforce processes and decisions are evidenced based and comply with the Developing Workforce Safeguards recommendations

Over the past year the increase in patient acuity and dependency levels, the continued impact of Covid-19 related staff absence, and increased bed occupancy continues to challenge the professional workforce and their deployment across the Trust. Safe staffing governance processes remain in place and have been further developed to ensure appropriate escalation criteria is complied with and the subsequent development of actions when required. All safer staffing decisions are supported by senior professional oversight and leadership to ensure that the safest decisions are made when considering the effective deployment of the workforce.

9. Nursing and Midwifery Workforce Review

9.1 Evidence Based Establishment Setting Methodology

The annual workforce review focuses on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It is vital to understand the nature of workforce pressures and actions to address, both in the long and short term.

Trusts are required to calculate and recommend the number and skill mix of nurse staffing required to meet the needs of patients by triangulating three critical sources of information. Patient acuity and dependency levels are identified using Safer Nursing Care Tool (SNCT). Safer Nursing Care Tool (SNCT) data collection took place during

May/June 2022. The SNCT is the only nationally approved, evidence-based tool to support safe staffing within in-patient areas; data collection takes place for 20 days bi-annually (to allow for seasonal differences). The recommendation within the tool is to undertake at least two data collection cycles before making any changes to workforce establishments, May/June 2022 is the third data collection taken in the Trust.

In addition to SNCT data, professional judgement and patient outcomes are presented in order to fully triangulate the data and variables. Professional Workforce Review panels were held and the ward/department Matron, Senior Clinical Matron, Head of Nursing and Heads of Professionals, Finance and Workforce Business partner, Care Group manager and Operational Manager invited to discuss workforce planning within their areas (annual review).

The panels provided data presentation and the opportunity to discuss workforce planning and workforce achievements and challenges. A standard template was used and populated by the senior teams across the care groups for all wards/departments and services to ensure relevant and accurate data and information was available. The face-to-face panels support a 'ward to board' approach to workforce reviews and support the balanced discussion of hard data and soft intelligence.

The panels have evolved and this review included Heads of Professionals to ensure the Allied Health Professionals (AHP) workforce was fully represented and reviewed where appropriate and to support progression with any alternative workforce plans. In addition, the Advanced Clinical Practice (ACP) Lead attended the panels to support options to expand the ACP workforce in clinical areas.

9.2 Acuity and Dependency Tools

The Trust uses the Safer Nursing Care Tool (SNCT) and the Safer Nursing Care Tool Children and Young People (SNCT CYP) as the evidence based establishment-setting tools.

The SNCT tools recommends that a minimum of 22% funded headroom should be included for all nursing and midwifery staff within in-patient areas. This recommendation then forms a mandated setting within the tool that cannot be reduced prior to completing the data analysis. The Trust currently has a funded headroom of 21% for registered staff and 19.4% for unregistered staff with no allocation of maternity leave in the uplift calculation.

For the purpose of this report, all SNCT data will be presented following analysis at 22% as per the tool settings. The tool collects data on the average number of patients by level of acuity (0, 1a, 1b, 2, 3) and average whole time equivalent (WTE) recommended against current budgeted establishment. As all in-patient areas need to be safely staffed for all funded beds, the tool advises that each empty bed is calculated as level 0.

- Level 0 Patient requiring no assistance or minimal assistance from one person
- Level 1a Patient at acute risk of deterioration / a complex post-operative patient
- Level 1b Patient who has higher dependency, requires assistance from two people
- Level 2 Patient requiring invasive monitoring or support with single organ compromise
- Level 3 Patient requiring mechanical ventilation / support with 2+ organ compromise

The Delivery Suite and Pre/Post Natal Ward utilise Birth rate plus (BR+) which is a nationally recognised tool for maternity services based on the number of deliveries and antenatal and post-natal care requirements, which is undertaken every three years. The last Birth rate plus data analysis and establishment review took place in 2019 and the review for 2022 is currently taking place where data collection using a retrospective review of 3 month staffing and patient data has commenced. As this review is underway the outcome of the review will be included in the next bi-annual review and presented via the identified groups and committees.

10. Presentation of Workforce Metrics

All workforce metric data from January 2022 to August 2022 for Nursing and Midwifery have been reviewed, key points to note are as follows:

10.1 Care Hours per Patient Day (CHPPD)

Care Hours per patient day (CHPPD) is a measurement of workforce deployment that can used at ward and service level or be agreggated to Trust level. It is a unit of measurement recommended to record and report the deployment of staff working on in-patient wards and captures the registered nurse and HCSW hours. All acute Trusts are required to report their actual monthly CHPPD and it is recorded by dividing the total numbers of hours of care provided by staff by the total number of patients in the ward. The Trust wide CHPPD data for the period of January 2022 and August 2022 has been reviewed and the key points to note are as follows:

- From a Trust wide perspective, safe staffing was maintained throughout this period with a positive variance between required and actual CHPPD of +1.05.
- Healthy lives Care Group which reflects the Paediatric wards showed a variance of +3.86
- Responsive Care Group that reflects all medical speciality in-patient areas and the Emergency Assessment Unit showed a variance of -1.13 reflecting the larger proportion of the current RN vacancy levels across the Trust.
- Collaborative Care Group that reflects all Surgical and Orthopaedic speciality in-patient wards showed a variance of +0.60
- Safe Care Live (SCL) generates both a required and an actual CHPPD for all inpatient areas twice per day. This gives a more accurate reflection of staff allocation and staff to patient ratios across a 24-hour period. In response to the need to remain flexible in the way nursing and midwifery staffing is planned, SCL is used on a day to day basis to safely and efficiently assess accurate staffing levels and to redeploy nursing staff throughout the organisation.
- Birth Rate Plus is used across the Maternity in-patient wards to accurately record women's acuity and dependency levels that is then overlaid with actual staffing levels. This provides the ability to re-deploy Midwifery staffing to the most appropriate area to best deliver the needs of the overall service.
- There has been on-going focused work to improve the overall compliance across the Trust with both Safe Care Live and Birth-rate Plus.

10.2 Vacancies

The recruitment and retention strategic workforce action group continue to focus on improving the vacancy position and turnover across the Nursing and Midwifery roles.

- All disciplines have an improving vacancy position
- Registered Maternity vacancy is currently higher than the regional average. Recent work has supported exploring immediate actions to stabalise the Maternity services, which have included a review of all specialist and Ward Matron roles to enable an additional contribution to clinical practice to fill vacant duties. To further support this vacancy level there has been an agreement to pause any further roll out of the Continuity of Carer model whilst maintaining the current Rowan team. Further review will take place when the expected Birth Rate Plus report has been received.

10.3 Turnover

- Nurse turnover presents a positive position with more nurses taking up positions than nurses leaving between January 2022 and August 2022.
- The Maternity workforce has recently seen an increase in their leavers, which is higher than those planned to start. The service is fully cited on this level of turnover where plans to support the service delivery have been agreed.

10.4 Sickness and Absence

- The current sickness and absence levels across all Nursing and Midwifery staff groups are higher than the Trust target of 4.0%
- Maternity leave cover is not provided within allocated headroom.
- Sickness absence continues to be pro-actively managed as per the agreed Trust process between the Care Group management teams and Workforce Business Managers.

10.5 Planned and Actual Staffing

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

- In line with the National Quality Board requirements, the organisation continues to report the planned and actual staffing data on a monthly basis to NHSI.
- The average fill rates show a lower fill rate in RN during the day and a high rate of Health Care Assistants on nightshift. This often reflects the RN gaps and the increased provision needed for enhanced care.
- Between January 2022 and August 22 there has been a monthly average of 80% for Registered Nurse hours, 100% for Nursing Associate Hours and 105% of Unregistered Nurse hours.

10.6 Temporary Staffing Usage

Temporary staffing expenditure for Nursing and Midwifery services for the period of January 2022 to August 2022 has been reviewed and the following key points are to note:

- There appears to be a reduction in fill across most staff groups that can be associated with children's school holiday periods.

- As the Nursing and Midwifery vacancy levels reduce in line with the forecasted trajectory, there is an expectation that the amount of total demand hours will reduce and an improvement will there be seen in the overall fill rate.
- To support the current total demand Registered Nurse block booking from reputable agencies are continuously sought and utilised where appropriate.
- Alternative and new roles have been implemented to release time to care from Nursing and Midwifery teams such as the Team Support Worker role and the role of the Registered Nurse within Pre and Post Natal Maternity care.
- Local incentives have been agreed and are in place locally with NHSP to encourage both substantive staff and bank only workers to pick up additional hours, which include paying all staff at the top of their associated bank and a bonus payment incentive for picking up an agreed amount of additional hours throughout an 8-week period.

10.7 Outcome of the SNCT Data Review

Following the required data collection from all adult and paediatric in-patient wards and departments using SNCT, there is now a requirement to review the current establishments of some wards and departments to meet the demand based on patient acuity and dependency.

More recently, the Trust operating model has been agreed by the Executive Team that provides an uplift of the current establishment for ACU (a total of 10.77wte) and EAU (total of 16.20wte) in the nursing workforce. For the purpose of this report, the SNCT calculations have been based on current establishments because these were in place at the time of the data collection but the changes created by the operating model will be referenced.

A summary of the areas of exception (<u>over</u>-established by 5wte+) as identified within this data collection includes:

- **Paediatric ward** - suggested an over–establishment, however within the current establishment staff also manage the CYP elective unit and the new CYPED which is not included in the tool.
- **Surgical Decision Unit** – Suggested an over establishment, however, staff within the establishment also provide care to patients in assessment areas who are not in-patients and daily ward attenders.

A summary of the areas of exception (<u>under</u>-established by 5wte+) as identified within this data collection includes areas within:

- **Orthopaedic**
- **General Medicine and Gastroenterology**
- **Care of the Elderly**
- **Stroke**

All remaining in-patient's wards and departments had a variance between establishment and SNCT recommended establishment of -5wte to +5wte thus suggesting they have a workforce model that is generally fit for purpose.

11. Recommended Actions from the Workforce Review Panels

11.1 Emergency Services and Assessment

Action	Update
Undertake a review of the Emergency Department in January 2023 using the new Emergency Department establishment-setting tool.	Data to be taken in February 2023 in line with the Adult and Paediatric SCNT data collection plans.
Continue focused recruitment into EAU as per the agreed operating model	Further successful recruitment into this area for January 2023 has taken place.

11.2 Maternity Services

Action	Update
Await the outcome of the 3yr Birth Rate Plus establishment review across the Maternity in patient wards with the national Birth Rate Plus team.	Report due end January 2023.
To further review the workforce model for the in-patient Maternity areas to identify opportunities for further alternative modelling in line with the needs of this patient group.	Further successful recruitment into the band 5 RN in the pre and post-natal unit has taken place recently (3wte).
To conduct an immediate review of the current Registered Midwifery vacancy position.	In line with Ockenden and the nationally recommended Continuity of Carer model, the existing Rowan team have been maintained but there has been a pause on any further roll out of Continuity of Carer
To complete the review of the specialist Midwife and Ward Matrons roles to release capacity to support with clinical practice.	Ward Matrons currently supporting in clinical practice and new specialist post planned for implementation from January 2023.

11.3 Gastroenterology Services

Action	Update
Recruitment to Nutritional Specialist Nurse	Initial discussion has taken place to agree in principle a Dietetic Gastro Team Lead post (B7). Further discussions with lead consultants are planned.

11.4 Medical Wards (wards 36, 40 and 42)

Action	Update
SNCT suggests an under-establishment in these wards, the current establishment and workforce model is being reviewed part of the annual business planning process.	Introduction of the Patient Process Facilitator role (PPF) in the three wards. Introduction of an experienced Frailty Coordinator (band 7) in to ward 40 and 42 to support the current workforce with senior leadership and clinical expertise. Initial discussions have taken place regarding a review of the Enhanced Care service, expectations and efficiencies.

11.5 Stroke Services

Action	Update
SNCT suggests an under-establishment, the current establishment and workforce model is being reviewed part of the annual business planning process. A full collaborative workforce model review between the Community Stroke and the In-patient nursing models given the current separate proposed establishments. Work towards an enhanced 7-day service, increase intensity of rehabilitation and supported early discharge.	A regional stroke workforce review is taking place in order to standardise the approach to providing stroke services across the Team Valley. Key workforce leads within the Trust are currently engaged in this work.

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

12. Presentation of Patient Safety and Quality Outcomes

Nurse Sensitive Indicators are identified which include patient harm that could be sensitive to the number of available nursing staff, such as falls and pressure ulcers. Patient safety meetings take place across the Trust on a weekly basis where all potential and actual harms are discussed from the previous week with attention to any themes or staffing concerns. The continued work reviewing patient acuity and dependency helps to address whether the harms have occurred because of reduced nurse staffing. The number and category of both falls and

pressure ulcers across the Trust have been reviewed for the period of January 2022 to August 2022 and key findings are as follows:

12.1 Falls

A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause. Although falls may be sensitive to the number of available nursing staff, falls prevention requires a multidisciplinary approach.

- When reviewing the number of falls sustained across the Trust during this period it was identified that a total of 821 falls occurred and 686 (84%) resulted in no injury, 135 (16%) resulted in low harm and zero (0%) falls resulted in severe harm.
- The Trust sustaining zero falls resulting in severe harm reflects the improvement work that continues to take place to minimise the risk of harm from falls and the continued balance between patient mobility to prevent harm from deconditioning and the risk of patient falls.
- The in-patient wards that highlighted the highest level of falls were wards 40 and 42 (Frailty and care of the elderly) where patients usually require a higher level of enhanced and 1:1 care. Discussion at the workforce review panels for these two wards highlighted the specific needs of this patient group.
- There is currently a key focus on the recruitment of staff into the enhanced care team and the role and recruitment processes are under review.

12.2 Pressure Ulcers

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear. The patient's pressure ulcer could be categorised as 1, 2, 3 or 4. Although pressure ulcers may be sensitive to the number of available nursing staff, pressure ulcers prevention requires a multidisciplinary approach, and pressure ulcers rates will be affected by access to pressure ulcer prevention equipment and mobility aids, the availability of therapy, pharmacy and medical staff and the knowledge and skills of all healthcare professionals and support staff.

- When reviewing the number of Hospital and Community acquired pressure ulcers during this period it was identified that there were 313 validated pressure ulcers, 55.3% in the hospital and 44.7% in the community.
- The highest level of pressure ulcers being categories 1 and 2 across both the settings, 96% in the hospital and 72.8% in community.
- Whilst it is nationally recognised that Pressure Ulcers are a Nurse Sensitive Indicator, there is no evidence that the pressure ulcers that have developed during this period are directly linked to staffing levels.

12.3 Red Flags and Datix

98 red flags were raised in relation to safe nurse staffing between January 2022 and August 2022;

- 41 red flags raised based on the professional judgement of the nurse in charge to raise the concern of shortfalls in RN time.
- 12 red flag raised, anticipating a risk of there being less than 2 RN on duty

- 11 red flags raised to escalate that intentional rounding of patients has been missed.
- 1 red flag raised to escalate a missed medication.
- 1 red flag raised to escalate that a patient observation was not taken.

190 datix were submitted in relation to Nursing and Midwifery staffing escalations between January 2022 and August 2022.

Focused work has been undertaken to improve the level of compliance of Birth Rate plus, ensuring that all red flags raised are validated. Raised red flags will now be reported to the Board of Directors in a monthly report that will address the confirmed validated position.

Following the submission of a safe staffing related datix or red flag, a RESET visit to the clinical area from the aligned Senior Clinical Matron is initiated to formally review patient acuity and dependency levels, staff levels and skills in place and any patient or staff safety concerns. Results from the initiated RESET visit are then fed back to the safe staffing meeting to ensure that safe care is being provided. If the Senior Clinical Matron is unable to resolve the concerns raised there is a formal escalation to the Head of Nursing for further management to ensure patient and staff safety.

Twice daily safe staffing meetings take place to provide assurance that safe and efficient staffing levels are in place across the Trust using recognised nationally approved tools including Safer Nursing Care Tool (SNCT) and Birth-rate plus. Following these meetings clear and accurate documentation is completed to detail the patient acuity and dependency levels, staffing in place and any associated professional judgement considered when formulating safe staffing plans and the discussion of safe staffing related datix or red flag submission. Following each meeting there is a clear decision making process relating to further escalation to the Heads of Nursing or to the Deputy Chief and Chief Nurse when appropriate.

13. Professional Workforce Strategy

The professional workforce strategy was developed to address the strategic objectives posed by gaps across the professional workforce. The strategy underpins the Trust approach to Quality and Service Improvement with an aligned plan to all Trust wide workforce initiatives.

The strategy influences the decisions and responses to the issues affecting the supply of health and social care skills by building a shared understanding of workforce planning, as a multi-disciplinary activity including consideration of need, demand and supply.

The following six key strategic workforce action groups to support the delivery of the overall strategy and some of the key work streams associated with these groups have been summarised for the purpose of this report.

13.1 Recruitment and Retention

- The recruitment process for registered nurses has recently been amended to. replace generic advertising with bespoke adverts for all specialties.
- Recruitment for some staff groups continue via the recruitment centre process.

- The Transfer window process remains in place to support the internal movement of staff from one area to another.

13.2 Training and Development

- The registered nurse (band 5) developmental pathway has been refreshed and re-launched with newly registered nurses appointed into the Emergency Department.
- Cohort 3 of Team Support Workers (TSWs) will take part in their 4-month review session in January 2023 where they will be supported in making decisions about their next steps and the if required the possibility of proceeding onto an apprenticeship to support furthering their careers in the Trust.
- The Trusts internationally recruitment nurses continue on their structured education and training programme to support them in passing their OSCE to enable to them to register with the NMC and practice as registered nurses in the UK.
- There has been the recent introduction of a Practice Development Nurse to provide educational support to the IR nurses across all wards and departments.
- A structured programme to deliver the nationally recognised Chief Nursing Officer (CNO) Matrons Handbook has recently been developed.

13.3 National Preceptorship framework

- The new National Preceptorship Framework for Nursing to support the practice of newly registered practitioners was published in June 2022 by NHS England and NHS Improvement.
- The framework was developed in line with the Nursing and Midwifery Council (NMC) Principles of Preceptorship to support Preceptees, which now includes Nursing Associates.
- The Trust complies with the majority of the gold standards: delivering a formally structured and well established one-year programme (18 months for Midwives) which is continually evaluated to meet service needs
- The recent appointment of a Specialist Midwifery Band 7 role for retention, recruitment and pastoral care will support the development of the existing Maternity preceptorship programme and educational model in line with the retention of Newly Registered Midwives.

13.4 Data and Systems

- The development of a credible and transparent live workforce pipeline system now allows accurate workforce planning, ensuring an available workforce with the right skills.
- The system has now been handed over to the Trust Business Intelligence team to further develop this within the Yellow Fin system.

13.5 Surge and Escalation Planning

- Twice daily safe staffing meetings take place to provide assurance that safe and efficient staffing levels are in place across the Trust using recognised nationally approved tools including Safer Nursing Care Tool (SNCT) and Birth-rate plus.

- Following these meetings clear and accurate documentation is completed to detail the patient acuity and dependency levels, staffing in place and any associated professional judgement considered when formulating safe staffing plans and the discussion of safe staffing related datix or red flag submission.
- Following each meeting there is a clear decision making process relating to further escalation to the Heads of Nursing or to the Deputy Chief and Chief Nurse when appropriate.
- Specific escalation plans are in place for EAU/Emergency Care and Maternity to support the protection of service delivery in key areas such as Emergency care and Delivery Suite.

13.6 Alternative Workforce Modelling

- The Trust is fully engaged in the development of evidence based alternative workforce models.
- As part of the current surge planning an eleven bed frailty unit is being developed with an associated 19 short stay beds allowing for a mixed workforce model spanning Medical, Therapy, Nursing and Community Services to come together to wrap the required care planning and delivery of care around this specific group of patients.

13.7 Routes into Care

- Making the NHS the best place to work is a key commitment in both the Long Term Plan and the NHS People Plan which aims to empower leaders to provide greater development, flexibility and support options for staff which will all contribute to a more supportive working environment and will lead to a greater retention of staff.
- Significant collaborative work between Nursing, Therapy and Education teams have produced the first draft of a road map, identifying all possible routes into care within the Trust.

14. Conclusion

The purpose of this annual report is to provide the Board of Directors with comprehensive position in relation to the professional workforce capacity and advice upon compliance with national guidance. The review provides assurance in relation to the ongoing work and actions identified within this report including:

- In line with national guidance, the SNCT data collection has been completed and actions arising from the data analysis will be considered as part of the annual business planning processes.
- It has been identified that there may be a requirement for alternative workforce planning and a review of budget establishment in line with outcome of the SNCT data, in 3 in-patient wards. There is assurance that with the robust process in place in relation to patient experience and quality of care, the Trust is already sighted on these areas, providing enhanced support on a daily basis and developing an appropriate workforce to meet the changing needs of the patients.
- With the exception of the services highlighted in this report, the establishments in place remain fit for purpose. It is recognised that further changes in the acuity and dependency needs of patients in the future may impact service requirement

and will be considered in line with the strategic and operational governance in place identified in this report.

- Maternity workforce review and safer staffing management remains a high priority as outlined in the report and in line with the Ockenden report and recommendations.
- In line with Ockenden and the nationally recommended Continuity of Carer model, the existing Rowan team have been maintained but there has been a pause on any further roll out of Continuity of Carer at present. This has been agreed as part of the wider workforce review and a review of caseloads has taken place to support the delivery of maternity services. Further review will take place when the expected Birth Rate Plus report has been received.
- There is a continued clear focus on the safest redeployment of staff in line with individual staff members' level of skill and experience and patient's acuity and dependency needs to maintain the safest possible level of care to all patients.
- In line with the Nursing and Maternity workforce strategy, by introducing new roles, improving working conditions and supporting flexibility the Trust ambition is to attract, retain, and develop the workforce.
- Safer staffing management continues to be challenging due to existing vacancies, sickness absence levels, patient acuity and dependency levels and a sustained higher occupancy level which all impact on Trust fill rates with NHSP and subsequent CHPPD figures.
- All of the efforts being undertaken provide assurance there are workforce safeguards in place, the right staff, with the right skills are in the right place at the right time, whilst being financially sustainable.

15. Recommended Actions

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

- Review of the patient criteria, workforce establishments and alternative workforce modelling of wards 40, 42 and 36 to be undertaken by Responsive Care with support from but not exclusive to the Associate Director of Nursing and Professional Workforce and Workforce Business Partners.
- Review of the Critical Care workforce model following this workforce review to support the validation of the SNCT recommendations.
- Receive the outcome of the 3yr Birth Rate Plus establishment review across the Maternity in patient wards with the national Birth Rate Plus team with recommendations included in the next bi-annual report.
- Continue to monitor and support the compliance with Birth Rate plus to ensure validation of collected data.
- Continue with the recruitment of both domestic and international nurses
- For recommended actions in this report to be included in Care Groups annual workforce business planning process and to realign establishments in line with current budgets.
- To review the workforce models where alternative workforce modelling opportunities have been identified
- For a full update on the recommended actions from this report to be presented in the Bi-annual 6-month review in April 2023.

16. Risk and Mitigation

This report describes the nursing annual workforce establishment review process which has been completed in accordance with national guidance and awaits the formal establishment review of the Maternity Services. It highlights the on-going challenges presented in managing safer staffing across all services. There are some areas highlighted within this report which require further work to assure that their establishments are able to safely deliver the needs of their services. Recommended actions to achieve this assurance are outlined within this report.

There are naturally challenges associated with balancing establishment design with safer staffing and financial efficiency which will require mitigation through the robust governance processes that are already in place. Proactive workforce planning, alternative workforce design and strong working relationships across all teams and across the region will support the delivery of this work to ensure that patient and staff safety remains at the centre of all decisions, plans and actions associated with the safe staffing of all ward/departments and services.

17. Recommendations

The Board of Directors are asked to note the significant assurance provided within this report around safe Nursing and Midwifery staffing and to note the actions outlined within this report.

Lindsey Robertson
Chief Nurse, Director of Patient Safety and Quality

North Tees and Hartlepool NHS Foundation Trust

Trust Board

Title:	Maternity Board Report Quarter 3										
Date:	26 January 2023										
Prepared by:	Angela Storr, Quality Governance Lead Elaine Gouk, Clinical Director, Women & Children's Services										
Executive Sponsor:	Lindsey Robertson, Chief Nurse, Director of Quality and Patient Safety										
Purpose of the report	This paper provides the position in relation to oversight of Safety and Quality within Maternity services including items for escalation and mitigation										
	Approve		Assurance	X	Discuss	x	Information				
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led		

Executive Summary and the key issues for consideration/ decision:

This report provides a quarterly position to the Board on maternity, neonatal, and quality issues demonstrating that there are processes in place to identify safety and quality concerns with associated improvement plans and is part of compliance with the maternity incentive scheme safety actions 9.

In addition to the Trust report there is an established schedule for the Trust's Maternity and Neonatal Safety Champions to meet bi-monthly with the Board level Safety Champion and the Maternity Non-Executive Director Champion, to discuss local issues, local quality improvement projects and national or regional initiatives or reports. There is a pathway-demonstrating floor to Board communications and links with the Local Maternity Neonatal System. The Board champions undertake monthly visits to the clinical areas and share the feedback from staff and patients. Actions taken following feedback are shared in the monthly report to Patient Safety and Quality Standards Committee

This report includes:

- Reference to the Maternity Incentive Scheme (MIS) – full compliance, evidence and declaration report separately
- Serious Incidents (HSIB) overview
- Maternity Dashboard and improvement focus
- Perinatal Mortality Review Tool (PMRT)
- Workforce – including maternity and special care, which demonstrates an increasing vacancy rate in maternity services with appropriate mitigation and escalation to ensure safe staffing focused on Labour Ward. A full and comprehensive review has been commissioned by Birthrate+ and with a workforce transformation plan

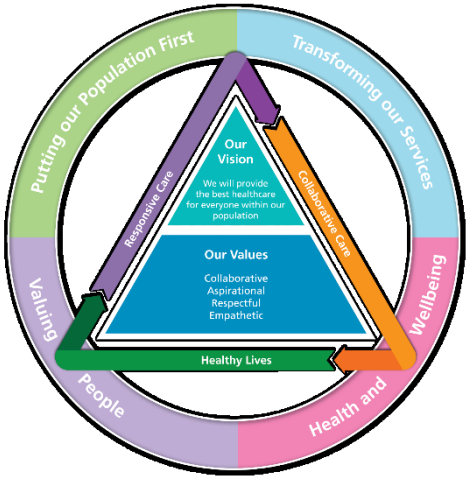
The Quarter 4 report will reflect the standard template developed by the LMNS, which provides information required for internal and system oversight.

How this report impacts on current risks or highlights new risks:

1A Patient Safety and Outcomes, 1B - Patient and Carers Experience, 2A - Recruitment and retention of staff with right skills and values No change to current risks identified in line with above board assurance frameworks and risk levels	
Committees/groups where this item has been discussed	Maternity Improvement Group Maternity Quality and Safety Council
Recommendation	• The Board of Directors are asked to acknowledge the significant safety improvement work undertaken within the maternity services • The Board of Directors are asked to note the processes in place to provide assurance that there is safe staffing across the maternity service and associated next steps;
Next steps for presentation e.g. Board Committee/Board meeting	Not applicable

Maternity Board Report
Quarter 3

January 2023



Summary of Contents

- Maternity Incentive Scheme – final compliance declaration
- Serious Incidents (HSIB)
- Maternity Dashboard
- Quarterly Reports
- Perinatal Mortality Review Tool (PMRT)
- Staffing

Maternity Incentive Scheme (MIS) final declaration of compliance Year 4

Progress:

- 16.01.23 - Review Healthy Lives Quality and Oversight meeting.
- 26.01.23 - Trust Board meeting MIS scheduled for presentation and sign off
- 27.01.23 - LMNS Sign off
- 26 January – 2 February 2023– portal opens for submission of signed Trust declaration (signed by Trust CEO & ICS AO

- Declaring compliance with 6 of the 10 safety actions at the beginning of January 2023 Benchmarking and compliance against each of the 10 safety actions has been completed. An evidence template and repository are also used to ensure that we have a record of all evidence to support a compliant declaration.

- Safety Actions partial compliance (not compliant) Safety Action 1,6 ,8 and 9.

- To be eligible for payment under the scheme - Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 2 February 2023

Serious Incidents Reported (1 Incident Reported – No HSIB)

Incident : Postpartum haemorrhage > 1500ml

Major post partum haemorrhage - 5,255mls following elective caesarean section (known placenta praevia); Patient was admitted to intensive care. The post partum haemorrhage was managed well.

The patient was returned to theatre due to abdominal pain, and ongoing bleeding. Patient underwent a cystoscopy, bilateral stents (urethral) subtotal hysterectomy and adhesiolysis to bowel under general anaesthetic. There was some concern about risk to bladder with a small serosal tear repair made in theatre.

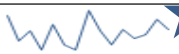
Immediate Actions

- Duty of candour undertaken (verbal with family); point of contact given to the patient and the patient concerns forwarded to investigation team;
- Close monitoring of the patient following delivery for further bleeding;
- Liaison was undertaken with the urology team;
- Terms of Reference meeting and full multidisciplinary case review;

Service Improvements

Project	Progress	Objectives
• Mat Neosip agenda Preterm optimisation (4 elements steroid , magnesium sulphate , delayed cord clamping , IV antibiotics)	• Progress 12 days of Christmas pre optimisation campaign	• Improve outcomes for premature babies.
• Detection of deteriorating woman estimation of post partum blood loss.	• Implemented delivery suite / Theatre / community – next step data collection	• Reduce the risk of maternal death from postpartum haemorrhage
• Uterine artery Doppler at 24 weeks gestation.	• Ultrasound Lead attended training Scan request now available on ICE (further work on use of APP)	• Improve fetal outcome and prevent intrauterine deaths.
• Training of staff to perform presentation scans at bed side (include band 6)	• All band 7s trained in scanning	• To ensure patients have informed choice about mode of delivery and identify fetal position
• Training of midwives and midwifery assistants to administer Flu Vaccine	• Training complete in community and Maternity day assessment unit	• To increase maternal uptake and reduce health implications on mother and baby from flu
• Development of Maternity Dashboard	• Ensuring oversight of relevant Safety standards by Trust Board (i.e. Stillbirth rates, Induction of labour , PPH)	• To produce a monthly dashboard which can be presented to board.

Maternity Dashboard

	Standard	Month	Q3	Trend
Live Births		214	624	
Still Birth Rate	*0.47%*	0.47%	0.32%	
Total Births		215	626	
Spontaneous vaginal deliveries		115	332	
Assisted Births		21	66	
Induction of Labour	*46.90%*	44.81%	44.98%	
Smoking at Booking	*11.00%*	15.09%	14.07%	
Smoking at Delivery	*11.00%*	14.15%	12.62%	
NeoNatal Deaths		1	1	
Births <=32 weeks		0.47%	0.48%	
Births <=36.6 weeks		12.09%	9.22%	
CoC placed on pathway		12.00%	7.96%	
CoC from BAME		6.67%	3.12%	
Complaints		2	8	
Compliments		35	85	
Friends and Family		96.77%	96.45%	

Key Improvements

- Instigated thematic review of all stillbirths occurring over a 12-month period covering 2021/22 has been undertaken with the support of external scrutiny. Awaiting report following the review;

- Three intrauterine deaths were reported to PMRT. Key area of focus to promote awareness around recording of CO (carbon monoxide) monitoring during pregnancy. *Smoking is recognised to increase a woman's risk of stillbirth*. The Saving Babies Lives Care Bundle version 2 (SBLCBv2) continues to make excellent progress towards full implementation - areas of focus are monitoring of CO levels throughout pregnancy and promotion of smoking cessation, training of sonographers to undertake uterine Doppler at 24 weeks and ensuring 90% of staff are trained in fetal monitoring;

- Ongoing improvement project in relation to the estimation of vaginal blood loss at the time of birth which has enabled an increased accuracy of assessment of maternal blood loss;

- 14 complaints; Common themes identified related to communication. Ongoing improvement with Maternity Voice partnership in developing the Facebook feedback page for patients and reviewing information provided for patients during the pregnancy journey;

- Rowan Midwifery Continuity of Carer (MCoC) team. June 2022, the local plans to pause the previously planned MCoC expansion programme was presented and supported at the Patient Safety and Quality Standards Committee. In September 2022, NHS England removed targets for the MCoC and advised to maintain and progress MCoC, only if there was safe minimum staffing. The Trust has paused further rollout of the MCoC and has maintained the Rowan team MCoC service provision. There are regular reviews of staffing in place

Workforce - Maternity

Row Labels	Sum of Budget	Sum of Actual	Sum of Variance		
Antenatal Assessment	11.5	10.38	-1.12		
Comm ED	6	4.2	-1.8		
Comm SOT & HP	26.59	21.55	-5.04		
Delivery Suite	32.42	24.34	-7.36		
Rowan Team	4.8	5.8	2		
Ward 22	23.13	19.96	-3.17		% Vacancy Rate
Grand Total	104.44	86.23	-16.49	16.49	15.79

- The service has a BirthRate+ staffing report for the midwifery establishment and the budget reflects this establishment; with an increase in vacancies in Q3 across B5 & 6
- Appropriate, embedded escalation processes are in place; increase temporary workforce including incentive rates via NHSP specialist roles including Ward Matrons working 50% operationally;
- NHSP fill rates across the whole service equates to 13.29wte filled and including 50% operational deliver leaves gap of 3.2 wte. Further workforce plans are being explored as part of maternity workforce transformation.
- Commissioned formal BirthRate+ Workforce review as per the national recommendations due Q4

Special Care Staffing

	Jul-22		Aug-22		Sep-22		Q2 22-23		% Days that met BAPM
RVI	8	23	23	8	10	20	41	51	55.4%
James Cook	9	22	6	25	2	28	17	75	81.5%
Sunderland	9	22	22	9	21	9	52	40	43.5%
North Tees	0	31	1	30	3	27	4	88	95.7%
Cramlington	0	31	2	29	5	25	7	85	92.4%
North Durham	7	24	9	22	3	27	19	73	79.3%
Darlington	0	31	2	29	3	27	5	87	94.6%
Carlisle	2	29	2	29	2	28	6	86	93.5%
Gateshead	0	31	0	31	0	30	0	92	100.0%
West Cumberland	12	19	3	28	2	28	17	75	81.5%

Number of days that did not meet BAPM
Number of days that did meet BAPM

- The Neonatal medical workforce achieves the required standards for a Special Care Unit.
- Nurse staffing is based on the British Association of Perinatal Standards (BAPM) at an 80% occupancy level, one nurse to four babies within the unit.
- The ‘Dinning Tool’ is used to support workforce planning reviewed as part of the workforce reviews every 6 months.
- There is monitoring of the staffing through the ODN with quarterly reports published - discussed with the Board Safety Champions at the MatNeo Safety Champions meetings.
- Compliance with these standards is highlighted in the table. In Quarter 2 our compliance was 95.7%.

Improvements & Developments

Improvements

- Maternity Safety Support Programme – advice and guidance
- Recruitment to Associate Director Maternity reporting to Chief Nurse;
- Recruitment to specialist roles including Retention Midwife, Digital Midwife and Infant feeding;
- Recruitment to 4 Senior Clinical Matron roles;
- Daily workforce huddles and completion of the daily regional sitrep
- Positive feedback from Student Midwives
- Recruitment to Band 5 midwifery roles
- Enhanced Preceptorship Programme
- AQUA culture programme

Ongoing Developments

- Recruitment and retention
- Improvement against CNST Incentive scheme: Safety Action 1,6 ,8 and 9
- Work ongoing towards compliance to the requirements of Ockenden.
- Completion of the Birth Rate + review and roll out .
- Work ongoing to ensure compliance towards all 5 elements of the Saving Babies Care Bundle V2 to reduce stillbirth rates (i.e. reduce smoking, roll out of Doppler scan at 24 weeks)

Thank you

North Tees and Hartlepool NHS Foundation Trust

Trust Board

Title:	Trust progress against the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4										
Date:	26 January 2023										
Prepared by:	Elaine Gouk, Clinical Director, Women & Children's Services										
Executive Sponsor:	Lindsey Robertson, Chief Nurse, Director of Quality and Patient Safety										
Purpose of the report	This paper provides the position and progress to the Board in relation to the compliance with the fourth year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions										
	Approve	x	Assurance	X	Discuss		Information				
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led		
Executive Summary and the key issues for consideration/ decision:											

Section 1 describes the purpose to the report, the declaration and the requirement of Trust Board
The Maternity Incentive Scheme requires the Trust's maternity services to submit the declaration form to the Trust Board and provide an accompanying presentation detailing the position and progress with the Maternity safety by the Head of Midwifery and Clinical Director. It also requires that the Trust Board to give permission to the Chief Executive to sign the declaration form, prior to submission to NHSR and to confirm there are no reports from national bodies that may subsequently provide conflicting information.

The Chief Executive will ensure that the Accountable Officer for the Integrated Care Board (ICB) is informed of the evidence and declaration form. The Chief Nurse has provided the Executive Chief Nurse for the ICB, a provisional overall compliance position in anticipation of the declaration.

The signed Board declaration form is required to be submitted to NHS Resolution Maternity Incentive Scheme by 12 noon on 2nd February 2023.

Section 2 includes a summary of the CNST
NHSR has published the Maternity Incentive Scheme for the fourth year running. This scheme for 2021/22 builds on previous years to evidence both sustainability and ongoing quality improvements. The safety actions described if implemented are considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025.

Section 3 reports the current position against the 10 incentives
Overall, the Trust has achieved full compliance in six of the 10 the Safety Actions, once evidenced by minutes, the decision of the Board. There is partial, but not complete compliance, in four of the 10 Safety Actions.

Section 4 provides a summary position against CNST Incentive Scheme Maternity Safety Action and includes improvements and reasons for partial compliance achieved to date.

The Trust has achieved full compliance in six of the 10 the Safety Actions once evidenced by minutes, the decision of the Board.

MSA 2 – The Trust is submitting data to the Maternity Services Data Set (MSDS) to the required standard;

MSA 3 – The Trust can demonstrate that we have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units (ATAIN) Programme**;**

MSA 4 – The Trust can demonstrate an effective system of clinical workforce planning to the required standard**;** Full compliance with Safety Action 4 will be achieved, once evidenced by minutes, the decision of the Board to acknowledge and engage with the Trust's commitment to the RCOG roles and responsibilities of the consultant in obstetrics and gynaecology in acute care.

MSA 5 – The Trust can demonstrate an effective system of midwifery workforce planning to the required standard**;**

MSA 7 – The Trust can demonstrate that we have a mechanism for gathering service users feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services**;**

MSA 10 - The Trust have reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22.
Partial compliance was achieved in 3 actions:

MSA 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

The Trust is using the National Perinatal Mortality Review Tool to review perinatal deaths and during the period from the 6th May 2022 to 5th December 2022, there were nine cases of perinatal deaths eligible for submission. It is important to note that In all cases investigations have been completed; the PMRT notification and surveillance form submission should be completed within seven days. All of our cases have had the notification information submitted, however the seven-day time frame had not been achieved in all cases. This has now been rectified and monitoring in place to ensure compliance with the required standard.

MSA 6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?

The Saving Babies' Lives care bundle is designed to tackle stillbirth and early neonatal death. It brings together five elements of care that are recognised to reduce risk: reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; effective fetal monitoring during labour; reducing pre-term birth. The Trust is compliant with three out of the five elements with improvement plans in place for element one and two:

Element 1:
Smoking status is assessed at the first contact and there is a smoking cessation pathway for support. Monitoring of carbon monoxide levels is undertaken and recorded in the handheld notes. There is an action plan in place to improve the compliance with carbon monoxide recording at each visit and there is an active maternity smoking cessation quality improvement project. The service has a plan to move to the Badgernet Maternity Information System which will aid in the recording and monitoring of the carbon monoxide readings undertaken in pregnancy.

Element 2:
A risk assessment to identify pregnancies at increased risk of developing fetal growth restriction (FGR) is undertaken at the time of booking. This is recorded in the handheld records. Pregnancies identified at increased risk, have additional ultrasound scan surveillance of growth. It is recommended that a uterine Doppler be undertaken at 24 weeks of gestation if the pregnancy is identified at risk of FGR. The sonographers are being trained as part of a quality improvement project and this should be in place during quarter 4. Women with a BMI>35 Kg/m^2 are offered growth scans from 32 weeks of gestation. Quarterly audits are undertaken to review babies born <3rd centile.

MSA 8 Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training over the next 3 years, starting from the launch of MIS year 4?

The Trust can demonstrate that here is a multi-professional training programme in place which has been revised to meet the requirements of the Core Competency Framework.

The training reports reflect the training days but do not reflect all of the training sessions from including 'ad hoc' skills drills or 1:1 fetal monitoring training sessions. To achieve full compliance with the standard, training for each staff group should be >90% for the training days.

There is a training action plan in place to improve the recording and monitoring of training completion with a trajectory to ensure compliance.

MSA 9 – Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal and quality issues?
The Trust can demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal and quality issues. There is a plan in place to revise the dashboard and further develop the information sharing processes with the Board.

How this report impacts on current risks or highlights new risks:	
Committees/groups where this item has been discussed	Maternity Improvement Group Maternity Quality and Safety Council Patient Safety & Quality Standards Committee
Recommendation	• The Board of Directors are asked to acknowledge the significant safety improvement work undertaken within the maternity services. • The Board of Directors are asked to acknowledge and engage with the Trust's commitment to the RCOG Workforce document on the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology and the action plan implemented to monitor compliance. • The Board of Directors are asked to give delegated authority to the Chief Executive to sign the Board declaration form confirming that they are satisfied that evidence provided to demonstrate compliance with seven of the maternity safety actions, meets the standards of the Maternity Incentive Scheme.
Next steps for presentation e.g. Board Committee/Board meeting	The Chief Executive to inform the Accountable Officer for the Integrated Care Board (ICB) the evidence and declaration form; The signed Board declaration form is required to be submitted to NHS Resolution Maternity Incentive Scheme by 12 noon on 2nd February 2023

North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

26 January 2023
Trust progress against the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4

Report of the Chief Nurse/Director of Patient Safety and Quality and the Clinical Director of Women and Children's Services

Strategic Objective*:* Putting Our Population First, Valuing People and Transforming our Services.

1.0 Introduction

1.1 NHS Resolution (NHSR) is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), to continue to support the delivery of safer maternity care. The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

1.2 The Maternity Incentive Scheme Year four has been interrupted and nationally paused during the year due to the impact of Covid-19 and the recognised operational pressures on the NHS.

1.3 As in previous years, the scheme incentivises investment for improvement in ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.4 Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

1.5 The Maternity Incentive Scheme requires the Trust's maternity services to submit the declaration form to the Trust Board and provide an accompanying presentation detailing the position and progress with the Maternity safety by the Head of Midwifery and Clinical Director. It also requires that the Trust Board to give permission to the Chief Executive to sign the declaration form, prior to submission to NHSR and to confirm there are no reports from national bodies that may subsequently provide conflicting information. The Chief Executive will ensure that the Accountable Officer for the Integrated Care Board (ICB) is informed of the evidence and declaration form. The signed Board declaration form is required to be submitted to NHS Resolution Maternity Incentive Scheme by 12 noon on 2nd February 2023.

1.6 This paper provides the position and progress to the Board in relation to the compliance with the fourth year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions.

2.0 Background

2.1 NHSR has published the Maternity Incentive Scheme for the fourth year running. This scheme for 2021/22 builds on previous years to evidence both sustainability and ongoing quality improvements. The safety actions described if implemented are considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025.

2.2 The maternity service has assessed itself against the current Maternity Incentive Scheme safety standards.

2.3 There are a range of external validation points with cross checking from MBRRACE-UK, NHS England and Improvement for Maternity Services Data Set, National Neonatal Research Database and Healthcare Safety Investigation Branch (HSIB).

3.0 Current Position

3.1 The reporting period for Year-4 of the CNST Maternity Incentive Scheme was deferred by NHSR due to Covid-19 and the operational pressures across the NHS.

3.2 Overall, the Trust has achieved full compliance in six of the 10 the Safety Actions once evidenced by minutes, the decision of the Board. There is partial, but not complete compliance, in four of the 10 Safety Actions.

3.3 The evidence is reviewed by the CNST working group on a monthly basis with assurance and exceptions reported through the Maternity Quality and Assurance group to Patient safety and quality standards committee.

4.0 The CNST Incentive Scheme Maternity Safety Actions

Safety Action 1
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Partial compliance with Safety Action 1 has been achieved.

The Trust submits information on eligible perinatal deaths to the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) site. The site hosts the Perinatal Mortality Review Tool (PMRT), which is a national tool to be used for recording findings and learning from a multidisciplinary case review of perinatal deaths from 22 weeks of gestation. All parents are informed that a review is taking place and are invited to submit questions from their perspective or raise any concerns to be considered in the review.

During the period from the 6th May 2022 to 5th December 2022, there were nine cases of perinatal deaths eligible for submission. In all cases investigations are completed. PMRT

notification and surveillance form submission should be completed within seven days. All of our cases have had the notification information submitted, however the seven-day time frame had not been achieved in all cases. There have been staff changes in the team submitting the initial PMRT information. A training need was identified for the new staff submitting the forms to ensure that the surveillance form was submitted as well as the notification form and that the interim report that has been completed in every case, is uploaded to the site. This has been addressed and in addition, the Patient Safety Lead has trained more staff in the process, to enable a more timely submission of all of the forms and information in every case. The case reviews require a multi-professional team and operational pressures have delayed completion of the investigations within the optimum timeframe in some of our cases. An action plan has been developed to improve the process and ensure monitoring of submission and completion.

Information from the learning following PMRT case reviews has been included in the quarterly report for Board. The PMRT quarterly report will be included in future maternity reports for the Board.

Safety Action 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Full compliance with Safety Action 2 has been achieved.

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. NHS Digital has confirmed that the MSDS data quality achieved the required standard in the required timeframe.

The Trusts has a Maternity Digital Strategy which has been shared with Local Maternity and Neonatal System (LMNS). Representatives from the Trust have engaged in the LMNS digital group who are working to improve standardisation of data submission.

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units (ATAIN) Programme?

Full compliance with Safety Action 3 has been achieved.

Transitional care services are delivered on the postnatal ward and the activity is coded. There is an agreed pathway that has been developed with support from the maternity and paediatric departments. On a monthly basis, the management of any unexpected admissions to the Special Care Unit of babies born at term, are reviewed and shared at the local risk management and joint maternity-neonatal meetings, to determine any common themes and learning points. The Neonatal ODN share Network and Trust reports on a quarterly basis and these reports have been discussed at the MatNeo Safety Champions meetings with the Board Maternity Safety Champions. The ATAIN action plan and updates on learning and developments have been shared with the LMNS and included in the submitted Board Reports. The quarterly Transitional Care audit reports and ATAIN action plan have been shared at the MatNeo Safety Champions meeting with the Board level Champions.

Safety Action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Full compliance with Safety Action 4 will be achieved, once evidenced by minutes, the decision of the Board

The Consultant Obstetric team and Senior Care Group Management team committed to incorporating the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) publication on Roles and Responsibilities of the Consultant Providing Acute Care in Obstetrics and Gynaecology. A local guideline was produced to clarify for all staff, the expectations for consultant attendance in certain obstetric emergency cases. The monitoring of compliance is undertaken by the incident reporting process. Incidents are reviewed at the safety meetings. Any out of hours' supervision related incidents are reported, along with the actions taken, in the monthly Maternity Report submitted to the Patient Safety and Quality Standards Committee. An improvement plan

The organisation has achieved the Anaesthetic Clinical Services Standard 1.7.2.1 listed in the Maternity Incentive Scheme with a duty anaesthetist immediately available 24 hours a day.

The Neonatal medical workforce achieves the required standards for a Special Care Unit. The nursing staffing on the Special Care Unit Staffing is based on the British Association of Perinatal Standards (BAPM) at an 80% occupancy level, which is one nurse to four babies within the unit. To be fully compliant there is a requirement for a supernumerary team lead to be incorporated into the current establishment. Due to the acuity, the standards may be met with a reduced establishment. The Dinning Tool is used to support workforce planning and this is reviewed, as part of the workforce reviews which occur every 6 months. There is monitoring of the staffing through the ODN with quarterly reports published and these have been discussed with the Board Safety Champions at the MatNeo Safety Champions meetings. There is an on-going action plan in place which outlines the actions taken since year three of the CNST MIS which includes exploring expansion of the supporting workforce and embedding the Safecare acuity tool.

Safety Action 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Full compliance with Safety Action 5 has been achieved.

The service has a BirthRate+ staffing report for the midwifery establishment and the budget reflects this establishment. The Trust is currently undergoing a formal BirthRate+ Workforce review as per the national recommendations and the results are awaited. There is local guidance on monitoring staffing and escalation plans in place. Local audits and mixed methodologies have been undertaken to ensure safe staffing. There is a delivery suite acuity tool that enables the organisation to identify when escalation to increase Midwives is required to enable the shift leader to be supernumerary. Targeted work is currently underway to improve the use of the acuity recording tool.

There has been an active plan for recruitment to the midwifery services. There have been several appointments made to strengthen the senior midwifery leadership team and

specialist midwifery roles which should be in place by the end of quarter 4. There is ongoing recruitment to strengthen the clinical governance team and midwifery workforce.

Safety Action 6

Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?

Partial compliance with Safety Action 6 has been achieved.

The Saving Babies' Lives care bundle is designed to tackle stillbirth and early neonatal death. It brings together five elements of care that are recognised to reduce risk: reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; effective fetal monitoring during labour; reducing pre-term birth. The Trust participates in the Perinatal Institute's Growth Assessment Protocol using customised fundal charts.

Element 1:
Smoking status is assessed at the first contact and there is a smoking cessation pathway for support. Monitoring of carbon monoxide levels is undertaken and recorded in the handheld notes. There is an action plan in place to improve the compliance with carbon monoxide recording at each visit and there is an active maternity smoking cessation quality improvement project. The service has a plan to move to the Badgernet Maternity Information System which will aid in the recording and monitoring of the carbon monoxide readings undertaken in pregnancy.

Element 2:
A risk assessment to identify pregnancies at increased risk of developing fetal growth restriction (FGR) is undertaken at the time of booking. This is recorded in the handheld records. Pregnancies identified at increased risk, have additional ultrasound scan surveillance of growth. It is recommended that a uterine Doppler be undertaken at 24 weeks of gestation if the pregnancy is identified at risk of FGR. The sonographers are being trained as part of a quality improvement project and this should be in place during quarter 4. Women with a BMI>35 Kg/m^2 are offered growth scans from 32 weeks of gestation. Quarterly audits are undertaken to review babies born <3rd centile.

Element 3:
Women are provided with an information leaflet at booking about reporting reduced fetal movements and audits are undertaken to assess the compliance and women's awareness. Women presenting with reduced fetal movements have a cardiotocograph (CTG) to assess fetal wellbeing. On the maternity day unit, computerised CTG assessments are undertaken to assess fetal wellbeing following presentation with reduced fetal movements and audit has shown 100% compliance with this standard. Equipment updates and training for all staff in other areas is being completed. The Fetal Wellbeing Lead Midwife oversees annual training in the use of CTG equipment and it is in the 2023 mandatory training plan.

Element 4:
All maternity midwifery and medical staff receive training on fetal monitoring as part of the departmental multidisciplinary mandatory training programme. The maternity department has also acquired the fetal monitoring e-Learning modules of the K2 Perinatal Training Programme for further training in antenatal and intrapartum fetal surveillance. There is a Fetal Wellbeing Lead Midwife and Obstetrician. In addition to the required training the fetal wellbeing leads undertake regular 1:1 training sessions and multidisciplinary, fetal monitoring

focused case reviews for learning, training sessions on labour ward and remotely. There is an action plan to include accurate recording of all training episodes for all staff groups.

Element 5:
A risk assessment is undertaken at booking to identify women at increased risk of preterm birth by the use of risk assessment tool. This enables early access to high or moderate risk pathways of care which aim to reduce the risk of preterm birth. Local audit has shown this risk assessment tool has been embedded into practice. There is a dedicated preterm prevention consultant antenatal clinic on each site to enable specialist care for pregnancies at high risk. There are dedicated consultant multiple pregnancy clinics on each site and the pathway of care follows the NICE guidance.

The progress of the actions plans and quality improvement work will be monitored at the Maternity Improvement Group, Maternity Quality Assurance and Safety Council and the Patient Safety and Quality Standards Committee.

Safety Action 7
Can you demonstrate that you have a mechanism for gathering service users feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services?

Full compliance with Safety Action 7 has been achieved.

The Maternity Voices Partnership (MVP) has been established with terms of reference in line with the national recommendations. The MVP have an agreed work plan that has been shared with the LMNS. There are MVP meetings to share feedback and the joint Chairs of the MVP have been included in the Maternity Improvement Group, which is chaired by Care Group Director and is attended by the maternity senior team.

The Trust Board Safety Champions undertake monthly walk abouts in the clinical areas to gain feedback. Actions taken following feedback from the MVP and other sources of user group feedback are included in the monthly report at the Patient Safety and Quality Standards Committee.

Safety Action 8
Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training over the next 3 years, starting from the launch of MIS year 4?

Partial compliance with Safety Action 8 has been achieved.

There is a multi-professional training programme in place. The programme undergoes regular review and has been revised to meet the requirements of the Core Competency Framework on Saving Babies Lives Care Bundle, fetal surveillance in labour, maternity emergencies, personalised care, care in labour and postnatal period and neonatal life support. Training involves a hybrid of face to face training and virtual multi-professional training sessions.

Emergency obstetric skills training occurs on multi-professional training days and also as planned and ad-hoc sessions in-situ, in the clinical areas.

The training reports reflect the training days and some of the other training sessions but do not reflect all of the training sessions from the ad hoc skills drills or 1:1 fetal monitoring

training sessions. To achieve full compliance with the standard, training for each staff group should be >90% for the training days.

Staff Group	Emergency Skills	Fetal Monitoring
Midwives	99%	99%
Other maternity staff – MA/HCA/RN/MSW	91%	N/A
Consultant obstetricians	94%	94%
Other obstetric doctors	85%	73%
Consultant anaesthetists	59%	N/A
Other obstetric anaesthetists	40%	N/A

There is a training action plan in place to improve the recording and monitoring of training completion and the training trajectories for completion. The training programme will be reviewed to ensure access to the training days and emergency skills drill sessions for all staff groups.

The progress of the actions plans and quality improvement work will be monitored at the Maternity Improvement Group, Maternity Quality Assurance and Safety Council and the Patient Safety and Quality Standards Committee.

Safety Action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal and quality issues?

Partial compliance with Safety Action 9 has been achieved.

There is an established schedule for the Trust's Maternity and Neonatal Safety Champions to meet bi-monthly with the Board level Safety Champion and the Maternity Non-Executive Director Champion, to discuss local issues, local quality improvement projects and national or regional initiatives or reports. There is a pathway showing floor to Board communications and links with the LMNS and regional quality. The Board champions undertake monthly visits to the clinical areas and share the feedback from staff and patients. Actions taken following feedback are shared in the monthly report to Patient Safety and Quality Standards Committee.

The Trust has supported engagement in the Maternity & Neonatal Safety Improvement Programme (MatNeoSIP) and has been represented at the NENC MatNeoSIP meetings and supported the national initiatives. There has been a programme of work initiated and on-going to enhance psychological safety in the maternity services.

Safety Action 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Full compliance with Safety Action 10 has been achieved.

The organisation can demonstrate that 100% of qualifying cases in 2021/22 were reported to HSIB and NHS Resolutions Early Notification Scheme.

There is an established process for incident review and reporting within the Trust. Serious incident reports are shared at the Trust Safety Panel which is chaired by the Board level Maternity Safety Champion and attended by the Maternity Non-Executive Director. A summary of serious incidents is presented at the Patient Safety and Quality Standards Committee along with the quarterly reports of all incidents, including claims and complaints.

There were four referrals to HSIB during the time period 1st April 2021 to 5th December 2022. The Trust informs families of the HSIB and EN Scheme processes and when applicable, duty of candour is applied. Any case referred to HSIB, and the learning from the local case review and the HSIB report, is shared in the monthly Maternity Report presented at the Patient Safety & Quality Standards Committee meeting.

5.0 Recommendation

5.1 The Board of Directors are asked to acknowledge the safety improvement work undertaken within the maternity services.

5.2 The Board of Directors are asked to acknowledge and engage with the Trust's commitment to the RCOG Workforce document on the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology and the action plan implemented to monitor compliance (Appendix 1).

5.3 The Board of Directors are asked to give delegated authority to the Chief Executive to sign the Board declaration form confirming that they are satisfied that evidence provided to demonstrate compliance with six of the maternity safety actions, meets the standards of the Maternity Incentive Scheme.

Lindsey Robertson
Chief Nurse
Director Patient Safety and Quality

Elaine Gouk
Clinical Director for Women and Children

Appendix 1

Action Plan

Title: RCOG Roles and Responsibilities of the consultant providing acute care in obstetrics & gynaecology

Developed by: Elaine Gouk **Lead:** CD WACS **Date** Updated January 2023

Item	Problem/Issue/Identified gap in service	Specific proposed actions:	Date action initiated:	Respon sibility: .	Planned completio n date:	Progress / Update	Final Evaluation or Impact
1	CNST-MIS year 4 Requirement to commit to the principles of the RCOG document	To get Consultant, Senior Maternity Team and Care Group Leads to confirm commitment to adopt principles in the RCOG document	31/05/22	CD	June 2022	31/05/22 Consultants informed of CNST requirement and previous support for the document and local guideline (M123) which was developed for consultant attendance, as per RCOG document. It was approved by the Trust Clinical Guideline Group & published 28/01/22 14/0622 Commitment to the RCOG document confirmed by the Senior Maternity and Care Group Management Team at the Maternity Improvement Group 14/06/22 22/09/22 Commitment to the RCOG document shared with the Trust Board Report in quarterly maternity safety report	Improved clarity on the expectations for consultant attendance
2	July 2022	Incident reported review	Jul 2022	CD	Aug 2022	No related incidents	
3	August 2022	Incident reported review	Aug 2022	CD	Sept 2022	No related incidents	
4	One incident reported September 2022 Inability to contact consultant by phone	Check contact information for consultant	Sept 2022	CD	Oct 2022	Contacts number/s for consultant checked Remind staff to check phone charged and vocera working at start of each shift – shared in Risky Business October 2022 – Complete Shared at PS&QS November 2022	
5	October 2022	Review reported incidents	Oct 2022	CD	Nov 2022	No related incidents	
6	November 2022	Review reported incidents	Dec 2022	CD	Dec 2022	No related incidents	

Item	Problem/Issue/Identified gap in service	Specific proposed actions:	Date action initiated:	Respon sibility: .	Planned completio n date:	Progress / Update	Final Evaluation or Impact
7	One incident December 2022 Issue with mobile phone – another consultant contacted and attended	To ensure consultants have a backup contact number for on call out of hours	Dec 2022	CD	Feb 2023	29/12/22 (NW) communication with switchboard to check lists and additional Trust phones ordered for Consultants with only one contact number. 19/01/23 – One phone order awaited. Incident and action to be shared at PS&QS in January maternity report	
8	Expand monitoring process	Add case note audit for of 10 cases / month in addition to datix incident review monitoring process	January 2023	CD	On-going	Audit process commenced	

Maternity incentive scheme - Board declaration Form

Trust name North Tees and Hartlepool NHS Foundation Trust
Trust code T487

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	No	Yes	-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	No	Yes	49,452	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	16,216	
Q9 Safety Champions	No	Yes	-	
Q10 EN scheme	Yes		-	
Total safety actions	**6**	**4**		
Total sum requested			**65,668**	

Sign-off process:

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Confirming that:
There are no reports covering either **this year (2022/23) or the previous financial year (2021/22)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Electronic signature

For and on behalf of the board of North Tees and Hartlepool NHS Foundation Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name:
Position:
Date:

Maternity Incentive Scheme Evidence Links

North Tees and Hartlepool NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Link to Evidence
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 1
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 2
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units (ATAIN) Programme?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 3
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 4
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 5
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2?	No	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 6
7	Can you demonstrate that you have a mechanism for gathering service users feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 7
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training over the next 3 years, starting from the launch of MIS year 4?	No	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 8

Maternity Incentive Scheme Evidence Links

North Tees and Hartlepool NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Link to Evidence
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal and quality issues?	No	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 9
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Yes	V:\Project Management\Individual Directorate Folders\Care Group 1 - Healthy Lives\Womens and Childrens\Obstetrics and Gynaecology\Project Workbooks 2022-23\Transformational\MIS - Year 4\Safety Action 10

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Learning from Deaths Report, Quarter 3, 2022-23										
Date:	26th January 2023										
Prepared by:	Janet Alderton, Head of Patient Safety										
Executive sponsor:	Medical Director										
Purpose of the report	To provide an overview of the learning obtained through the review of deaths that occur within the organisation. Also, to provide details from the clinical teams around actions that have been implemented as a result of the overall learning and, where available, to provide an evaluation of the impact of these.										
Action required:	Approve	X	Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People		Transforming our Services		Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

- The Trust HSMR value is **93.28** (November 2021 to October 2022), this is an increase from the previous reported value of **92.24** (October 2021 to September 2022). The latest SHMI value has increased to **99.19** (August 2021 to July 2022) from the previous rebased value of **98.61** (July 2021 to June 2022). Both statistics remain "within expected" ranges.

- The successful implementation of the Medical Examiners role has prompted a review of the Trusts policies; the Trust Mortality Lead and the Lead ME are reviewing the overall strategy and policy in relation to learning from deaths. The planned changes are expected to support clinical staff in completing reviews and identifying learning to generate quality improvement measures.

- There is summary information in the report relating to actions initiated as a result of learning from information relating to management of the Deteriorating Patient.

- To date in 2022-23, there are nine cases that have been investigated as Serious Incidents, five of these have been investigated and it is possible in four of these that the overall outcome may have been different with different care provision. There are a further four cases still being investigated and the outcome of this investigation will be reported in future reports.

How this report impacts on current risks or highlights new risks:

Any new risks identified through mortality review processes are assessed and added to the risk register as needed.

Committees/groups where this item has been discussed	• Patient Safety & Quality Standard Committee • Patient Safety Council
Recommendation	• The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover. • The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation. • The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

26th January 2023

Learning from Deaths Report, Q3, 2022-23

Report of the Medical Director

1. Introduction/Background

1.1 In March 2017, the National Quality Board (NQB) published national guidance "Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care". The guidance provides requirements for Trust to implement as a minimum in order ensure there is a focused approach towards responding to and learning from deaths of patients in our care.

1.2 The Trust strives to improve the care provided to all of our patients; the overall aim is to identify, understand and implement improvements where any issues may be related to the provision of safe and effective quality care. It is considered that as safety and quality improvements are initiated effectively and embedded, then the mortality statistics will naturally be maintained within "as expected" range.

1.3 The information presented in this report provides an overview of learning from deaths that has been obtained from mortality scrutiny and case reviews undertaken by the Trust. Information from a variety of speciality areas is being provided within the reports on a cyclical basis.

1.4 The number of mortality reviews undertaken by the Trust has been significantly reduced during the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. The introduction of the Medical Examiners scrutiny has assisted in ensuring all in-patient deaths are reviewed.

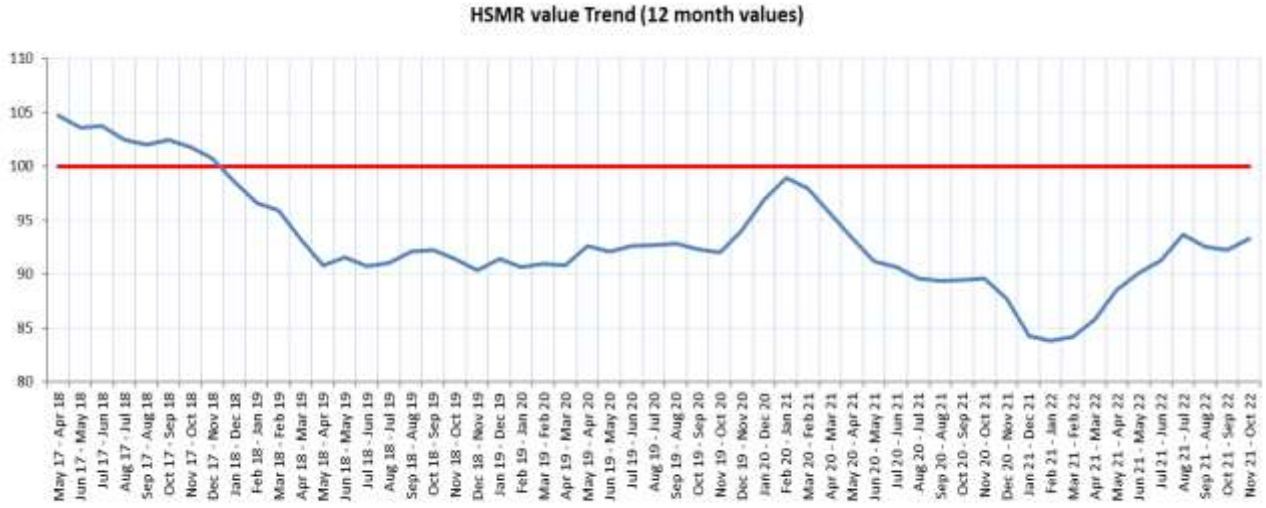
2. Mortality Data

2.1 Information related to mortality is gathered from data provided routinely by the Trust to the national system where all hospital episode statistics (HES Data) is collated. Hospital Standardised Mortality Ratio (HSMR) examines information covering 56 diagnostic groups that are identified as accounting for 80% of hospital deaths nationally.

This information is used to calculate an overall HSMR taking into account, gender of the patient, age, how the patient was admitted (emergency or elective), levels of deprivation, how many times they have been admitted as an emergency in the last year, if palliative care was provided and various details relating to presenting complaint on admission.

2.2 The latest HSMR value is now **93.28** (November 2021 to October 2022), this is an increase from the previous rebased value of **92.24** (October 2021 to September 2022).

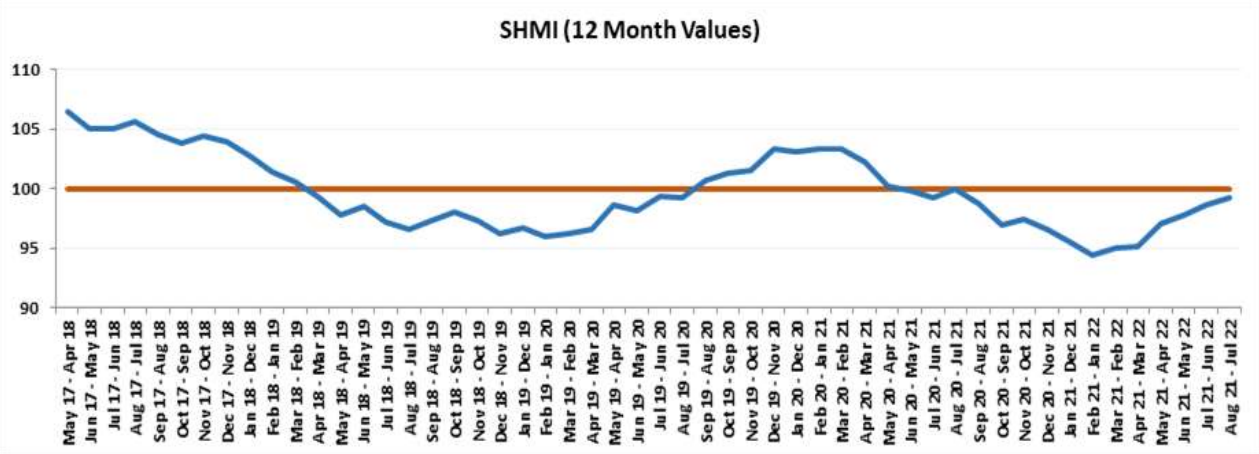
2.3 The value of 92.24 continues to remain inside the 'as expected' range. The following chart displays the 12 month rolling HSMR trends from April 2018 to October 2022:



2.4 The regional position sees the Trust 2nd lowest of the 8 regional Trusts with 93.28, (the range is 132.69 to 90.91).

2.5 The Summary Hospital-level Mortality Indicator (SHMI) is a ratio between the number of actual (observed) deaths to the "expected" number of deaths for an individual Trust, including deaths in hospital and up to 30 days following discharge. The ratio is calculated with consideration of gender, age, admission method, admissions in the last year and diagnosis being treated for the last admission.

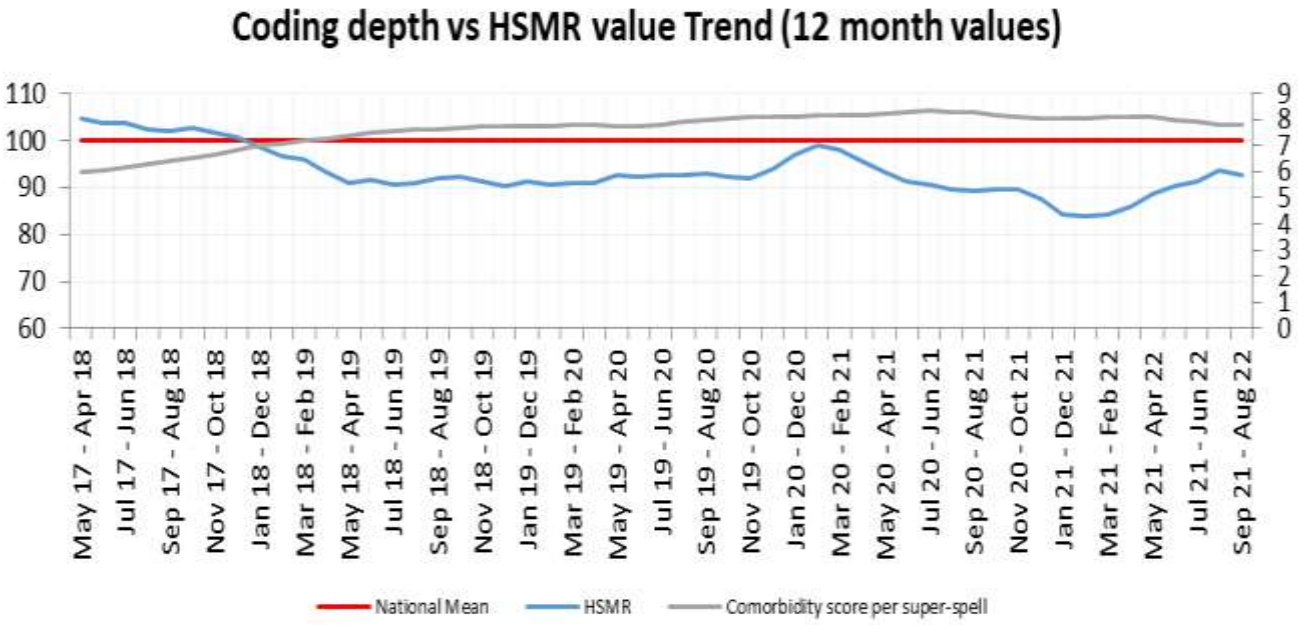
2.6 The latest SHMI value is now this has increased to **99.19** (August 2021 to July 2022) from the previous rebased value of **98.61** (July 2021 to June 2022). The value continues to remain inside the 'as expected' range. The graph below shows the 12 month rolling SHMI from April 2018 to July 2022:



2.7 The regional position sees the Trust 4th lowest of the 8 regional Trusts with 99.19, (range is 111. to 91.49).

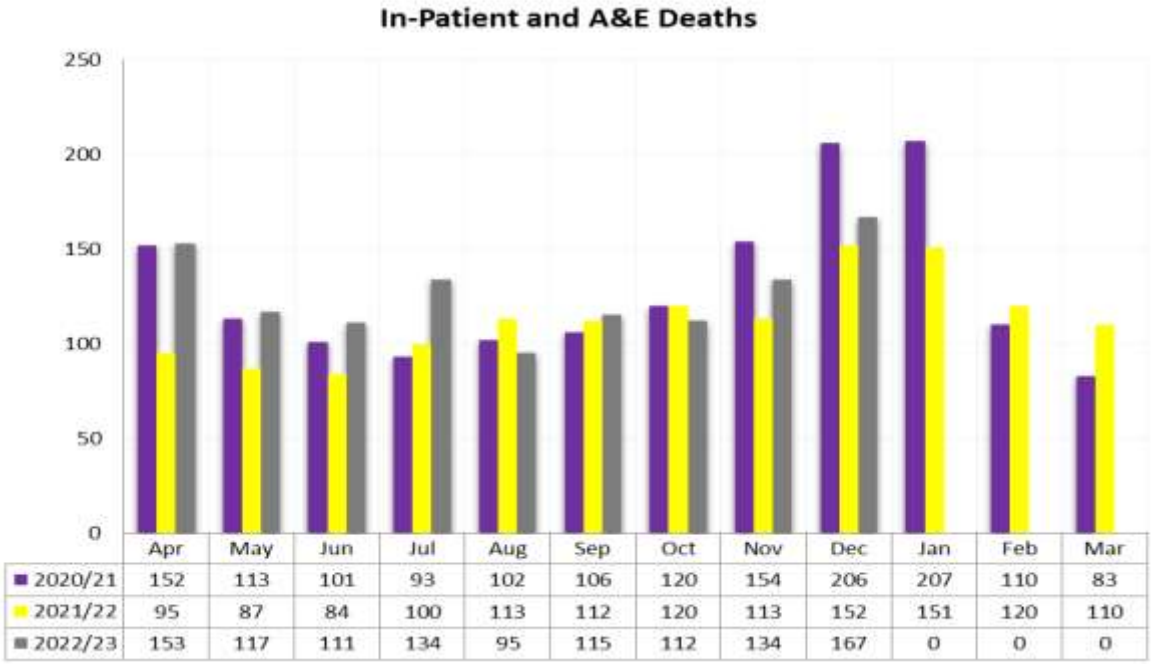
2.8 There continues to be an ongoing focus on ensuring there is accurate documentation of the diagnosis and co-morbidities; this information is required to ensure there is clear clinical communication between healthcare professionals who are caring for the patients.

The Trust is currently maintaining a high level of clinical coding, with a current average of eight co-morbidities recorded for patients; this level of coding is now thought to more accurately reflect overall health problems and deprivation within the local population. Maintaining this level of information reflects the quality in not only the clinical documentation, but also the quality of the clinical coding activity within the organisation. This has been challenging during the Covid pandemic, there had been changes in clinical coding national requirements; previous reports had highlighted that this had led to some uncertainty in relation to longitudinal prediction of the mortality statistics.



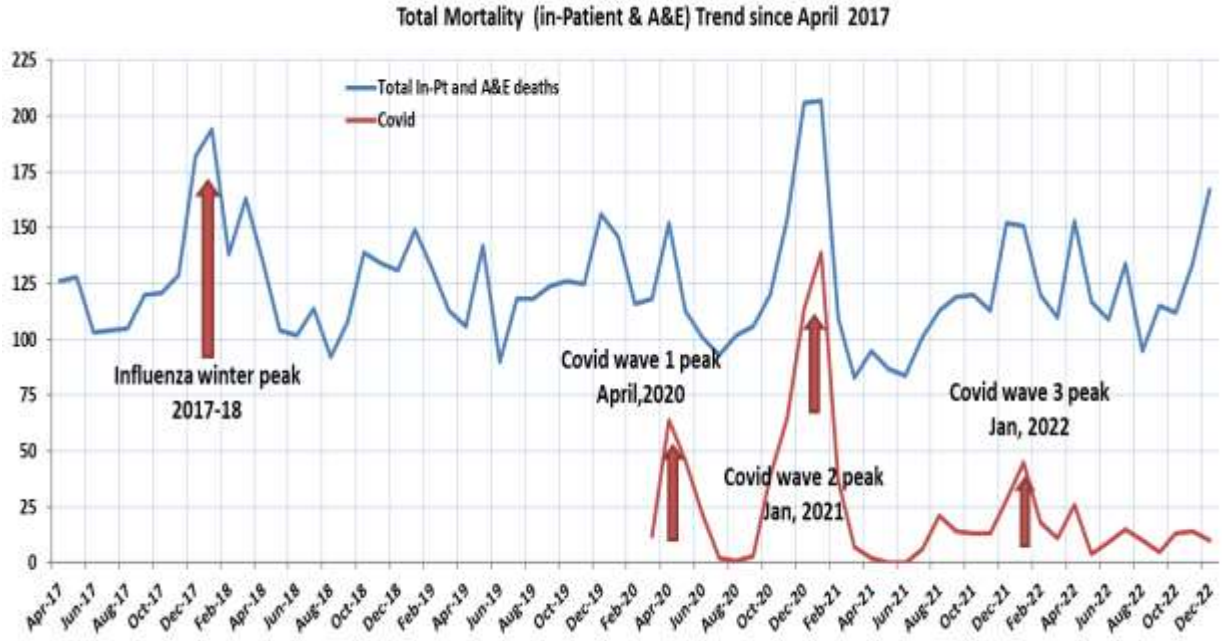
3. Mortality reviews

3.1 The Trust policy currently identifies that all in-patient deaths and those in the Accident and Emergency department are included in the scope of the mortality reviews. The chart below shows the total numbers of deaths by month since April 2020 to the end of December 2022.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	152	113	101	93	102	106	120	154	206	207	110	83
2021/22	95	87	84	100	113	112	120	113	152	151	120	110
2022/23	153	117	111	134	95	115	112	134	167	0	0	0

3.2 The following chart shows the monthly trend and fluctuations in mortalities since April 2017 to December 2022. The red markers represent key areas of peak deaths linked with influenza over the winter of 2017-18 and Covid-19 from March 2020. The red line represents the numbers of Covid deaths logged by the Trust since March 2020.



3.3 All patient deaths are scrutinised by the Medical Examiners (ME) team, part of this involves contacting the patient's family or carers to discuss their death. This provides the opportunity for family's / carers to raise any concerns they might have but also for them to discuss with the ME, the medical cause of death or if there has been a referral to the Coroner, and why.

3.4 Mortality case reviews can be requested following the ME discussions, but are also undertaken for the following cases, which are linked to specific national review processes:

- All deaths where a patient has a registered Learning Disability (LD) – in conjunction with the Learning Disability Mortality Review Programme (LeDER).
- All maternal deaths – in conjunction with M-BRRACE-UK.
- All deaths where the patient has a severe mental illness – in conjunction with local Mental Health Trusts as required.
- All child deaths (up to 18th birthday) – in conjunction with the Child Death Overview Panel (CDOP) process, this may also link into Perinatal Mortality or LeDeR reviews.
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool; (these figures are not included within overall mortality data provided in the tables above).

3.5 The Trust is currently reviewing its processes for mortality case reviews; there will continue to be the required reviews as outlined above, however, these will be linked closely with learning from other complex cases where a patient may not have died or also any relevant thematic reviews that are identified. Cases will then be considered at a variety of speciality mortality and morbidity (M&M) meetings; the learning from these review sessions will then be shared at a Trust wide group to allow identification of overarching issues that may require local or more significant quality improvement work. These changes are based around the national "Better Tomorrow Programme: learning from deaths, learning for lives"; which is a national programme providing support and tools for Trusts to use. As the Trust work develops, more detail will be

provided in future reports, currently 14 members of staff have been trained in the use of the review tool and this will support completion of SJRs.

3.6 The following table provides a summary of the data, by financial quarters, to date for 2022-23. The numbers of mortality cases given scrutiny by the Medical Examiners team has been included in the chart below to demonstrate the integration of the two approaches to reviewing the care of our patients. The ME team can refer any cases into the overall mortality review system for further interrogation of clinical care or if necessary into the established governance structures.

To date in 2022-23, there are nine cases that have been investigated as Serious Incidents, five of these have been investigated and it is possible in four of these that the overall outcome may have been different with different care provision. There are a further four cases still being investigated and the outcome of this investigation will be reported in future reports.

2022-23	Q1	Q2	Q3	Total
Total deaths in scope	388	349	412	**1149**
Deaths in compulsory criteria	49	51	37	**137**
Compulsory case reviews completed (no.)	27	32	9	**68**
Compulsory case reviews completed (%)	55%	63%	24%	**50%**
Compulsory reviews pending	21	19	28	**68**
Reviews & ME scrutiny completed	375	350	260	**985**
Review/ Scrutiny completed of all deaths (%)	96%	99%	63%	**86%**
Reviewed Deaths considered avoidable (no.)	2	2	0	**4**
Reviewed Deaths considered avoidable (%)	0.1%	0.1%	0%	**0.1%**
Reviewed Deaths considered not preventable (no.)	373	348	260	**981**
Reviewed Deaths considered not preventable (%)	99.9%	99.9%	100%	**99.9%**

3.7 Where a patient's death immediately raises concern, this is reported, and then escalated through the Trusts incident reporting and investigation process, implementing Duty of Candour procedures as required. The details of the case will then be considered in line with the national Serious Incident framework to ensure any lessons learned are identified and reported to the Trusts commissioners. A case record review is completed as part of the investigation process. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.

3.8 During October and November 63% of mortalities have been given either scrutiny by the ME team, or where the patient passed away on ITU, reviewed by the clinical team involved. The data for the reviews and scrutiny in December is not yet available for reporting. Stillbirths are reviewed using the Perinatal Mortality Review Tool and have been added to the overall mortality numbers. There has been a low number of other SJRs completed for those cases identified as requiring further review. As the ME team are now identifying cases where they consider additional learning can be obtained, they are requesting SJRs are completed, the relevant clinical teams are being asked to complete these. The Trust Mortality Lead will be progressing this requirement in order to collate the learning from these reviews; the output from these will then be utilised to enhance the content of future reports.

3.9 The Trusts Safety Panel receives summary reports giving details of thematic learning from the following groups:

- Cardiac arrest reviews
- Intensive Care deaths
- Medical Examiner scrutiny
- Emergency Department deaths

These areas provide a monthly summary providing details of the number of cases reviewed; these provide information to help identify trends in "real time" so that actions and improvements are generated and initiated promptly. Details of thematic issues raised are included in the and will be in future reports as the relevant services provide updates on lessons learned, improvements made and overall evaluation of impact.

4. Learning from Deaths

4.1 Deteriorating Patient

4.1.1 The Deteriorating Patient Group provides oversight of any learning from serious incidents relating to the failure to recognise and respond to a deteriorating patient and ensures staff receive the appropriate training and advice to respond to a deteriorating patient. The group consists of senior clinical staff and is multidisciplinary, with all speciality groups represented. This is to ensure good communication and sharing of information. This group is also working in collaboration with the Regional Deteriorating Patient and Critical Care Outreach Group (DePACCO), with information shared at both groups for wider learning.

4.1.2 The Deteriorating Patient Board Assurance Framework relates to all aspects of care and management of the deteriorating patient. This gives assurance there are appropriate controls in place for all identified areas of risk and ensures there is sufficient evidence available to provide assurance to the Trust Board. The framework is to be presented, at least annually, to the Trusts Patient Safety & Quality Standards Committee, a sub-group of the Trust Board.

4.1.3 The Deteriorating patient assurance framework provides information relating to the following:

- Relevant evidence based policies and procedures are current and in place to assist in ensuring there is appropriate identification and escalation of deteriorating patients in both acute and community settings.
- Relevant evidence based policies and procedures are current and in place to assist in ensuring there is appropriate identification and management of sepsis for patients of all ages, in both acute and community settings.
- Relevant evidence based policies and procedures are current and in place to assist in ensuring there is appropriate identification and management of Acute Kidney injury (AKI) for patients of all ages, in both acute and community settings.
- Relevant evidence based policies and procedures are current and in place to support the appropriate transfer arrangements for all patients internally to the Trust and externally, such as those to tertiary or specialist centres for escalation of care.
- Relevant evidence based speciality based procedures are developed, are current and in place for patients of all ages, in both acute and community settings.
- The appropriate monitoring systems are in place to provide assurance in relation to the above policies and procedures; this can be either national or local audits or data collection for key performance indicators.
- Collaboration with the Trusts Specialist Palliative Care Team to support recognition and referral for, and the initiation of, appropriate treatment plans for palliation.

- The current training profiles relating to the management of acutely ill patients of all ages and compliance overall and within Care Groups; including classroom based, e-learning, simulation scenarios both in the Simulation suite and ward based.
- Interrogation of the Trusts incident reporting system and other areas of data collection to generate learning and quality improvement activities.

4.2 Current actions

4.2.1 The Deteriorating Patient Group have developed a “dashboard” which displays data to reflect compliance with the key areas of work linked to the group. The dashboard continues to be enhanced and displays relevant KPIs in relation to the deteriorating patient, including mandatory training compliance, incidents and audit compliance. .

4.2.2 The Trust has utilised every opportunity to enhance care of the deteriorating patient; one key area of this is the use of digital solutions to support staff monitoring, recognising and escalating. The Trust has been rolling out e-observations across the organisation; there are a number of areas in which this is not fully established and plans are in place to implement this within the next digital system upgrade. Using systems such as this allows remote identification of patients who are deteriorating; as an example of this, the Critical Care Outreach team (CCOT) can view National Early Warning Scores (NEWS) information remotely, prompting communication with the clinical team or a ward visit.

4.2.3 All paediatric and SCBU transfers for upgrade of care are incident reported and a transfer review is completed. They are then discussed within the weekly paediatric patient safety meetings to identify good practice or any areas for development. In addition, there is a quarterly Meeting with NECTAR with identified cases for joint review. The paediatric team attend and have a regular agenda item at the DPG.

4.2.4 During 2021 the Trust established a new Respiratory Support Unit (RSU); it was recognised during the pandemic that bespoke areas were required to ensure patients with respiratory diagnoses were managed in appropriate clinical surroundings. There is representation of the RSU Matron within the Deteriorating patient group.

4.2.5 The trust was recognised to be an outlier with regard to NELA (National Emergency Laparotomy audit) in that patient who have a NELA score of >5% should be admitted to a level 2 facility >85% of the time. A collaborative approach between surgery and anaesthetics have seen significant improvements and have consistently demonstrated >95% compliance.

4.2.6 In addition ward 31 have recently changed their model to have a band 6 senior nurse on each shift to ensure a senior decision maker and ward oversight 24 hours each day and have commenced, when resources are available, rotation of staff into critical care to enhance their knowledge and understanding of the deteriorating patient.

4.2.7 The group have facilitated further training for registered nurses in sepsis recognition, blood culture training and Patient Group Directions (PDG) for intravenous antibiotics.

4.2.8 All adult inpatient areas have identified a Sepsis and AKI champion, this enables cascading of information to the wider ward teams.

4.2.9 The Trust have modified the Acute Illness Management (AIMS) and introduced training for Health Care Assistants, to support early recognition, escalation and treatment of a deteriorating patient.

4.2.10 The Trust AKI subgroup has been re-established with key stakeholders. The group will meet monthly and feed into the deteriorating patient group on key improvement plans.

4.2.11 A monthly audit of Respiratory patients requiring Non Invasive Ventilation (NIV) was implemented following a serious incident with the implementation of a digital monitoring chart. A registered nurse now completes all physical observations of patients requiring NIV.

4.2.12 Regional transfer training continues for both ITU and Emergency Department staff involved in external transfer with plans to extend this to the Stroke Unit team to facilitate transfer of patients requiring an upgrade of neurological care.

4.2.13 The trust has a Neurological Fast Response Team (NFRT) to enable the swift admission to critical care, stabilisation and transfer to a tertiary centre for neurosurgical intervention.

4.2.14 Incidents involving a failure to recognise and respond to a deteriorating patient are presented within the Deteriorating Patient Group and improvement plans reviewed and represented once complete.

4.2.15 The Deteriorating patient group monitor the Trust risk, failure to recognise and respond to the deteriorating patient, and oversee the actions associated with this risk.

4.2.16 At the weekly senior clinical professional huddle, there is feedback by the Senior Clinical Matron (SCM) on individual areas following incidents relating to the deteriorating patient.

4.2.17 The trust has supported a secondment since October 22 of 1.69wte deterioration nurse specialists to improve the response to the deteriorating patients particularly those with sepsis and/or AKI. They provide educational and clinical support to teams and provide audit to measure overall performance.

4.2.18 There has been a trust wide ‘Stop the Clock’ initiative to support nursing teams to stop and review their patients NEWS scores at appropriate times to ensure patients with high NEWS are being identified and escalated in a timely manner

4.2.19 The deterioration Nurse specialists have developed new AKI pocket cards, which have been disseminated to all staff across the trust.

4.2.20 CCOT and deterioration nurse specialist have a monthly planned deteriorating patient training day starting March 23 – September 23. The day will cover NIV, NHF, Tracheostomy, AKI and sepsis. The areas targeted will be wards 24/25/EAU/31.

4.2.21 An End of Life care facilitator has been in post for 3 months with a key focus on education, digital transition and leading the oasis suite refurbishments.

4.2.22 There has been progress within community services utilising soft signs to identify potential sepsis to initiate treatment and potential reduction in hospital admissions.

4.2.23 There has been a collaboration between the critical care team and the emergency medical team on EAU. Since November 2022 Monday to Friday the critical care consultant attends the 9am huddle on EAU and discusses patients who are deteriorating and require escalation. In addition, out of hours at 9pm and at weekends this is attended by the CCOT and or ITU medical team. The feedback has been positive and there has been improvements and efficiencies made with regard to patient escalation and admission to HDU/ITU.

4.2.24 ITU have many planned training and development days throughout the year, there will be places offered to ED staff including transfer, difficult airway and TARGET days.

5. Conclusion/Summary

5.1 The Trust HSMR value is **93.28** (November 2021 to October 2022), this is an increase from the previous reported value of **92.24** (October 2021 to September 2022). The latest SHMI value has increased to **99.19** (August 2021 to July 2022) from the previous rebased value of **98.61** (July 2021 to June 2022). Both statistics remain "within expected" ranges.

5.2 The successful implementation of the Medical Examiners role has prompted a review of the Trusts policies; the Trust Mortality Lead and the Lead ME are reviewing the overall strategy and policy in relation to learning from deaths. The planned changes are expected to support clinical staff in completing reviews and identifying learning to generate quality improvement measures.

5.3 There is summary information in the report relating to actions initiated as a result of learning from information relating to management of the Deteriorating Patient.

5.4 To date in 2022-23, there are nine cases that have been investigated as Serious Incidents, five of these have been investigated and it is possible in four of these that the overall outcome may have been different with different care provision. There are a further four cases still being investigated and the outcome of this investigation will be reported in future reports

6. Recommendations

6.1 The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover.

6.2 The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation.

6.3 The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

Dr D Dwarakanath

Medical Director / Deputy Chief Executive