



# **Board of Directors Meeting**

**Thursday, 27 January 2022  
at 1pm**

**Boardroom  
University Hospital of North Tees  
and via MS Teams**

20 January 2022

Hardwick  
Stockton on Tees  
TS19 8PE

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Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 27 January 2022 at 1.00pm** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely



**Professor Derek Bell, OBE**  
**Joint Chair**

### Agenda

		Led by
1. (1.00pm)	Apologies for Absence	Chair
2. (1.00pm)	Declaration of Interest	Chair
3. (1.05pm)	Patient Story (verbal)	L Robertson
4. (1.30pm)	Minutes of the meeting held on, 2 December 2021 <b>(enclosed)</b>	Chair
5. (1.35pm)	Matters Arising and Action Log <b>(enclosed)</b>	Chair

### Items for Information

6. (1.40pm)	Report of the Joint Chair <b>(enclosed)</b> and Vice Chair Update (verbal)	Chair
7. (1.55pm)	Joint Partnership Board Update (verbal)	Chair / S Hall
8. (2.05pm)	Report of the Chief Executive <b>(enclosed)</b>	J Gillon
9. (2.25pm)	Board of Directors Declarations of Interests and Fit & Proper Persons Declaration <b>(enclosed)</b>	B Bright

### Quality

10. (2.30pm)	Professional Workforce Bi-annual Report <b>(enclosed)</b>	L Robertson
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## **Strategic Management**

11. (2.40pm) Capital Programme Performance Q3:2021/22 **(enclosed)** N Atkinson

## **Performance Management**

12. (2.50pm) Integrated Compliance and Performance Report **(enclosed)** L Hunter, L Robertson,  
N Atkinson & N McMillan

## **For Information**

13. (3.05pm) Elective Recovery Position **(enclosed)** L Buckley

14. (3.10pm) Vaccination as a Condition of Employment (VCOD) **(enclosed)** N McMillan

15. (3.15pm) Learning from Deaths Report Q3: 2021/22 **(enclosed)** D Dwarakanath

16. (3.20pm) Guardian of Safe Working Hours Report **(enclosed)** D Dwarakanath

17. (3.25pm) Any Other Business

Date of next meeting

(Thursday, 24 March 2022, 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 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, 2 December 2021 at 1 pm at the University Hospital of North Tees / Via Video Link

Due to the current position regarding COVID-19, the decision was made that the Board of Directors meeting would be conducted via video-conferencing. This approach enabled the Board of Directors to discharge its duties and gain assurance whilst providing effective oversight and challenge, and supporting the national guidance regarding social distancing.

These minutes represent a formal record of the meeting.

#### Present -

Professor Derek Bell, Joint Chair*	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	Vice Chair
Ann Baxter, Non-Executive Director* <i>[via video link]</i>	AB
Philip Craig, Non-Executive Director* <i>[via video link]</i>	PC
Jonathan Erskine, Non-Executive Director*	JE
Kevin Robinson, Non-Executive Director*	KR
Rita Taylor, Non-Executive Director* <i>[via video link]</i>	RT
Julie Gillon, Chief Executive*	CE
Neil Atkinson, Director of Finance*	DoF
Levi Buckley, Chief Operating Officer*	COO
Barbara Bright, Director of Corporate Affairs and Chief of Staff	DoCA&CoS
Graham Evans, Chief Information and Technology Officer <i>[via video link]</i>	CITO
Lindsey Wallace, Deputy Director of Performance and Planning <i>[via video link]</i>	DDoP&P
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Tracy Squires, Deputy Chief People Officer <i>[via video link]</i>	DCPO
Chris Tulloch, Deputy Medical Director <i>[via video link]</i>	DMD

#### In attendance: -

Tony Horrocks, Lead Governor / Elected Governor for Stockton *[via video link]*  
Margaret Docherty, Elected Governor for Stockton *[via video link]*  
John Edwards, Elected Governor for Stockton *[via video link]*  
Ian Simpson, Elected Governor for Hartlepool *[via video link]*  
Alan Smith, Elected Governor for Hartlepool *[via video link]*  
Angela Seward, Lead Governor, South Tees Hospitals NHS FT *[via video link]*  
Posmyk Boleslaw, Chair, Tees Valley CCG *[via video link]*  
Emily Craigie, Demographic Reporter – Teesside Live *[via video link]*  
Ruth Dalton, Head of Communications and Marketing *[via video link]*  
Samantha Sharp, Personal Assistant (note taker)

#### BoD/4662 Apologies for Absence / Welcome

Apologies for absence were noted from Deepak Dwarakanath, Linda Hunter and Alan Sheppard.

#### BoD/4663 Declaration of Interests

Declarations of interest were noted from the DoCA&CoS and DoF in respect to their roles with North Tees and Hartlepool Solutions LLP and SH (Non-Executive Director) and RT (Non-Executive Director) in respect to their roles with Optimus Health Ltd.

A declaration of interest was also noted from the CITO in respect to his role in the ICS and KR (Non-Executive Director) who was a Non-Executive Director of Spectrum Community Health CIC.

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\* voting member

## **BoD/4664 Patient Story**

Unfortunately, due to technical difficulties experienced at the meeting, the patient story video was unable to be shown and a link would be circulated following the meeting to attendees.

**Resolved:** that, the link to the patient story be circulated to those in attendance.

## **BoD/4665 Minutes of the meeting held on, Thursday, 28 October 2021**

**Resolved:** that, the minutes of the meeting held on, Thursday, 28 October 2021 be confirmed as an accurate record.

## **BoD/4666 Matters Arising and Action Log**

### **a. BoD/4595 Community Diagnostic Hub**

Community Diagnostic Hub model and corresponding financial implications to be revisited at a Board Seminar in January following the comprehensive spending review.

**Resolved:** (i) that, the verbal updates be noted; and  
(ii) that, the Community Diagnostic Hub model and financial implications be revisited at a Board Seminar following the comprehensive spending review.

## **BoD/4667 Report of the Joint Chair and Vice Chair Update**

A summary of the report of the Chairman was provided with no new information to report not included within his written report.

The Company Secretary read a statement in respect to recent concerns raised around potential developments affecting both the Trust and South Tees Hospitals NHS FT following a series of meetings with the Vice Chairs, Non-Executive directors, Lead Governors, local authorities and councillors. To take the concerns forward, there was a need to ensure due process and adherence to governance requirements in line with statutory requirement with plans being developed to enable these matters to be progressed over the coming weeks.

Focus remained on the importance of 'levelling up' for the Tees Valley and North Yorkshire with focus remaining on providing the best quality health and care delivery for the populations served.

It was noted that an urgent meeting of the Council of Governors was planned and would take place as soon as possible. An updated statement for the Governors would be issued today.

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

## **BoD/4668 Report of the Chief Executive**

A summary of the report of the Chief Executive included: -

- As of the previous day, there were 43 confirmed COVID-19 cases within the Trust, seven within ITU, five mechanically ventilated. A slight reduction in the number of cases was noted over the past seven days and were now below the North East and England average. An exponential rise in reporting of the new variant, Omicron, was noted across the country and staff were being supported around the new guidance in respect to infection prevention and control procedures. The Trust had received a commendation from the Getting It Right First Time team in response to its handling of the COVID-19 pandemic;
- Pressure continued within urgent and emergency care with an enhanced support program

of improvement in place for the department. There had been an increase in staff to manage the high acuity of patients and to support improvements in patient care and safety. A multi-agency Tees Valley winter summit had been held in assessing the challenges and developing rapid improvements to manage as winter approaches. Proposals would be considered and implemented through the local A&E Delivery Board;

- The Trust continued to deliver its ambitious recovery plan and despite an increase in referrals, the Trust had maintained a positive downward trajectory on over 52 week waits with no patients waiting over 104 weeks;
- NHSE had a 10 year strategy to develop human resource and organisational development functions within the NHS with the Trust reviewing and preparing an assessment;
- Focus continued on the health and wellbeing of staff with several initiatives in place. Collaborative work continued to ensure that the variety of wellbeing offers were coordinated with support from psychology, chaplaincy, occupational health and the People Development Team. The October wellbeing focus was the 'Menopause' recognising the importance of support for those experiencing menopausal symptoms and the impact on their lives. Recognise, Engage, Actively listen, Check risk and Talk (REACT) would be launched in December promoting mental health awareness. The Palliative Care team had been awarded a Bright Ideas in Health Award for developing creative writing for wellbeing workshops. The joint flu and COVID-19 vaccination campaign continued with 52.2% of staff having the COVID-19 booster vaccine and 50.6% their flu vaccination. Vaccination clinics hours had been extended to accommodate additional demand from recent national directives. Work continued to support and encourage those unvaccinated to become fully vaccinated. 54% of staff had responded to the national NHS staff survey above the national average and the Trust 2020/21 response rate.
- The Trust recruited 889 patients to the RECOVERY study and remained the second highest recruiting Trust in the country.
- The Trust is working in partnership with South Tees Hospitals NHS FT to establish Community Diagnostic Hubs following the successful early adopter programme bid.
- The Faculty for Leadership and Improvement team supports the 100 Leaders Programme and will share a video showcase of the learning experience from the Pack Leaders;
- Discussion at the NENC Population Health and Prevention Board centred around the approach for the NENC to tackle personalised care with a presentation delivered by Claire Braid, Personalised Care Programme Manager. In addition, Jane Hartley, Lead for the Voluntary Organisations Network North East shared a proposal from third sector partners regarding organisations working together to tackle health inequalities;
- The fourth meeting of the Joint Management Executive Group was held on 9 November where discussion centred around the draft ICB consultation along with a paper outlining proposed arrangements with regard to working with Place Based Partnerships;
- Sam Allen had been appointed as Chief Executive of the ICB for the NENC ICS, taking up her role at the end of January 2021;
- The CE delivered a masterclass to existing and aspirant Clinical Leads and Directors around the structure and function of the ICS/ICP and how as an organisation this supported collaborative working across the region;
- Volunteer driver, Colin Ogden had received the prestigious Volunteer of the Year award at this year's Unsung Hero Awards for non-clinical NHS staff and volunteers across the UK. Colin had volunteered with the Trust for the past eight years.

In response to a comment made by JE, the CE highlighted that the Trust had a duty of care to look after its staff and in doing so improve the morale of staff to tackle challenges. Noted that it was the role of line managers to recognise and support staff with coping strategies to face challenges.

In response to a query from KR, the CE acknowledged that it was essential that the Trust collaborate in acute service provision and work with primary and social care colleagues to provide the best services to patients by developing a health system fit for the future.

The Joint Chair asked JE to update on the Schwartz rounds in relation to involving community staff. JE noted a community Schwartz round was being arranged with community staff who help to keep patients out of hospital when appropriate, noting pressures had been exacerbated during the pandemic with more acutely unwell patients. JE extended an invite for the Board to attend Schwartz Rounds, space permitting. The Joint Chair requested that Schwartz rounds and their role be presented at a future Board Seminar.

The Joint Chair placed on record his thanks to all Trust volunteers and the vital role they play in delivering services for patients, particularly during the current challenges.

- Resolved:**
- (i) that, the contents of the report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return to services building on a new operating model be noted; and
  - (ii) that, an update on Schwartz Rounds be presented at a future Board Seminar.

### **BoD/4669 Corporate Strategy Update**

The DoCA&CoS provided an update on progress against the Corporate Strategy measures and metrics. The DoCA&CoS outlined the measures and metrics highlighting steps to be taken to illustrate improvement in the Trust's corporate performance. Measures would be reviewed on a quarterly basis to ensure that the indicators remained relevant to the strategic direction of the Trust and would, where appropriate, be revised and amended with potential for additional, alternative measures depending on the needs of the Trust at that time.

JE highlighted the positive work undertaken in respect to the 'Green Plan' highlighting the need for investment. The DoCA&CoS responded that all business cases developed needed to articulate its response to sustainability and the 'Green' agenda. The Trust were ensuring it was in a position to bid for funding for sustainability projects and also working with its partners across the Tees Valley to review the benefits of joint working to secure funding.

- Resolved:** that, the content of the report and progress to date in progressing performance against the metrics be noted.

### **BoD/4670 Integrated Compliance and Performance Report**

The DDoP&P provided an overview of performance against key access targets included in the Single Oversight Framework and the Foundation Trust Terms of Licence for the month of October 2021 for performance, efficiency and productivity, quality and safety, workforce and finance.

Key points included:-

- **Single Oversight Framework:** Compliance against cancer standards had improved with the Trust achieving all but the 62 day referral to treatment standard. Noted that the number of two week rule referrals reported above pre-COVID-19 levels. A month on month reduction to those waiting over 52 weeks was noted with no patients waiting over 104 weeks. Recovery against the diagnostic standard had improved with a reduction in patients waiting over six weeks compared to the previous month;
- **Operational Efficiency and Productivity Standards:** Bed occupancy remained high and this was supported through a flexible bed base. Ambulance handover delays were evident, with protracted waits in A&E, reflecting pressures across the Trust and region.
- **Safety and Quality:** The Trust continued to perform well against the majority of quality and safety metrics, including HSMR/SHMI, complaints and infection control measures. The number of complaints showed a decrease across all stages compared to the previous month. The number received and themes continued to be closely monitored. A slight increase in the overall number of falls in October was reported with the majority resulting

in no harm. All four categories of pressure ulcers fall within the control limits. Nursing fill rates continued to be challenging due to continued vacancies, staff sickness absence and low fill rate from temporary staff. The registered nurse vacancy level had significantly reduced in October due to newly registered nurses joining the Trust with a further cohort of new nurses taking up their positions from January 2022. Although staff fill rates were below target, safe staffing had been maintained;

- Workforce: Sickness absence continued to increase, reporting at 6.45% in September, 0.68% attributable to COVID-19. 'Anxiety/stress/depression' remained the top sickness reason accounting for 30% of all sickness absence during the month. Appraisal compliance reported at 85% against the 95% standard, an increase of 1% when compared to the previous month. Overall compliance for mandatory training was 87%, remaining unchanged from the previous month. Staff turnover reported at 10.45%, an increase of 0.25% from the previous month;
- Finance: At Month 7, the Trust had delivered an in-month deficit of £318k and a year to date surplus of £4,242m, both ahead of plan. The year to date contributions from both Optimus and the LLP were ahead of plan. The Group cash position for Month 7 was £69.1m, ahead of plan. Month 7 capital expenditure was £6.1m against a year to date plan of £5.5m, showing a month on month improvement.

The Board congratulated Lindsey Wallace on her appointment as Deputy Director of Planning and Performance.

Following clarification sought by KR, the COO reported that the Trust continued to 'field test' against the proposed new A&E standards highlighting that these had not yet been finalised. The COO provided a synopsis of the proposed new standards highlighting the focus was on doing what was right for the patient on their individual pathway. There had been some deterioration in the Trust's performance against the proposed new standards over the past year noting that although activity had not increased when compared to 2019/20, patient acuity had. The CE noted that longer delays in ED were associated with poorer outcomes and this should be considered within the new system standards. The new standards included system metrics not just within A&E and would come into effect in April 2022.

JE noted that the Trust had achieved 8 out of 9 cancer standards and sought to understand the barriers preventing the Trust from achieving the 62 day cancer standard. The DDoP&P responded that complex pathways often prevent the Trust in achieving this standard. There had been an increase in 2 week rule referrals with patients choosing to delay appointments/treatments also contributing to the reported position.

- Resolved:**
- (i) that, the Trust's performance against the key operational, quality and workforce standards be noted; and
  - (ii) that, the significant ongoing operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that was being undertaken to address these going forward be acknowledged..

## **BoD/4671 Elective Recovery Position**

The COO provided an overview of the current elective recovery position within the Trust and steps being taken to maximise elective capacity and provide support at a system level.

There continued to be challenges with increasing referrals. Steps were being taken to ensure proactive planning of elective capacity on a weekly basis and that theatre utilisation was optimised. General surgery, urology and orthopaedics were seeing the main areas of increased referrals.

Key challenges for the Trust and the wider system continued to relate to workforce with plans to address recruitment and retention challenges in place.

The COO reported the Trust remained in a strong position in terms of elective recovery with clear plans to deliver the recovery trajectories. Opportunities exist to support both the internal waiting lists and the wider system recovery by ensuring the system 'levels up' through collaborative demand planning, forecasting, managing combined waiting lists and clinical pathways.

In response to the Joint Chair, the COO provided an update on the range of activity undertaken at the University Hospital of Hartlepool emphasising its importance at system level and noted that additional activity would be funded via the Elective recovery Fund.

RT highlighted she was pleased the Trust were reporting fewer 52 week waits compared to many Trusts with no over 104 week waits and were able to support the wider system, however raised concern around staff health and wellbeing and funding. The COO explained that funding was via the Elective Recovery Fund highlighting the successful bids submitted via the Targeted Investment Fund. The COO also explained that the Trust continued to use insourcing and was not fully reliant on its staff to undertake additional shifts.

**Resolved:** that, the content of the report is noted.

#### **BoD/4672 Research and Development Annual Report 2020/21**

The MD/DCE presented the 2020/21 Research and Development Annual Report highlighting that the Durham Tees Valley Research Alliance (DTVRA) was the key vehicle to deliver on the Trust's strategic aims, ensuring stability of workforce and growth in research activity and income.

Two trials were very successful in terms of recruitment; Novovax and RECOVERY. Trials requiring significant Pharmacy support and plans were being explored to pump prime additional staff to reopen and create new studies to re-establish a healthy portfolio of commercial drug trials.

The Trust saw the highest number of patients recruited to participate in NIHR portfolio research with 3215 patients. This compares favourably with other Trusts of a similar size nationally.

The Joint Chair emphasised the importance of research benefits for patients and the positive impact on staff recruitment and thank the research team for their significant efforts.

**Resolved:** (i) that, the content of the report be noted; and  
(ii) that, the 2020/21 Research and Development Annual Report be received.

#### **BoD/4673 Board of Directors and Council of Governors' Meetings Dates 2022**

The Board and Council of Governors' meetings 2022 schedule was included for information

**Resolved:** that, the schedule of meetings for 2022 be noted.

#### **BoD/4674 Any Other Business**


There was no any other business reported.

#### **BoD/4675 Date and Time of Next Meeting**

**Resolved:** that, the next meeting be held on Thursday, 27 January 2022 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 2:30 pm.

Signed:



Date: 27 January 2022

BoD Public						
Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
25 March 2021	BoD/4461	<b>NHS Regulation Bill – White Paper: Integration and Innovation – Working together to improve health and social care for all</b> Board and Council of Governors' development sessions to be scheduled to look at how the ICS would function in the future	B. Bright		Completed	A series of dates are being agreed to facilitate joint board to board sessions with the first session in March focussed on cyber security and digital. The topic for the April date is being confirmed. The ICS update/discussion will form part of the schedule during the year. Joint CoG development sessions have been discussed with the Lead Govenors with agreement reached that these will be faillitated at an appropriate time.
27 May 2021	BoD/4537	<b>NHS Resolution Clinical Negligence Scheme for Trusts (CNST)</b> Market place event to be considered to showcase the great work being done within Maternity Services	L. Robertson			Agreed – date to be confirmed as restrictions ease
23 September 2021	BoD/4595	<b>Community Diagnostic Hub</b> Year 2 to 5 Community Diagnostic Hub model and the corresponding financial implications to be revisited at a Board Seminar at a later stage following the Comprehensive Spending Review	N. Atkinson L. Buckley B. Bright		Completed	Update on Community Diagnostic Hubs provided to the Board at the seminar on 13 January 2022. Further updates will be provided as the project progresses
28 October 2021	BoD/4628	<b>Report of the Chief Executive</b> Schwartz Round to be facilitated for community staff	T. Squires J. Erskine		Completed	The Schwartz Round for community staff is provisionally planned for March.
28 October 2021	BoD/4631	<b>Integrated Compliance and Performance Report</b> CN/DoPS&Q to provide an update regarding the investigation to understand the current position between hospital and community acquired infections	L. Robertson		Completed	This has been completed and has been presented to an executive strategy session
28 October 2021	BoD/4635	<b>Data Protection and Cyber Assurance Year-End SIRO Report 2020/21</b> Joint cyber security training to be arranged for both Boards	B. Bright G. Evans		Completed	The session is scheduled for 29 March 2022.

## Board of Directors

Title of report:	Joint Chair's Report										
Date:	27 January 2022										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Sponsor:	Professor Derek Bell, Joint Chair										
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		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:											
<p>The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level.</p> <p>Key issues for Information:</p> <ul style="list-style-type: none"> <li>NHS pressures;</li> <li>Department and site visits;</li> <li>Meeting with MPs</li> <li>Tees Valley Chairs Meeting</li> <li>NHS Confederation Seminar – Health Inequalities</li> <li>Same Day Emergency Care</li> <li>John Edwards</li> </ul>											
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 is asked to note the content of this report.										



# **North Tees and Hartlepool NHS Foundation Trust**

## **Meeting of the Board of Directors**

**27 January 2022**

### **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 NHS Pressures**

The Trust continues to face high demand across its services. Significant winter pressures remain with not all patients accessing services having COVID-19. Despite the pressures, the Trust is able to deliver good safe care for patients and I would like to place on record my thanks to all staff in the organisation and in the health and care sector for their continued dedication and commitment. The Trust strives to promote the uptake of the Covid and flu vaccines to staff, patients and members of the public.

##### **2.2 Department and site visits**

Since the last Board meeting, I have continued to undertake site and departmental visits in Stockton, Hartlepool and Peterlee. On a recent visit to Peterlee Community Hospital, I met a number of staff and patients who highlighted their positive experience of the services being provided.

##### **2.3 Meeting with MPs**

As part of my broader induction programme, I am currently in the process of meeting with local MPs and Local Authorities. I have met with Alex Cunningham, MP for Stockton North and am scheduled to meet with Shane Moore, Leader of Hartlepool Borough Council and Jill Mortimer, MP for Hartlepool over the next few weeks.

##### **2.4 Tees Valley Chairs Meeting**

A meeting of the Tees Valley Chairs Meeting took place on 20 January, which was a positive meeting, attended by all the Chairs. The delay to the commencement of the Integrated Care Board (ICB) as part of the North East North Cumbria Integrated Care Service (NENC ICS) from 1 April to 1 July 2022 was acknowledged to allow further establishment of the new entity and the involvement of partner organisations.

There was a broad discussion about the importance of recognising the impact of winter pressures and the pandemic on staff, as well as the future impact of the requirement for all patient facing NHS staff to be fully vaccinated against Covid-19 from 1 April 2022. There was also discussion around the development of community-based services and e-health services so patients care can be managed at home and reducing the pressure on hospital services. An update was provided regarding improving access to mental health services for hard to reach groups of the population as part of the health inequalities agenda and equity of services for all.

## **2.5 Turning the tide on Health Inequalities**

I am attending a virtual Seminar hosted by NHS Confederation on 26 January for Chairs and Non-Executive Directors of provider organisations regarding addressing health inequalities. Nationally the aim is to improve health outcomes for all by providing exceptional quality healthcare, with equitable access, excellent patient experience and the best outcomes. Addressing health inequalities was set out as part of NHS England's planning guidance for 2021/22 and continues to be developed. This will supplement the work being carried out locally to better understand the demographics and health requirements of the populations we serve.

## **2.6 Same Day Emergency Care**

One of the ambitions of the NHS Long Term Plan nationally is for Emergency Departments to provide Same Day Emergency Care (SDEC), which means emergency patients can be rapidly assessed, diagnosed and treated in the same day who otherwise would be admitted to hospital. It is part of the wider aim to provide the right care, in the right place, at the right time for patients, and will benefit the healthcare system by reducing waiting times and hospital admissions. The SDEC model is building on previous improvement work in ambulatory emergency care services across the NHS to provide a consistent approach to patient pathways.

Locally, the Trust operates the SDEC model through all our admission routes to ensure early appropriate speciality input when required. During 2021 (calendar year), patients treated under the SDEC model accounted for an average of 36% of all emergency admissions, with lengths of stay less than 24 hours. In addition to operating the emergency model, the Trust also has an Integrated Single Point of Access (iSPA) which provides timely involvement of health and social care resources as part of a multi-disciplinary team to ensure patients have the right response at the right time, by the right person. This results in timely and effective outcomes that can help to prevent unnecessary hospital admissions.

The Trust has developed the Holdforth Hub, which is designed to support early discharge, prevent hospital admissions, and increase resilience in the community nursing teams to support care closer to home. The Hub provides urgent care to patients from across Hartlepool, Stockton and East Durham and includes a range of pathways such as deep vein thrombosis, respiratory – prophylactic antibiotics, IV antibiotics, Ferinject infusions for Iron Deficiency Anaemia and delivery of Biologics for asthma patients. The care is delivered within patients own homes or within the Hub.

## **2.7 John Edwards**

It is with great sadness that I report that John Edwards, Elected Governor for Stockton passed away on Monday, 10 January 2022. John was first appointed as a Governor of the Trust in 2014 and we thank him for his contribution to the Council of Governors and pass on our condolences to his family.

## **3. Recommendation**

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

**Professor Derek Bell**  
**Joint Chair**

## Board of Directors

Title of report:	Chief Executive Report										
Date:	27 January 2022										
Prepared by:	Julie Gillon, Chief Executive Barbara Bright, Director of Corporate Affairs/Chief of Staff 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:											
<p>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 Improvement, 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:</p> <ul style="list-style-type: none"> <li>• COVID-19 current position and continued recovery</li> <li>• Staff Health and Wellbeing</li> <li>• Research and Development</li> <li>• 2022/23 Priorities and Operational Planning Guidance</li> <li>• Integrated Care System</li> <li>• Joint Management Executive Group</li> <li>• Community Diagnostic Centres</li> <li>• Government Response to the Paterson Enquiry</li> <li>• Faculty for Leadership and Improvement</li> <li>• NENC Health Inequalities Summit – 6 December 2021</li> <li>• North Tees and Hartlepool NHS FT – Estates Strategy</li> <li>• Clinical Directors Enhanced Masterclass</li> <li>• Hartlepool Health Academy</li> <li>• Retirement of Professor Jane Metcalf</li> <li>• Breast Unit celebrates 20<sup>th</sup> Anniversary</li> <li>• New CT Scanner</li> <li>• National accolade for the University Hospital of Hartlepool</li> </ul>											
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 will be 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 pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model.										

**North Tees and Hartlepool NHS Foundation Trust**  
**Meeting of the Board of Directors**

**27 January 2022**

**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. Key Issues and Planned Actions**

**2.1 Strategic Objective: Putting our Population First**

**2.1.1 COVID-19 Current Position and Continued Recovery**

**2.1.1.1 COVID-19 Current Position**

As at 17 January 2022, the Trust is caring for 118 COVID-19 positive patients, three of which require critical care intervention. The numbers of COVID-19 positive patients within the organisation has increased significantly since the Board of Directors' briefing in December with the impact of the omicron variant in the community reflecting the number of patients admitted with Covid infection. The beds occupied by COVID-19 positive patients has increased threefold since mid-December 2021.

The pattern of infections mirrors previous waves with London and the Southeast reporting high levels of infection followed by the Midlands, the Northwest before increasing in the Northeast. NHSE advice is that the pressure on hospitals is likely to peak in mid-January, similar to the Trust's internal modelling which suggest a potential peak of beds occupied by Covid-19 patients by 19<sup>th</sup> January

North East and North Cumbria currently has a rate of 2,291, (7 Day Infection Rate Per 100,000 Population based on Pillar 1 and Pillar 2 positive test results up to 11 January 2022) By comparison the rate for England, for the same time period, is 1,521 positive tests per 100,000 population. Both Hartlepool and Stockton are currently in the top ten highest rates by Local Authority Area (11 January 2022), with infection rates of 2,692 and 2,513 respectively.

**2.1.1.2 Omicron and impact on staff**

Genome sequencing of positive Covid PCR tests demonstrates that Omicron is now the dominant variant in the North East and Cumbria. The importance of continued adherence to Infection Prevention and Control (IPC) measures remains a priority in minimising further spread of infection and the Trust continues to support staff and clinical services with clear IPC standards and guidance.

The new variant has had a significant effect on the number of staff absences due to self-isolation and positive and contact cases. To support staff and minimise the impact on service provision. The Trust has continued to provide rapid testing for Trust staff to minimise delays between testing and results being reported. There were a further 99 staff due back to work within 2 days and a further 97 staff due back in 3-7 days.

**2.1.1.3 Hospital Activity and Operational Pressures**

In line with the Winter Plan previously presented to the Board of Directors, there was a planned reduction in some elective activity over Christmas and into early January. The Trust has consolidated theatre lists to minimise reduced activity and continued to provide services at Hartlepool Hospital. The Trust continued to achieve the Elective Recovery Fund Trajectories in Quarter 3. System collective activity did not attract the associated funding flows.

Extended provision of insourcing services and waiting list initiatives during February and March will maintain waiting time and waiting list positioning toward the zero >52 week waiting list trajectory for 31 March 2022. The Trust continues to deliver the zero >104 week wait position.

## **2.2 Strategic Objective: Health and Wellbeing**

### **2.2.1 COVID and Flu Vaccination Programmes**

The Trust has continued to maintain a Vaccination Hub for Covid-19 booster vaccinations, an 'Evergreen' offer for first and second doses, in addition to delivering flu vaccinations for staff, colleagues in social care and to the family members of Trust staff. After an initial positive uptake in 2021 there has been a plateauing of uptake vaccinations.

Work continues to support staff as the deadline for Vaccination as a Condition of Deployment regulations approaches. The Trust is working closely with staff side representatives to support staff in accessing vaccinations and to bust myths associated with hesitancy.

### **2.2.2 Staff Health and Wellbeing**

The second issue of the Health and Wellbeing Magazine has been made available online; it hosts all the 'need-to-know' contact information for health and wellbeing support, now informed by colleagues, with recipes, book reviews, wellbeing activity reviews, fiscal and pastoral care. It has become a 'social engagement' piece connecting staff and has been very positively received.

December saw the roll out of an initiative from the '100 Leaders' programme, with a staff 'thank you' A hamper was created for and delivered to staff and volunteers containing a range of sustainable gifts to support health and wellbeing ambitions..

The number of wellbeing sponsors continue to increase, with ambitions to go further to provide improved and targeted access to wellbeing; further cohorts of Mental Health First Aid Training are planned for February and March.

### **2.2.3 Research Team leading the way in COVID-19 treatment nationally**

#### **2.2.3.1 Research and Development Update**

Current overall recruitment is lower than expected in part due to high level of support for interventional, resource intense COVID Studies. Non-COVID studies have recommenced and new studies sent for approval and opening with potential for additional studies to boost recruitment. A number of studies (30) are currently awaiting set up / approval and some large recruiting studies in Obstetrics & Gynaecology due to open shortly.

#### **2.2.3.2 COVID Studies**

COVID studies are no longer classified as "Urgent Public Health" studies for prioritisation.

#### **2.2.3.3 NOVAVAX Trial**

NOVAVAX have received European Medicines Agency and World Health Organisation approval for the vaccine with MHRA approval awaited.

#### **2.2.3.4 RECOVERY Trial (Treatment trial for COVID in-patients)**

The Trust has 901 patients recruited to the RECOVERY study to date and remains the second highest recruiting Trust in the country (in terms of percentage of COVID patients recruited) with high-dose corticosteroid, Empagliflozin and Sotrovimab treatment arms currently available.

#### **2.2.3.5 Clinical Characteristics Protocol by International Severe Acute Respiratory Emerging Infection Consortium (CCP ISARIC) (observational data collection study for COVID inpatients)**

The high recruiting CCP ISARIC COVID observational study has now been paused in all DTVRA sites and most sites across the country whilst priority recruitment focuses in just 30 national sites.

## **2.3 Strategic Objective: Transforming our Services**

### **2.3.1 2022/2023 Priorities and Operational Planning Guidance**

The 2022/2023 priorities and operational planning guidance was published on 24 December 2021, this focuses on the challenge of restoring services, meeting new care demands, and reducing care backlogs which are a direct consequence of the Covid-19 pandemic. The NHS is expected to increase capacity and resilience to deliver safe, high quality services that will meet the full range of healthcare needs and will:

- Accelerate plans to grow the substantive workforce and work differently to focus on the health, wellbeing and safety of staff;
- Use what has been learnt throughout the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies;
- Work in system partnership to make the most effective use of resources available across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity;
- Use the additional funding to increase capacity and invest in buildings and equipment to help staff deliver safe, effective and efficient care.

The Trust is preparing plans in collaboration across the Tees Valley and the North East and Cumbria Provider Collaborative.

Effective partnership working is critical to achieving the priorities set out in the guidance and the strategic aims for the Integrated Care Systems (ICSs) include; improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money and supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put all ICSs on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

### **2.3.2 Integrated Care System (ICS)**

On 24 December 2021 it was announced that a new target date of 1 July 2022 for the establishment of statutory ICSs had been set, replacing the original target date of 1 April 2022. This is to allow sufficient time for the remaining parliamentary stages of the Health and Care Bill. It is expected this date will provide some flexibility for preparation for the new statutory arrangements and the management of immediate priorities in response to the COVID pandemic. Recruitment to designate statutory positions continues and preparations for the ICB and ICP establishment are taking place.

### **2.3.3 Joint Management Executive Group (JMEG) of the NENC ICS**

The fifth meeting of the JMEG was held on the 22 December 2021. Discussion centered on the revised version of the draft ICB constitution and feedback from NHS England along with a review of a paper to establish integrated care partnerships and next steps.

### **2.3.4 Community Diagnostic Centres (CDCs)**

The Trust continues to work in partnership with South Tees Hospitals NHS Foundation Trust to establish CDCs. In 2021/22 as part of the successful bid to the early adopter programme the Trust received capital and revenue investment for additional equipment. This is being used to develop CDC spoke sites at University Hospital Hartlepool and Lawson Street in Stockton on Tees, on a temporary basis whilst the permanent CDC hub is being developed in Phase Two. Investment in equipment and workforce at spoke sites will provide additional capacity, support pathways in the community and provide timely access. The Trust was also successful in being identified as one of three Endoscopy Training Academies across the ICS. The academy will be located at the University Hospital of

Hartlepool within the CDC spoke site and deliver high quality effective training to endoscopy trainees. The design and construction work is underway with delivery planned for early 2022/23.

CDC planning guidance for the next three years (received in December: NHS England).supports capital and revenue funding. A business case is in development in line with the national process to support the next phase of implementing the strategic plan for CDCs. In 2022/23 there will be a further focus on clinical pathways and workforce development. This is a major move in the Trust's strategic direction to take health onto the high street and to operationalise the Population Health and Prevention agenda in tackling health inequalities.

## **2.4 Strategic Objective: Valuing our People**

### **2.4.1 Government Response to the Paterson Enquiry**

On 16 December 2021 the government published its response to the independent inquiry into the issues following the conviction of surgeon Ian Paterson. The inquiry was established to ensure that patients and the public get the answers they deserve and lessons are learnt to protect patients.

The inquiry demonstrated the need to do more, making 15 recommendations to the government and other health sector bodies to make improvements in areas that demonstrated weaknesses in Ian Paterson's case. A number of themes emerged to provide greater confidence in the system with regard to protecting patient safety. These themes cover the entirety of the patient journey including initial consultations with clinicians, fitness of clinicians to practice and post treatment activity including ongoing scrutiny of clinicians' outcomes, pathways for raising concerns and rapid action in all cases where something goes wrong.

The Trust is in the process of working through the recommendations in order to produce a gap analysis and identify any areas for improvement, as appropriate.

### **2.4.2 Faculty for Leadership and Improvement**

The first cohort of the 100 Leaders Programme ended in December 2021. Final evaluations are underway to highlight successes with a succinct library of courageous change summaries to be made available to showcase work by the end of January 2022.

The sustainability of these projects is evident through the continuation into 2022 and inclusion in Care Group and Corporate business plans for 2022/23. New cohorts in April and June this year will be launched and the faculty is committed to working with external partners to develop a programme that is fit for purpose and future-proof.

### **2.4.3 North East and North Cumbria Health Inequalities Summit**

The first NENC Health Inequalities Summit concentration on 'inclusion health' was held virtually on 6 December 2021 chaired by myself. Sir Liam Donaldson, Chair of the ICS provided the opening address and Dr Bola Owolabi, Director of Health Inequalities at NHSE/I shared the National NHSE/I Framework for Health Inequalities. The event provided the opportunity for staff working across healthcare to showcase practical examples of work and to improve access, experience and outcomes.

### **2.4.4 North Tees and Hartlepool NHS Trust Estate Strategy**

The five year Estates Strategy (2022-2027) was presented, discussed and approved at the Board Seminar on 13 January 2021. The current strategy builds upon the Trusts Expression of Interest submitted to the New Hospital Infrastructure Programme which clearly outlined the Trusts ambitions within the context of the Tees Valley and the re-development of the existing Trust Estate.

The strategy provides the next steps in the Trusts estate development and addresses the issues raised by the six facet survey, the opportunity to improve clinical adjacencies, enhanced patient and staff experience; to deliver value for money and develop a health system fit for the future.

#### **2.4.5 Clinical Directors Enhanced Masterclass**

I had the opportunity to deliver a second masterclass to existing and aspirant Clinical Directors on 12 January 2022 around the structure and function of the ICS/ICP, what this means for our population and how as an organisation we can support collaborative working across the region.

#### **2.4.6 Hartlepool Health Academy**

The Trust continues to work with Hartlepool Local Authority, Hartlepool College of Further Education and Jacob Project Engineers regarding the development of a business case to progress Hartlepool Towns deal fund for the establishment of a Health Academy on the University Hospital of Hartlepool site. The Academy will develop skills to unlock the economic potential of Hartlepool.

#### **2.4.7 Retirement of Deputy Medical Director: Professor Jane Metcalf**

On 20 December the Trust officially said farewell to Professor Jane Metcalf, Deputy Medical Director. Her dedication to the many fields she worked within (elderly care, gastroenterology, academia, the liver service development) all supported a progressive approach to health and care outcomes for our staff, students, communities and patients.

#### **2.4.8 Breast Unit celebrates 20<sup>th</sup> anniversary**

December saw the 20th anniversary of the opening of the breast screening and treatment unit in the North Tees Hospital. The multidisciplinary team in the unit diagnoses around 360 cancers per year – almost one a day – through the mobile asymptomatic breast screening service and carries out around 180 symptomatic appointments (referred by GPs) per week across North Tees and Hartlepool sites.

#### **2.4.9 New CT scanner**

A new cutting edge CT scanner which will help diagnose heart issues quickly and accurately for patients across Teesside has been installed at the University Hospital of North Tees. The new low-dose scanner forms part of a new rapid-access chest pain clinic and the Siemens Somatom Drive will help with the early diagnosis of many cardiac diseases, as well as a range of other health issues including identifying blood clots (pulmonary embolism).

The addition of a high quality dual source CT scanner to the trust will allow patients with cardiac chest pain to be seen, scanned and commenced on treatment in a single 'one-stop' clinic and will put the cardiology team at the forefront of delivering rapid, safe, high quality care to cardiac patients.

#### **2.4.10 National accolade for the University Hospital of Hartlepool**

The University Hospital of Hartlepool ended 2021 with a national accolade recognising commitment to patient safety. The National Joint Register (NJR), which monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes, has awarded the elective care team its Quality Data Provider certificate.

Only hospitals that achieve the NJR's ambitious targets of providing evidence to support patient safety, standards in quality of care, and overall cost-effectiveness in joint replacement surgery, can achieve the prestigious award.

### **3. Recommendation**

The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model.



## Board of Directors

Title of report:	Declaration of Interests and Fit and Proper Persons Declaration									
Date:	27 January 2022									
Prepared by:	Sarah Hutt, Assistant Company Secretary									
Executive Sponsor:	Barbara Bright, Director of Corporate Affairs and Chief of Staff									
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:										
<p>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.</p> <p>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.</p> <p>A copy of the register is appended to this report for information.</p>										
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	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> <li>note the contents of the appended updated register; and</li> <li>note that the register will be referred to in the Annual Report 2021/22 and will be available for public inspection.</li> </ul>									

## 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 Chair	Non-Remunerated Director of Quality Governance Collaborative and for Quality in Governance  Chair of SEL SDEC NHS South East London	None	None	Trustee of Royal Medical Benevolent Fund  Chair and Trustee of Tenovus (Scotland) – Edinburgh	Clinical Advisor (non-remunerated) to NHS Scotland	✓
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 Scrutineer of safeguarding / Chair of Statutory Safeguarding Partnership – Darlington Borough Council	School Governor at Thirsk High School and Sixth Form College	✓
Mr Philip Craig Senior Independent Non-Executive Director	None	None	None	None	None	✓
Prof Jonathan Erskine Non-Executive Director	Executive Director of European Health Property Network	JEER (Jonathan Erskine Consultancy and Research)	None	None	Honorary Professor of the Bartlett School of Sustainable Construction, University College London  Wife is a member of the governing body of Teesside University	✓

## 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
Mr Kevin Robinson Non-Executive Director	Non-Executive Director of Spectrum Community Health CIC	None	None	None	None	✓
Mrs Rita Taylor Non-Executive Director	Chair / Director, Trading Company for North Tees and Hartlepool NHS Foundation Trust (Optimus Health Ltd)	None	None	None	None	✓
Mrs Julie Gillon Chief Executive	None	None	None	None	None	✓
Dr Deepak Dwarakanath Executive Director – Medical Director / Deputy Chief Executive	None	None	None	Member of the Royal College of Physicians Edinburgh Council	None	✓
Mr Neil Atkinson Executive Director Director of Finance	Director of NTH Solutions, a Trading Company for North Tees and Hartlepool NHS Foundation Trust	None	None	None	None	✓
Mrs Barbara Bright Executive Director Director of Corporate Affairs and Chief of Staff	Director of NTH Solutions, 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))	✓
Mr Levi Buckley Executive Director Chief Operating Officer	None	None	None	None	Partner is Chief Executive of Health Works Charity which works with the NHS in Newcastle (From 6 May 2021)	✓

**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 Graham Evans Executive Director Chief Information and Technology Officer	None	None	None	Trust Representative to HealthCall Board  Chief Digital Officer for NENC ICS  Honorary Professor at Teesside University	Son employed by NTH Solutions LLP  Wife is a Trustee of the Butterwick Hospice Care Charity	✓
Mrs Linda Hunter Executive Director Interim Director of Planning and Performance	None	None	None	None	None	✓
Mrs Lindsey Robertson Executive Director Chief Nurse / Director of Patient Safety and Quality	None	None	None	None	None	✓
Mr Alan Sheppard Executive Director Chief People Officer	None	None	None	Vice President of the NE&NC Branch of the Healthcare People Management Association	None	
Alan Hunter Director of Strategy and Partnership	None	None	None	None	None	✓

## Board of Directors

Title of report:	Professional Workforce Bi - Annual Report											
Date:	27 January 2022											
Prepared by:	Emma Roberts, Interim Head of Professional Workforce Karen Sheard, Deputy Chief Nurse											
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality											
Purpose of the report	This report provides a mid-year review (2021/22) following the last annual professional workforce report produced in July 2021 to provide assurance that workforce processes and decisions are evidenced based and comply with the Developing Workforce Safeguards recommendations (Ref).											
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:												
<p>Workforce capacity and demand continues to be a challenge due to a variety of reasons (covered within this report); the trust is experiencing unprecedented workforce gaps due to the impact of Covid-19 and the Omicron variant. The resulting impact of the high transmission rate has meant significant numbers of staff are isolating or absent due to related sickness.</p> <p>It is important to note that the data collected during the third wave of the coronavirus pandemic, meant several wards and departments were flexing bed bases up and down based on the acuity and dependency needs of patients and safe staffing availability at the time, thus creating a variation between the planned and actual establishments</p> <p>Key Issues:</p> <ul style="list-style-type: none"> <li>• The overall average Care Hours per Patient per Day (CHPPD) figures for 2021/22 demonstrate that safe staffing has <b>continued to be a significant challenge</b>, when looking at the overall average;</li> <li>• The data identifies the <b>under establishment</b> across all in-patient areas averaged at 52.12wte;</li> <li>• Five areas were identified to have a greater than 5 WTE <b>under establishment</b> and 2 areas were identified as having a greater than <b>5 over establishment</b>;</li> <li>• Hours filled by RN' s and HCA's through temporary staffing continues to be reduced;</li> <li>• The average fill rates in hours and (UNIFY data) continues to show a lower fill rate in Registered Nurses during the day and a high rate of Health Care Assistants (HCA's) on</li> </ul>												

nightshift. This often reflects the RN gaps and the increased provision needed for enhanced care.

- Average RN, Midwifery & AHP sickness across six months remains a significant challenge. July 2021 had the highest levels of sickness absence with a peak of 8.43% & 7.5% respectively. Average sickness absence rates for Medical and Dental staff between Dec 2020 and Dec 2021 is 2.5%, lower than the Trust target of 4%. It is important to note that this includes sickness due to Covid symptoms and staff absences due to Covid related isolation.

Quality aspects of patient care, particularly outcomes, monitored with no red flags identified in relation to workforce shortages affecting quality and safety.

- The report identifies significant work being undertaken to improve recruitment & retention against a reducing (5.2% across all RN, Midwifery, AHP and Care staff groups) vacancy position including commitment to International recruitment; with specific focus upon Children's Speech and Language Therapy at 21.3%.
- The medical and dental workforce have worked flexibly over the last 12-months to support Trust in its response to the coronavirus pandemic. The Guardian continues to champion safe working practices and is currently working with leads to ensure compliance with working rules is maintained. Overseas trainees (medical & dental) due to start in August may be delayed because of the pandemic, resulting in vacancies and rota gaps. There are 37 overseas new starters across the region and the LET will keep Trusts updated on any potential risks to start dates;

There is a clear need to review the establishments in the areas where there are validated under establishments, (greater than five whole time equivalents). In relation to ward 40 and 42, which identifies a need to increase the unregistered workforce, anticipating that this will be achieved in a staged approach where there are vacancies and flexing of the registered workforce. Ward 36 have a validated, significant, under establishment, which needs to be addressed.

Whilst this report provides a vast amount of information demonstrating assurance that the Trust has a robust process and safety controls in place in relation to workforce there is further work to ensure that the overall triangulation, analysis of the workforce pressures and improvements truly reflect the impact upon patient care and outcomes. The next report will evolve to ensure that this analysis is in place providing the ability not to just look back and current, but to predict workforce requirements into the future

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

Through robust workforce processes and assurance frameworks, ensuring there are workforce safeguards in place, the right staff, with the right skills in the right place at the right time, patient safety and delivery of the highest quality of care has been maintained and continuously improved during massive sustained impact from Covid-19, across the entire workforce.

Board Assurance Frameworks have been reviewed and no new identified risks have been highlighted other than already developed and agreed;

Committees/groups where this item has been discussed

This is the first presentation of the report;

Recommendation

The Board of Directors are asked to:

	<ul style="list-style-type: none"><li>• Note the huge effort in response to unprecedented pressures created by Covid-19 and the work undertaken to have safest staffing levels across the organisation;</li><li>• Note the impact of the Covid-19 pandemic on both increased patient acuity and increased staff sickness;</li><li>• Agree to the further work required to utilise the now validated data to revise budgeted establishments;</li><li>• Note the actions being progressed to further improve workforce recruitment, development and retention.</li></ul>
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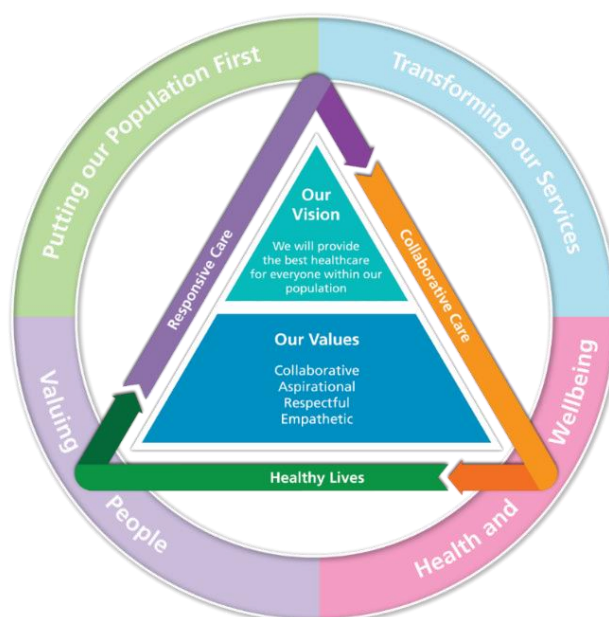
# North Tees and Hartlepool NHS Foundation Trust

## Meeting of the Board of Directors

27 January 2022

### Professional Workforce Bi-Annual Report

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



## 1.0 Introduction

- 1.1 National Health Service (NHS) provider boards are accountable for assuring the right culture, leadership and skills are in place for safe, sustainable and efficient staffing, supporting safe, effective, caring, responsive and well-led care.
- 1.2 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.
- 1.3 In relation to workforce planning, the guidance recommends that establishment setting is undertaken annually, with a mid-year review and this process should consider the following:
  - Patient acuity and dependency
  - Activity levels
  - Seasonal variation in demand
  - Service developments/changes and commissioning
  - Staff supply and experience



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

1.4 This report provides a mid-year review (2021/22) following the last annual workforce review produced in July 2021 and 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 within the annual report July 2021
- Vacancy, recruitment and retention position for all staff groups
- The use of temporary bank and agency staff for all staff groups
- A Trust wide summary of the workforce data analysis completed in October 2021 with specific Care Group specialities and departments being discussed by exception only.
- Assurance that workforce processes and decisions are evidenced based and comply with the Developing Workforce Safeguards recommendations (presented in **appendix 1**)

1.5 Whilst this report provides a vast amount of information demonstrating assurance that the Trust have robust process and safety controls in place in relation to workforce there is further work to ensure that the overall triangulation, analysis of the workforce pressures and improvements truly reflect the impact upon patient care and outcomes. The next report will evolve to ensure that this analysis is in place providing the ability to not just look back and current, but to predict workforce requirements into the future.

## **2.0 National Context**

2.1 Workforce supply remains high on the national agenda, to prevent shortages across nursing and other vulnerable staff groups.

Prior to the coronavirus pandemic, there was already a shortage of circa 50,000 nurses, and still the healthcare system is nowhere near bridging that gap. In December 2020, a report by the Health Foundation (Building the NHS Nursing Workforce in England) identified that the government needed to exceed its target of 50,000 new nurses in England by 2024/25 to recover from the coronavirus pandemic.

2.2 In support to ensure workforce is front and centre, NHSI/E established the Safe Staffing Faculty programme, commissioned by the Chief Nursing Officer for England. The trust, have two senior nurses who have completed the programme, further strengthening the safe staffing knowledge and skill set within the organisation.

## **3.0 Local Context**

3.1 Workforce capacity and demand continues to be a challenge due to a variety of reasons (covered within this report); at the time of writing this report the trust is experiencing unprecedented workforce gaps due to the impact of Covid-19 and the Omicron variant. The resulting impact of the high transmission rate has meant that significant numbers of staff are isolating or absent due to related sickness. Local risk assessments are in place to review critical service demand supporting decision making where staff identified as a household contact, to return to work. These risk assessments, completed locally, however, agreed by the Chief Nurse/Director of Infection, Prevention Control and the Deputy Chief Executive/Medical Director to ensure that critical service provision maintained whilst balancing against staff health and wellbeing.

## 4.0 Registered Nursing, Midwifery & Care Workforce

### Staffing Calculation Tools and Systems

#### 4.1 Care Hours per Patient Day (CHPPD)

- 4.1.1 NICE (2018) recommend that the assessment and review of staffing levels be based on average nursing hours per patient. This emerged as a key recommendation from the Carter report (2016) described as CHPPD being a primary measure of safe staffing and describes both the staff required and staff available in relation to the number of patients.
- 4.1.1 The overall average CHPPD figures for 2021/22 in **table 1**, shows that safe staffing has **continued to be a significant challenge**, linked to the reasons already outlined, when looking at the overall average. The specific CHPPD by area for October 2021 noted in **appendix 2**

Table 1. Average Trust CHPPD 2021

	Required CHPPD	Actual CHPPD	Variance
July 2021	8.74	7.85	-0.89
August 2021	8.56	7.56	-1.00
September 2021	8.58	7.51	-1.07
October 2021	8.38	7.07	-1.31
November 2021	8.91	7.75	-1.16
December 2021	9.00	7.64	-1.36

#### 4.2 Safer Nursing Care Tool (SNCT)

- 4.2.1 The SNCT (Shelford Group, 2013) is the only nationally approved, evidence-based tool to support safe staffing within in-patient areas; data collection takes place for a minimum 20 days bi-annually (to allow for seasonal differences). The acuity data is collected using clinical descriptors (presented in **appendix 3**) and matched with pre-set staffing multipliers to ensure that nursing establishments reflect patient needs in acuity / dependency terms. The recommended number of staff, following analysis, is in whole time equivalent only i.e. registered and unregistered staff; recommending staffing levels based on an analysis of the actual patient acuity and dependency on the ward at the time of data collection.
- 4.2.2 The recommendation within the tool is to undertake **at least two data sets** before data validation and **any changes made to establishments**. Two data sets (March and October 2021) are available to support discussion as we move towards changes to funded establishment.
- 4.2.3 In addition to this, there is a minimum number of nurses required to deliver safe care regardless of ward size, 11.5 whole time equivalent (WTE) Registered Nurses (RN's) are required to provide two nurses 24/7.
- 4.2.4 No national workforce tool can incorporate all factors alone and therefore triangulation with professional judgement is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated; applied to increase confidence in recommended staffing levels and provide balanced assurance.

### 4.3 Birth Rate Plus

- 4.3.1 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 most recent Birth rate plus data analysis within the trust took place in 2019; the next review will take place in 2022. **There are no proposals to change the workforce models as they currently continue to meet the demands of the service.** A thorough workforce review; however, is being scoped in line with the national move towards Continuity of Care model (CoC).

### 5.0 SNCT Data Collection

- 5.1 A comprehensive and thorough review of Nurse and Midwifery staffing was undertaken during May/June 2021 (data collection in March 2021). **Professional judgement panels** including: ward matron, senior clinical matron, and Head of Nursing/Midwifery, Finance and Workforce Business partners; **convened to discuss annual workforce planning including forecast of capacity and demand.** The face-to-face panels support a 'bottom up' approach to annual workforce reviews and support the balanced discussion of hard data and softer intelligence.
- 5.2 The second cycle of Safer Nursing Care Tool (SNCT) data collection took place during October 2021. The results of the data collection are included at **appendix 4**. All in-patient areas must have safe staffing for all funded beds, the tool therefore advises that each empty bed calculated as level zero.
- 5.3 It is **important to note** that the **data collected during the third wave of the coronavirus pandemic, meant several wards and departments were flexing bed bases up and down based on the acuity and dependency needs of patients and safe staffing availability at the time, thus creating a variation between the planned and actual establishments.**
- 5.4 The tool only provides nursing workforce establishment requirements based on patient acuity. Skill-mix requirements are not included and therefore considered at a local level. The SNCT also states that a minimum of 22% funded headroom should be included for all nursing and midwifery staff within in-patient areas. This is part of the full evaluation to ensure headroom alignment across the Trust.

### 6.0 Key findings (SNCT Data Collections March and October 2021)

- 6.1 The data identifies the **under establishment** for all in-patient areas averaged at 52.12wte.
- 6.2 The information below is by exception (**over-established by 5wte**) as identified within both data sets including:
- **EAU** SNCT indicates an over-establishment of c10.3wte, however, the EAU workforce also resource the waiting area (assessment hub) and ambulatory care unit, not captured within the tool. Throughout the pandemic, ambulatory care has been re purposed and in the main provides an in-patient acute assessment area for Covid positive patients. Amendments will be included for the next data set to ensure the calculation is accurate.
  - **SDU** SNCT data suggested an over-establishment of c7.0wte; however, resource also covers the patients who attend the ward for same day care including Covid swabbing and hot clinic activity that are not included in this tool. Amendments will be included for the next data set to ensure the calculation is accurate.

6.3 The information below is by exception (**under-established by 5wte**) as identified within both data sets including:

- **Ward 26** SNCT data showed an under-establishment of c9.0wte
- **Ward 24** SNCT data showed an under-establishment of c8.0wte. This demonstrates the increase in acuity within the Respiratory Support Unit. The **bed base on this ward has since reduced to 28 from 31, which supports the revision of the under-establishment** to provide a more accurate position.
- **Ward 36** SNCT data showed a significant under-establishment of c13.2wte. The acuity of this ward indicates that a **higher registered workforce** is required rather than unregistered.
- **Ward 40** SNCT data suggested an under-establishment of c9.4wte. The dependency for this ward indicates that a **higher unregistered workforce** is required rather than registered.
- **Ward 42** SNCT data showed a significant under-establishment of c15.5wte. Despite the funded bed base being 34, there is a regular flex to 36 beds, which was the position at the time of the data collection. The dependency for this ward indicates that a **higher unregistered workforce** is required rather than registered.

6.4 The full analysis of the data collection from October 2021 and the March 2021 is included at **appendix 4**.

6.5 The SNCT - now licensed for use by the Emergency Department; SNCT data will be included in the bi-annual data collection to provide evidence of staffing requirements within this specialty.

6.6 The Trust was selected to undertake beta testing for the newly developed Community Nursing Safe Staffing Tool (CNSST). Data collection took place across two community teams, analysed and inputted into the required tool. This has been submitted to NHSE/I.

## **7.0 Safe Care Live (SCL)**

7.1 SCL is a unique daily staffing software that matches staffing levels to patient acuity, providing control and assurance from bedside to board. It allows timely comparisons of staff numbers and skill mix alongside actual patient demand, allowing informed decisions to be made regarding the need for staff deployment. SafeCare, has been awarded an endorsement statement by The National Institute for Health and Care Excellence (NICE) in relation to its guidelines for Safe Staffing.

7.2 SCL is used within the trust on a twice-daily basis to accurately assess safest staffing. Based upon this assessment, nursing staff are deployed throughout the organisation to ensure the right staff are in the right place to provide optimum patient care. SCL provides information on a shift by shift basis for each unit (ward/department) which includes whether there is an under or over utilisation of the staffing resource, the overall percentage of temporary staff working that shift, the detail of any unfilled shifts, the calculated nurse to patient ratio, CHPPD and skill mix.

## **8.0 Filled Rates and Hours**

8.1 In line with the National Quality Board (NQB) publication, the organisation continues to report the planned and actual staffing data on a monthly basis to NHSI. The average fill rates in hours and (UNIFY data) continues to 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.

## 9.0 Temporary Staffing

9.1 NHS Professionals (Trust commissioned Bank provider) provide performance data; specifically fill rate position, which has identified a decrease in the ability to fill the required shifts. Professional judgement is applied, where there has been an increase in the number of additional shifts requested. Additional NHSP shifts are often due to reduced capacity (e.g. short notice sickness absence) or an increase in demand (e.g. additional surge beds, increase in patient acuity).

9.2 Average NHSP fill rates from April – December 2021 show that for Registered Nurse shifts:

- 36% shifts filled by NHSP
- 15.4% of shifts filled by Agency
- 48.6% shifts remained unfilled

9.3 Average NHSP fill rates from April – December 2021 show that for Unregistered Nurse shifts:

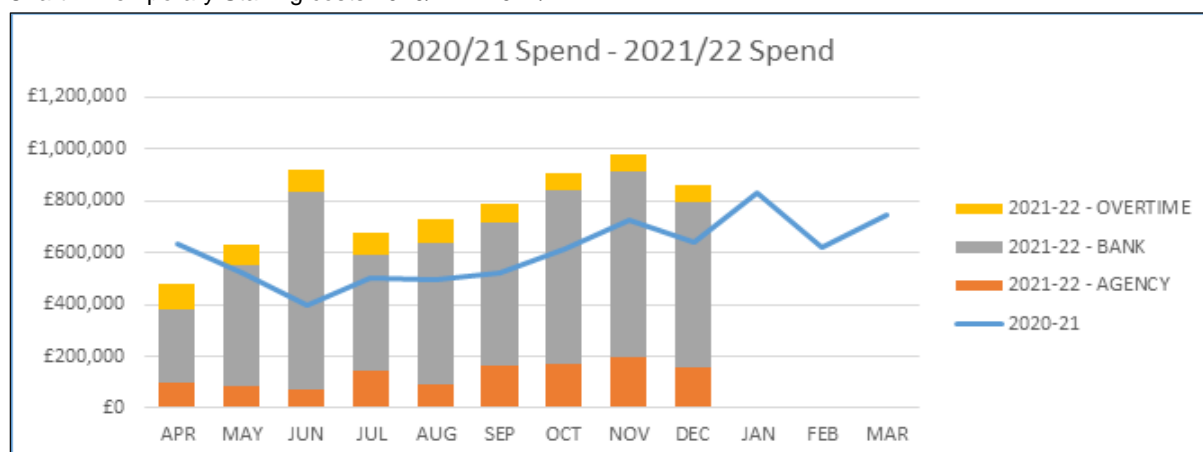
- 67.3% shifts filled by NHSP
- 32.6% shifts remained unfilled

9.4 A number of incentive schemes are in place to improve fill rates, which are under weekly review within a longer-term strategic plan to reduce substantive vacancies.

## 10.0 Temporary Staffing costs

10.1 Temporary staffing expenditure for Nursing and Midwifery staffing below in chart one; including a year on year comparison for Bank, Agency and overtime usage.

Chart 1. Temporary Staffing costs 2020/21 – 2021/22



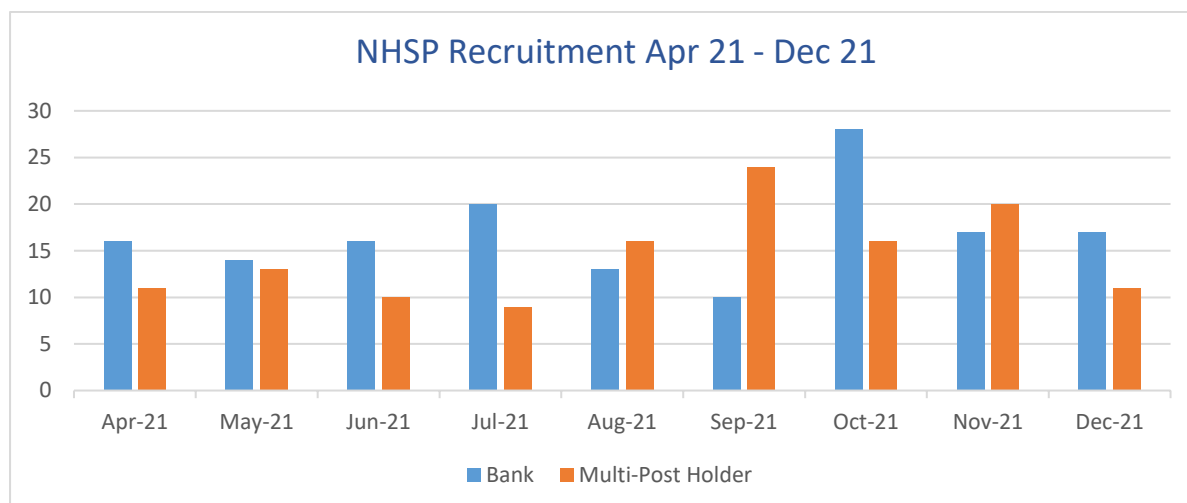
10.2 Agency expenditure trend is consistent with previous years and the reduction of agency usage across the organisation remains a key priority. Bank expenditure has gradually increased in line with an increase in pay to the top of the band for all staff groups. Staff unavailability remains high resulting in less availability of staff to fill bank shifts in addition to their contractual hours. Additional incentives to encourage nursing staff to pick up additional hours has results in a further increase in bank spend.

- 10.3 Agency spend has gradually increased in some areas due to the requirement to block book agency workers in order to maintain a nursing workforce with the appropriate skills in the right areas (e.g. Orthopaedics and Emergency Assessment Unit). Despite the increase in agency usage, the organisation continues to maintain a favourable benchmarking position when compared with other Trusts nationally. The Trust remains in an excellent position (3<sup>rd</sup>) nationally for agency spend year to date (YTD), ensuring the most cost effective, safe staffing resource in clinical areas whilst maintaining and improving quality and patient safety. However, to note that the Model Hospital Data has not been refreshed since June 2021.
- 10.4 The Trust continues to recruit to as many permanent positions as possible to meet establishments and reduce the demand for premium agency staffing. The implementation of the Team Support Worker (TSW) role throughout FY20/21 and 21/22 for six months periods has resulted in additional support staff being made available in clinical areas to support a wide variety of tasks; supporting clinical staff to deliver high quality, and safe patient care. The Team Support Worker roles have provided benefits to patient experience, staff satisfaction and has contributed to a significant reduction in complaints related to communication. In line with workforce development strategies, the organisation is committed to support TSWs to capitalise on the opportunities offered by the Trust and educational partners. Many of the initial TSW cohort are currently progressing through the HCA apprenticeship, which will result in the development of qualified HCA staff following the successful completion of a two year apprenticeship. This opportunity will reduce reliance on temporary staffing in this workforce group and supports the “grow your own” model of workforce recruitment.
- 10.5 Throughout the winter period, staff unavailability have posed increasing risks to patient safety and safe staffing levels. This annual pressure has been further compounded with the Covid-19 pressures experienced across the Trust. The reliance on temporary staffing has been consistent, however, because of unprecedented demand, fill rates have reduced. Although, filled hours volumes has increased in comparison with the previous financial year. This is a result of the organisation committing to an increased rate of pay for Band 2, 4 and 5 Nursing and Midwifery staff. Initially agreed from 9<sup>th</sup> November 2020 and have continued to be in place due to the patient safety risk associated with a potential reduction in filled hours if pay rates revert to spine point 3.

## **11.0 NHSP Recruitment**

- 11.1 NHSP are actively recruiting both bank only and multi post holders in order to meet the current demands of unfilled hours. Chart 2 presents recruitment figure in whole time equivalent from April to December 2021.

Chart 2



## 12.0 Model Hospital National Performance Position (Latest position - June 2021)

12.1 Analysis of the Model Hospital data highlights the Trust's overall performance in temporary staffing spend, agency cost reduction and use of resources.

12.2 Model Hospital highlights for the trust include;

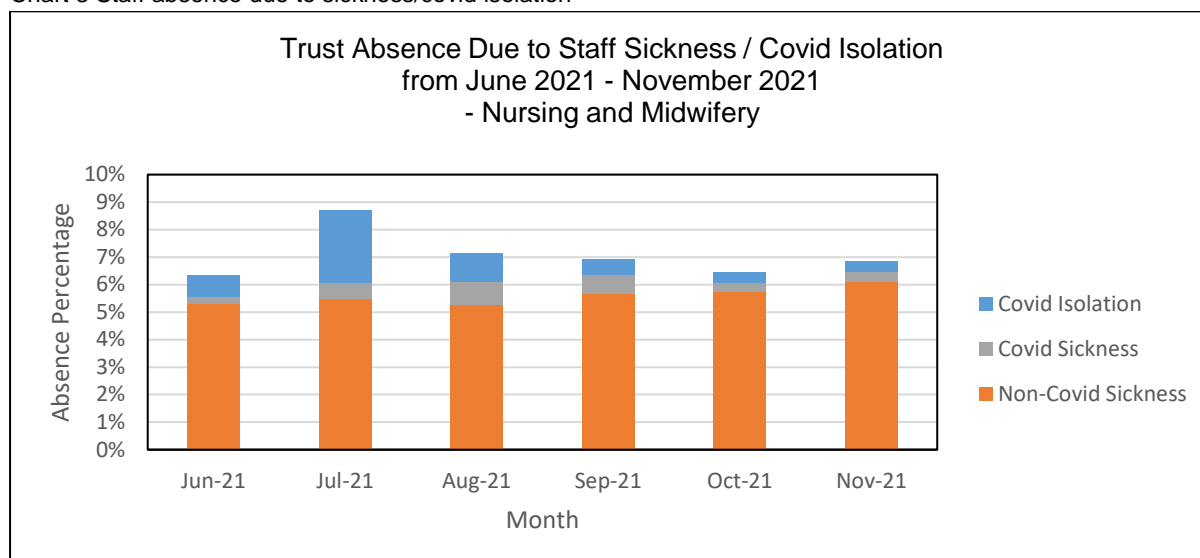
- Second lowest provider Trust nationally for Bank staff spend YTD
- Third lowest Trust nationally for Agency staff spend YTD
- Lowest quartile within national distribution for agency spend as a % of total staffing spend at 4.0%

12.3 Charts to illustrate the Trust position are at **appendix 5**.

## 13.0 Nursing and Midwifery sickness

13.1 Chart 3 below shows the overall nurse and midwifery sickness and absence June to November 2021. The average across those six months was 7.06% (a reduction from 8.7% presented at the last workforce review in June 2021), this however remains a significant challenge. July 2021 had the highest levels of sickness absence with a peak of 8.43%. It is important to note that this includes sickness due to Covid symptoms and staff absences due to Covid related isolation. Within the funded headroom, 4% is allocated for both registered and unregistered nurses/midwives for predicted sick leave. The rates continue to be over and above this with 5.6% average sickness absence for non-covid related (an increase from 4.5% reported at the last workforce review in May 2021). It is important to note that community-nursing teams do not have funded headroom therefore any sickness cover has to come from existing staff or temporary staffing at additional cost.

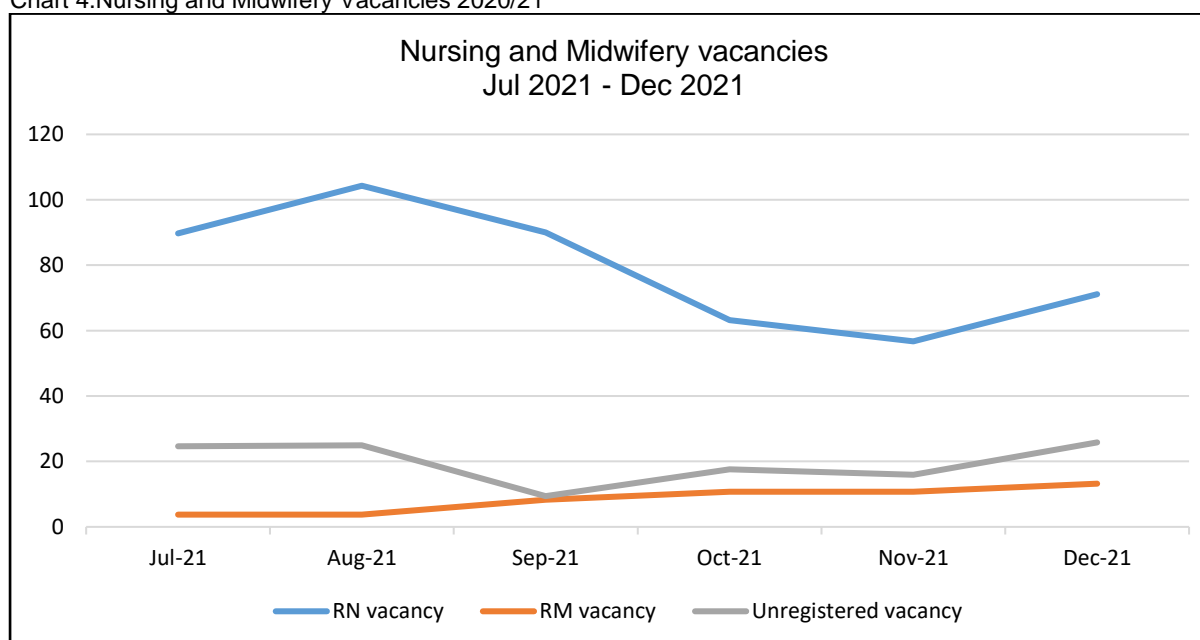
Chart 3 Staff absence due to sickness/covid isolation



## 14.0 Nursing and Midwifery Vacancies

14.1 Chart 4 below shows the Nurse and Midwifery vacancies July to December 2021.

Chart 4. Nursing and Midwifery Vacancies 2020/21



## 15.0 Nursing and Midwifery Turnover

15.1 The nursing and midwifery turnover for July to December 2021 presented in table 2 below. The data shows a steady increase in turnover across both staff groups month on month.



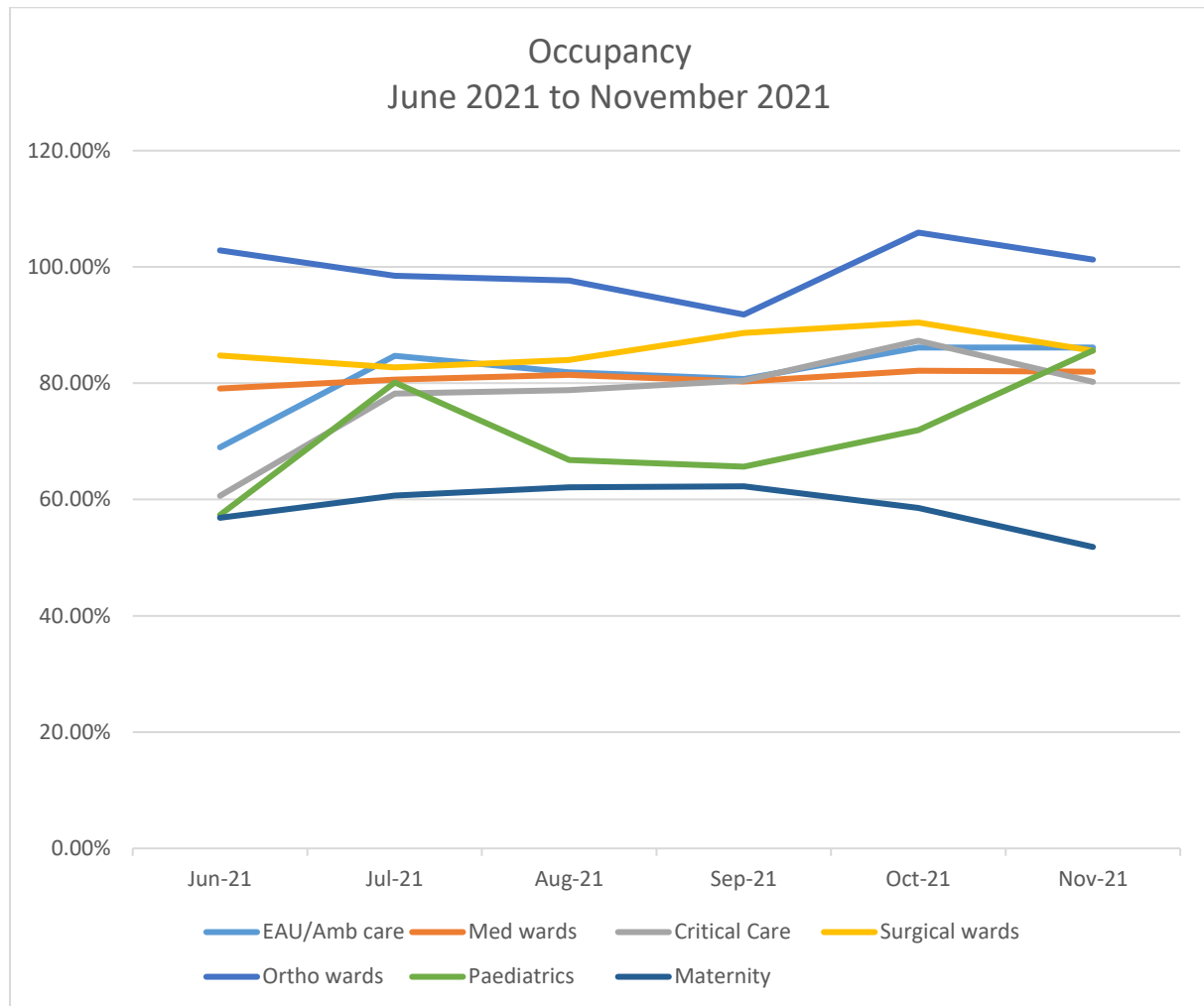
Table 2. N&M Turnover 2021

<b>Turnover (wte)</b>	<b>Registered Nursing and Midwifery</b>	<b>Unregistered Nursing and Midwifery</b>
<b>July 2021</b>	8.53wte	8.33wte
<b>August 2021</b>	8.58wte	9.38wte
<b>September 2021</b>	8.86wte	10.79wte
<b>October 2021</b>	8.95wte	11.14wte
<b>November 2021</b>	9.19wte	12.43wte
<b>December 2021</b>	9.09wte	12.68wte

## 16.0 In-Patient Occupancy

16.1 The bed occupancy from June to November 2021 (inclusive of surge beds) at chart 5 below.

Chart 5. Occupancy 2021



## 17.0 Monitoring of Clinical Outcomes

17.1 SNCT data is not acted upon in isolation, as quality aspects of patient care, particularly outcomes, must be taken into account. Nationally undertaken by means of monitoring Nurse Sensitive Indicators (NSIs). 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 organisation 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.

17.2 A **fall**, defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause, may be sensitive to the number of available nursing staff; falls prevention requires a multidisciplinary approach. Falls rates are affected by:

- availability of physiotherapy, occupational therapy, pharmacy and medical staff
- knowledge and skills of all healthcare professionals and support staff
- safety of the environment, furniture and fittings
- access to mobility aids and equipment

Despite the number of falls sustained across the trust (907 April to December 2021) a high proportion (83.2%) of falls resulted in no injury to the patient. This reflects the improvement work that has taken 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 a patient falling.

- 17.3 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. Pressure ulcer are categorised as 1, 2, 3 or 4. Although pressure ulcers may be sensitive to the number of available nursing staff. Pressure ulcer prevention also requires a multidisciplinary approach, rates affected by:

- access to pressure ulcer prevention equipment and mobility aids
- availability of physiotherapy, occupational therapy, pharmacy and medical staff knowledge and skills of all healthcare professionals and support staff

Despite the number of developed pressure ulcer across the trust (347 April to December 2021), the highest level of pressure ulcers, were category 1 and 2 (94% in hospital and 71% in the Community).

## 18.0 Nurse and Midwifery Recruitment and Retention

- 18.1 Strategic workforce action groups are in place to support the agreed required outcomes in relation to recruitment and retention. The workforce 'strategy on a page' at **appendix 6** and the associated workforce operational plans can be found in **appendix 7**.

- 18.2 The Trust continues to undertake a number of **recruitment** initiatives with the aim to see a further increase in both the registered and unregistered nurse establishment across the organisation. These initiatives include:

- Frequent use of social media platforms to provide information to the public around opportunities within the Trust with a particular focus on promoting the Trust as the employer of choice
- Recruitment continues via value based monthly recruitment centres and this method has proven to be a positive way of attracting pre-registered, registered and unregistered nurses to the Trust.
- Bespoke recruitment continues to be successful in some specialist areas with targeted recruitment to attract the right workforce with the right skills and experience (e.g. critical care, theatres).
- The Trust invested in international recruitment and a submitted bid in line with the agreed funding offer has been successful in granting the Trust £3000 per international nurse recruited. This will support the provision of the preferred attractive and competitive relocation package, promoting North Tees as one of the preferred areas to work.
- Health Care Assistants, recruited to turnover rate in key areas, with a temporary flex of registered nurse vacancy where appropriate.
- A significant number of unregistered nursing staff completing the Foundation Degree for Assistant Practitioners (APs) using the Apprenticeship Levy.
- Trainee Nursing Associates have successfully completed a two-year pilot Foundation Degree programme with Health Education England (HEE) and Teesside University.

- Building the nursing workforce of the future with continuous links with local schools, colleges and Higher Educational Institutes to raise the profile of nursing.
- Widening access into employment with the implementation of a new 'Team support worker' role (6-month fixed term contracts) which offers a cohort of Band 2 staff, with little or no previous NHS experience, the chance to support clinical and administrative teams across the organisation. The role releases nursing time to care, reducing the pressure on nursing teams by undertaking tasks such as answering phones, patient buzzers, communicating with patients and relatives, stocking and tidying and general admin or patient care duties.

18.3 Making the NHS the best place to work is a key commitment in both the Long Term Plan and the NHS People Plan. Recently NHS England and NHS Improvement published 'Retaining our People' retention programme (October 2019) 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. Specific **retention** initiatives within the trust include:

- Monthly Education panels across all Care Groups are being strengthened in line with the revised workforce strategy to support education and training, succession planning and leadership development
- The 'Transfer Window' has now moved to monthly in line with the recruitment centres to support staff retention and professional development. Substantive nursing staff, supported to move across specialities within the Care Groups and given the opportunity to discuss the options of more flexible contracts and rotational posts, which aim to support staff in maintaining their work life balance and achieving their preferred skill sets.
- Initiatives relating to on boarding are being progressed in line with the workforce strategy and supported with Workforce and Communications teams.
- Fourteen units currently self-roster increasing ownership and work-life balance for staff; additional areas will be assessed for suitability to move to this process in Feb/Mar 2022.
- Top of band pay rates agreed are under review as a collaborative approach is established with South Tees Hospitals NHS FT.
- A relaunch of the Matrons Handbook will support Ward/Dept. Matrons in their personal and professional development.
- Career clinics will further support staff in their professional development; this will commence from April 2022 and will be a collaborative approach between nursing and workforce teams.
- Monthly registered nurse development days re-launched by the Heads of Nursing to continue throughout 2022 with a continued focus on personal and professional development and the health and wellbeing of staff.
- Career pathways and leadership modules are currently being explored to help support Registered Nurses moving into Matron and Deputy Matron roles.

## 19.0 Allied Healthcare Professionals (AHPs)

- 19.1 The NHS Long Term Plan committed to further develop the national AHP strategy however this was paused in 2020 in response to the pandemic, work resumed in 2021 to create a strategy to replace 'AHPs into action'.
- 19.2 Within the trust, recent changes to the operating model and collaboration between Care Groups provides opportunity to review workforce requirements across pathways. AHPs play a vital role in many patient pathways including stroke, respiratory, frailty

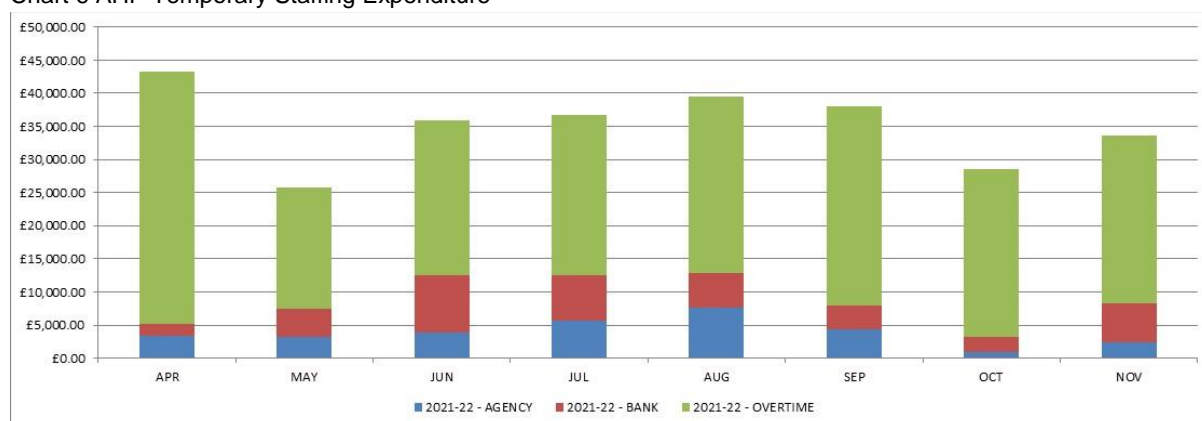
and diabetes. Within each pathway, there are opportunities to review how the best care delivered in the right place at the right time. This approach to transformation will support the growth of AHP roles whilst developing services in line with the strategic aims of the Organisation.

- 19.3 In partnership with nursing colleagues, AHPs are working in collaboration with primary care networks across Hartlepool and Stockton. The integrated single point of access and new integrated roles across professions provides a platform to develop relationships with partners in primary care as well as delivering more support to care homes utilising the *Enhanced Health in Care Homes* framework.
- 19.4 Locally, the Physiotherapy and Occupational therapy teams are part of a collaborative intermediate care service, delivering enablement and rehabilitation to our local population. The acute Physiotherapy and Occupational therapy team's work with ward based teams and experienced nursing staff to facilitate discharge planning and promote independence and recovery for patients who find themselves in an acute hospital bed. The integrated discharge team (IDT) is led by therapists and social workers (along with voluntary sector workforce) forming part of the wider team facilitating patient flow on a daily basis. AHP Leaders are actively involved in a regional network looking at the development of evidence based safe staffing models within acute areas.

## 20.0 AHP Temporary Staffing

- 20.1 Temporary staffing continues to be used to backfill gaps within the AHP workforce. Chart 6 below shows the expenditure between April and November 2021. The highest expenditure continues to be related to overtime with a smaller bank expenditure.

Chart 6 AHP Temporary Staffing Expenditure

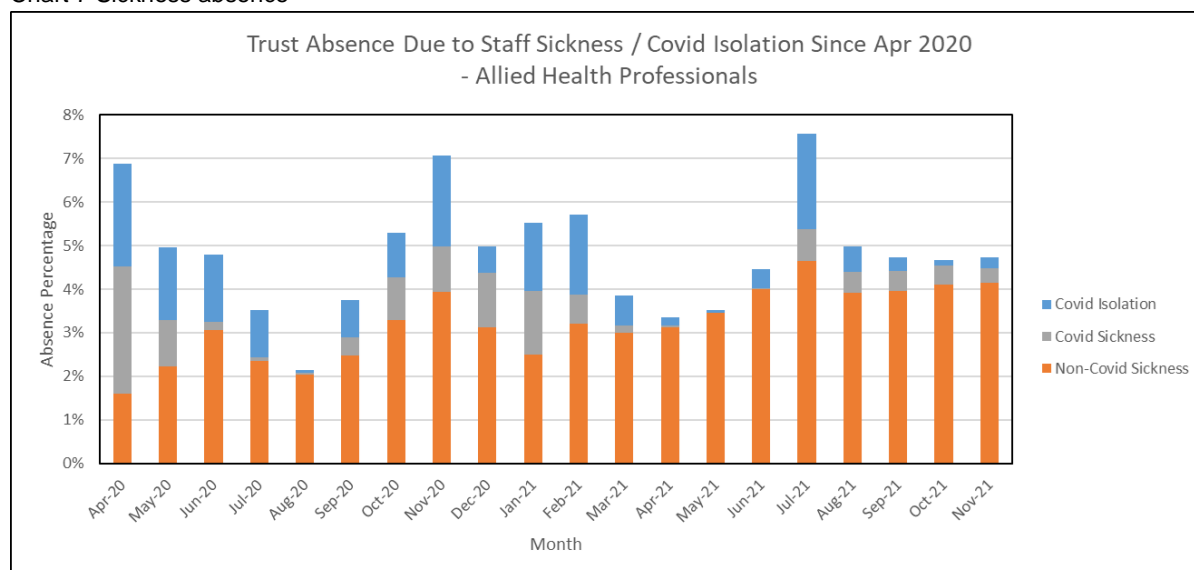


- 20.2 A consultation has commenced with current AHP bank staff to transfer over to NHSP to ensure that all future bank work will be completed through NHSP with the aim to increase AHP usage to support a reduction in overtime spend.

## 21.0 AHP Sickness Absence

- 21.1 Sickness absence for AHPs from April November 2021 at chart 7. Sickness remains a challenge with July 2021 showing the highest levels of sickness absence with a peak of over 7.5%. It is important to note that this includes sickness due to Covid symptoms and staff absences due to Covid related isolation.

Chart 7 Sickness absence



## 22.0 AHP Vacancies

22.1 Table 3 below shows the current vacancy levels across the AHP services at month 8. Vacancy factor remains high in Dietetics and Paediatric Speech and Language Therapy although improvements demonstrated across the majority of the AHP groups.

Table 3 Vacancy position

Profession	Budgeted WTE	Vacancy	%
Occupational Therapy	62.15	-9.66	-15.5% (over recruitment)
Physiotherapy	168.3	-3.29	-1.95% (over recruitment)
Nutrition & Dietetics	25.5	2.5	9.8%
SALT (Adults)	6.73	1.73	1.73%
SALT (Children)	92.42	19.73	21.3%
Podiatry	32.24	0.81	2.5%
Diabetic Eye Screening	7.22	0	0%
Audiology	11.04	-0.2	1.8%
Radiology	83.1	7.25	8.7 %

## 23.0 AHP Recruitment and Retention

23.1 In addition to the initiatives in place for Nursing and Midwifery workforce, the recruitment initiatives for AHP workforce include:

- Appointment of a fixed term AHP practice placement facilitator and AHP placement support officer has seen an increase in placement numbers. This work has seen creative new forms of placements both clinical and non-clinical, which will support successful recruitment in the future.
- Following temporary funding from Higher Education England, the Trust has appointed a Strategic Workforce Lead for AHP until the end of March 22. This

provides an opportunity to assist and accelerate the planning and growth of the AHP professions both in the short and longer term. The focus of this post is to develop a long-term strategic plan for AHP's that works in collaboration with the nursing and medical professions in order to achieve the Trust's long-term vision.

- A number of AHP professions have adapted an approach to recruit to turnover to help address short term staffing short falls within the year.

23.2 In addition to the initiatives in place for Nursing and Midwifery workforce, the **retention** initiatives for AHP workforce include:

- E-rostering is in place for all AHP groups. Flexible working hours is supported to meet clinical and service demand. A key focus of recent work has been on the standardisation of practice inclusive of length of appointments/sessions and numbers of patients seen in those sessions to further support retention.
- Measures are in place to embed succession planning systematically across AHPs to ensure a sustainable workforce and to consider the impact of both an ageing population and an ageing workforce.
- Education and career pathways are offered for all AHPs from apprenticeship through to registered practitioner and onwards. Working with Higher Education Institutions (HEI) to deliver a sustainable placement programme ensures an appropriate supply of graduates entering NHS Service over the next three years and on-going continuing professional development supporting the increased use of Advanced Practice roles.
- Recent success of both physiotherapy and Occupational therapy apprenticeship programmes with support workforce staff having started on the programme in Sept 21.
- There are new and emerging roles including AHP Consultant, Advanced Practice and Extended Scope Practitioner roles that can and will address medical recruitment gaps, providing senior clinical leadership and decision-making. Advanced practice opportunities feature across all local AHP groups. 2022 will see the first Physiotherapist to qualify with an ACP certificate. This trailblazing role offers us opportunities to work across emergency, primary and community care services. This work has led to scoping of future roles and opportunities within the AHP workforce, such as community respiratory support.

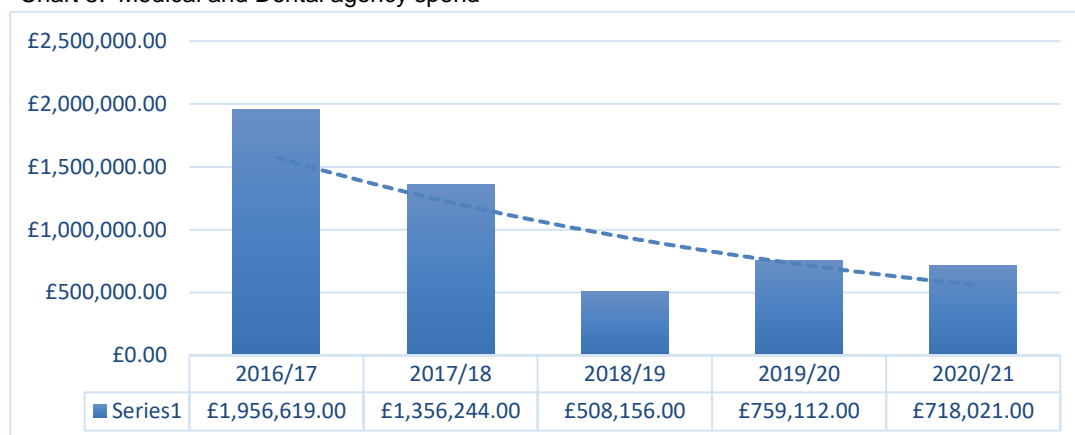
## **24.0 Medical and Dental Workforce**

24.1 The Trust currently has a workforce of 678 doctors/dentists, which includes 100 doctors employed on zero hour's contracts to support with workforce shortfalls. Medical and Dental staff equates to 10% of the Trust workforce.

## **25.0 Medical and Dental Temporary Staffing – Medical Locums**

25.1 A total of £718k spent on agency locums during 2020/21, demonstrates a decrease of £36k when compared to 2019/20 expenditure. Chart 8 shows the expenditure trend over the last five years.

Chart 8: Medical and Dental agency spend



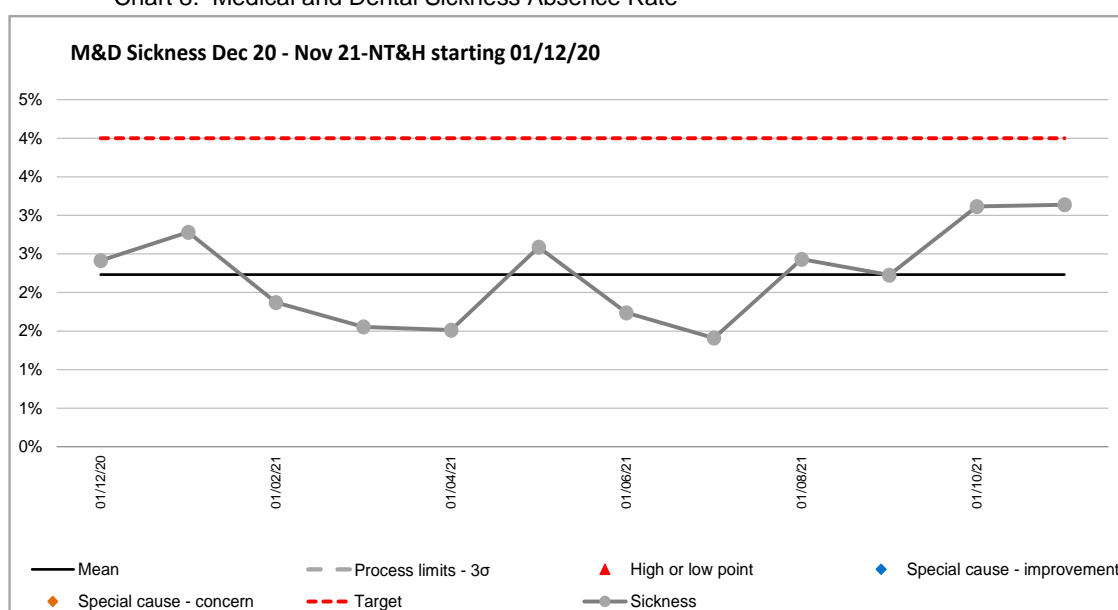
- 25.2 The largest proportion of spend (£201k) is attributable to the pandemic response and subsequent resilience measures. A further £425k is attributable to Pathology, Surgery and Urology, and Anaesthetics, which have held long-standing consultant and SAS grade vacancies.
- 25.3 Agency medical locums can command very high premium rates, to keep costs to a minimum the organisation has clear governance processes in place, which ensures all other options fully explored before proceeding to agency.
- 25.4 The LET collaborative bank provides cover for training grades and trust equivalent grades. 937 shifts, released to the bank between April 2020 - March 2021; 622 of these shifts were filled whilst 315 remained unfilled, providing a Trust fill rate of 66%.
- 25.6 The total 2019/2020 annual budget for medical and dental staff was £52.2m, the actual spend was £56.3m; an overspend of £4.1m. To help maintain service delivery and patient safety, substantive staff and those on zero hour contracts work additional hours. Internal consultants have delivered a number of additional activities outside their agreed job plan.

## 26.0 Medical and Dental Sickness

- 26.1 Average sickness absence rates for Medical and Dental staff between Dec 2020 and Dec 2021 is 2.5%, lower than the Trust target of 4%. There has been a spike in the absence rate in November and December 2021. These figures, below in chart 8, do not include reported sickness for trainees employed by the LET, as the Trust does not hold this information centrally.



Chart 8: Medical and Dental Sickness Absence Rate



## 27.0 Medical and Dental Vacancies

27.1 According to data collected from individual directorates within Care Groups, there are 24.26 WTE vacancies across the Trust, 24.03 WTE relate to consultant posts and 2.28 WTE to SAS grade posts.

## 28.0 Medical and Dental Turnover

28.1 The average turnover rate for medical staff between July and December 2021 is 6.06%; calculated on the number of leavers as a percentage of the average headcount of medical staff over the 12-month rolling period. If attrition rate for non-voluntary leavers were included, the rate would increase to 9.09% as shown below in table 4. Figures exclude zero hour workers, flexi-retirees, and trainees who rotate between specialties or Trusts every four to six months.

Table 4 Turnover

<b>M&amp;D Staff Starters, Leavers and Turnover Jul-Dec 2021</b>					
<b>Directorate</b>	<b>Starters</b>	<b>Leavers</b>	<b>Voluntary</b>	<b>Involuntary</b>	<b>Combined</b>
345 Accident and Emergency Directorate	5	5	19.05%	4.76%	23.81%
345 Anaesthetics Directorate	4	2	3.85%	0.00%	3.85%
345 EAU/Ambulatory Directorate		2	11.11%	11.11%	22.22%
345 Endoscopy Directorate	2	1	0.00%	33.33%	33.33%
345 Healthy Lives Management Directorate			0.00%	0.00%	0.00%
345 In-Hospital Care (Healthy Lives) Directorate			0.00%	0.00%	0.00%
345 In-Hospital Care (Responsive Care) Directorate	1	1	2.22%	0.00%	2.22%
345 Medical Director Directorate			0.00%	0.00%	0.00%
345 Obstetrics and Gynaecology Directorate	4	2	5.71%	5.71%	11.43%

345 Orthopaedics Directorate	5	3	2.74%	5.48%	8.22%
345 Out of Hospital Care Directorate			0.00%	0.00%	0.00%
345 Paediatrics Directorate		2	7.84%	0.00%	7.84%
345 Pathology Directorate	1	3	27.27%	0.00%	27.27%
345 Radiology (Collaborative Care) Directorate			0.00%	0.00%	0.00%
345 Radiology (Responsive Care) Directorate	2		0.00%	0.00%	0.00%
345 Research and Development Directorate			0.00%	0.00%	0.00%
345 Surgery and Urology Directorate	8	3	5.48%	2.74%	8.22%
345 Workforce Directorate	2	3	40.00%	80.00%	120.00%
<b>Grand Total</b>	<b>34</b>	<b>27</b>	<b>6.06%</b>	<b>3.03%</b>	<b>9.09%</b>

## 29.0 Medical and Dental Recruitment and Retention

- 29.1 In order to fill consultant vacancies, a number of areas are targeting trainees approaching completion of their specialist training, about to achieve their 'certification of completion of specialist' training (CCST).
- 29.2 The Trust continues to undertake a number of recruitment initiatives to address medical workforce shortages across all specialties. These include international recruitment schemes to attract workers from overseas, such as the Medical Training Initiative (MTI) scheme and international medical training fellowships.
- 29.3 Other initiatives continue including development of medical associate roles (MAPs) to support the medical workforce, such as advanced critical care practitioners, surgical care practitioners, physician's associates, and physician's assistants. These healthcare professionals work alongside doctors and can help ease workload pressures by assisting with certain duties. They can also provide some cover and stabilisation during trainee rotational periods and support trainee doctors in attending training, clinics, and theatres. The General Medical Council (GMC) will be taking on the regulation of Physician Associates and Anaesthesia Associates.
- 29.4 Overseas trainees due to start in August may be delayed because of the pandemic, resulting in vacancies and rota gaps. There are 37 overseas new starters across the region and the LET will keep Trusts updated on any potential risks to start dates. The Three doctors start dates delayed due to Covid, will be unable to join the Trust until December. These posts currently filled by DiT who started their rotations later and will therefore fill the gaps from August to December.
- 29.5 During April 2021, the Trust welcomed a cohort of 18 newly qualified doctors from Newcastle Medical School as part of a special national drive to help the NHS respond to the coronavirus pandemic; deployed to medical wards under supervision. Where possible, the Medical Education Team also brought foundation trainees back into the Trust who were on placement in a non-hospital setting to support areas with staffing.

- 29.6 Further engagement with senior trainees to fill potential consultant vacancies, including consideration of generic engagement half-days. As well as international recruitment, including the MTI scheme, and international medical training fellowships to address trust doctor and SAS grade gaps.
- 29.7 The Annual Review of Competence Progression (ARCP) assessments for doctors in training normally takes place between May and July each year. In light of the pandemic, the Statutory Education Bodies considered the adjustments required to ensure the ARCP process could proceed this year. This included a reduction in portfolio requirements for trainees, temporary suspension of penultimate year assessments (PYAs), and changes to the format of the panel. Any adjustments were in line with the governing rules outlined in The Reference Guide for Postgraduate Foundation and Specialty Training in the UK.

### **30.0 Workforce Planning and Deployment**

- 30.1 In response to the coronavirus pandemic, working patterns and duties have been amended at short notice to reflect any temporary service changes and ensure back-up cover for any related absences. The medical workforce has worked flexibly over the last year to support the Trust in this unprecedented time. The current job planning annual round has been temporarily paused and a new target date of August 2021 for full sign-off has been set by the Medical Director
- 30.2 Medicine, Emergency Medicine, Orthopaedics, Surgery, Anaesthetics, Paediatrics and Obstetrics and Gynaecology are all using electronic rostering, which provides mobile access to rosters and the ability to electronically request annual leave. These systems are also being used to roster on-call and record unavailability for consultants and provide visibility of the workforce and supportive effective redeployment.
- 30.3 All rota templates have been amended to ensure compliance with the changes to working hour's limits and rest requirements outlined in the revised 2016 doctors in training contract. There has been focussed work in emergency medicine and since August 2021, all their rotas meet the maximum one in three-weekend rule.

### **31.0 Safe Working Hours**

- 31.1 The medical and dental workforce have worked flexibly over the last 12-months to support the Trust in its response to the coronavirus pandemic. The Guardian continues to champion safe working practices and is currently working with leads to ensure compliance with working rules is maintained.
- 31.2 Exception reporting continues to be the mechanism used to highlight additional hours worked, non-compliance with safe working hours, lack of support, and missed educational opportunities; 123 exceptions were submitted between April 2021 to date, mainly by foundation level trainees in medicine specialties for additional hours worked.
- 31.3 NHS Employers and the British Medical Association (BMA) have issued a joint statement on the application of the 2016 contract limits for the duration of the pandemic emergency. This statement provides guidance on where working hour's limits and rest requirements outlined in the terms and conditions of service (TCS) can be flexible. As the contract provisions are in place to ensure the health and safety of trainees, this should be as limited as possible and for as short a time as necessary. If required, this should be done in discussion with trainees and the Guardian of safe Working Hours.

## **32.0 Summary**

- 32.1 The impact of COVID-19 continues to pose a number of challenges for the workforce; staff shortages due to sickness, imposed isolation and caring responsibilities, disruption or cancellation of elective activities and training. The Trust continues to monitor the situation closely. The report has provided a comprehensive position and associated response to the issues identified to ensure continuity, and delivery of safest, high quality patient care.
- 32.2 There have been a number of changes made to ways of working across departments. This has included changes in rota patterns; staff working from home; flexing working hours over varying times of the day to ensure adherence to social distancing rules; and staff placed on standby duties to provide cover for last minute absences. Health and Wellbeing support offered to staff during the pandemic included, but not limited to, free car parking, free refreshments and lunches, break out areas away from work areas, support and wellbeing hotline, listening into action app and bespoke psychology support.
- 32.3 There is a need to now start to review the establishments, using the data, in the areas where there are validated under establishments (greater than five whole time equivalents). In relation to ward 40 and 42, which identifies a need to increase the unregistered workforce, anticipating that this will be achieved in a staged approach where there are vacancies and flexing of the registered workforce. Ward 36 have a validated, significant, under establishment, which needs to be considered as a priority by the Corporate Team and Care Group and included as part of business planning.
- 32.4 Technology utilised fully to support workforce planning and ensure the workforce is deployed effectively. It is also a key enabler in ensuring compliance with working hour's limits and rest requirements.
- 32.5 Introducing new roles, improving working conditions, and supporting flexibility the Trust has attracted, retained, and developed the workforce; whilst continuing to plan and take forward recruitment and retention strategies for all staff groups. Domestic and international recruitment will support the aspiration of no registered nurse vacancies by September 2022.

## **Conclusion**

- 32.6 Through robust workforce processes and assurance frameworks, ensuring there are workforce safeguards in place, the right staff, with the right skills in the right place at the right time, patient safety and delivery of the highest quality of care has been maintained and continuously improved during massive sustained impact from Covid-19, across the entire workforce. The impact cannot be underestimated; working collaboratively across Care Groups but also the external relationships focused upon discharge and Infection Control has built sustained and trusting relationships always focused upon the benefit to the patient.
- 32.7 There is a clear need to review the establishments in the areas where there are validated under establishments (greater than five whole time equivalents). In relation to ward 40 and 42, which identifies a need to increase the unregistered workforce, anticipating that this will be achieved in a staged approach where there are vacancies

and flexing of the registered workforce. Ward 36 have a validated, significant, under establishment, which needs to be addressed.

- 32.8 Whilst this report provides a vast amount of information demonstrating assurance that the Trust have robust process and safety controls in place in relation to workforce there is further work to ensure that the overall triangulation, analysis of the workforce pressures and improvements truly reflect the impact upon patient care and outcomes. The next report will evolve to ensure that this analysis is in place providing the ability not to just look back and current, but to predict workforce requirements into the future.
- 32.9 There is a need and ambition to strengthen collaboration with partners across the health and social care system, key to achieving sustained improvements in workforce, for the immediate provision and also looking to the future; influencing HEI's, attracting the right workforce and retaining the general and specialist provision to provide sustained services for the population.

### **33.0 Recommendations**

- 33.1 The Board of Directors are asked to note the huge effort in response to unprecedented pressures created by Covid-19 and the work undertaken to have safest staffing levels across the organisation.
- 33.2 The Board of Directors are asked to note the impact of the Covid-19 pandemic on both increased patient acuity and increased staff sickness.
- 33.3 The Board of Directors are asked to agree to the further work required to utilise the now validated data to revise budgeted establishments
- 33.4 The Board of Directors are asked to note the actions being progressed to further improve workforce recruitment, development and retention.

**Emma Roberts, Head of Professional Workforce**

**Karen Sheard, Deputy Chief Nurse**

**On behalf of  
Lindsey Robertson, Chief Nurse  
Executive Sponsor**

## Developing Workforce Safeguards Compliance Document

Recommendation	Trust position reported in January 2022	Identified Actions
<b>1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.</b>	<p><b>Compliant</b></p> <p>Right staff with the right skills in the right place at the right time.</p> <p>Establishments in line with service demand and agreed establishments</p> <p>Demand templates reviewed bi-annually in line with Nursing and Midwifery (N&amp;M) workforce review.</p> <p>Adherence to NICE guidance – skill mix</p> <p>Safe Care Live (SCL) used operationally to support staff redeployment based on demand</p>	

	Over lay of professional judgment on shift by shift basis.	
<b>2. Trusts must ensure the three components of safe staffing are used in the safe staffing process:</b> <ul style="list-style-type: none"> <li>• Use of evidence based tools</li> <li>• Incorporation of professional judgement</li> <li>• Use of patient quality outcomes</li> </ul>	<b>Compliant</b>  As part of the nursing and midwifery workforce establishment review the use if all 3 components can be demonstrated	Workforce establishment SOP under revision to confirm process with annual SNCT training, bi-annual data collection and monthly inter-rater reliability data checks.  ED SNCT ready for use and Community Nursing SNCT beta testing complete.
<b>3. NHSI will base the assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.</b>	<b>Compliant</b>  Safe staffing twice daily meetings  TOR and Safe Staffing SOP  E Rostering policy	

	SCL data – CHPPD presented to Exec level monthly	
<b>4. NHSI will review the annual governance statement through our usual regulatory arrangements and performance management processes, which compliment quality outcomes, operational and financial measures.</b>	<b>Compliant</b>  Statement from Chief Nurse and Medical Director via the Bi-annual workforce review presented to board.	
<b>5. NHSI will seek assurance through the SOF monitoring performance.</b>	<b>Compliant</b>  Annual Governance statement completed as part of the bi-annual workforce board report - compliant	To review performance against the SOF prior to the next annual workforce review to ensure compliance is maintained.
<b>6. As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.</b>	<b>Compliant</b>  Statement forms part of bi-annual workforce review board report- compliant (Nursing, Midwifery and Care Staff.	



<p><b>7. Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The Board should discuss the workforce plan in a public meeting.</b></p>	<p>Compliant</p> <p>Annual workforce plans signed off by CEO and Executive Team</p> <p>Process in place to provide statement via board report delivery and annual plan reporting.</p>	
<p><b>8. Board must ensure their organisation has an agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital Dashboard. Trusts should report on their to their Board every month.</b></p>	<p><b>Partial compliance</b></p> <p>Local quality dashboards in place</p> <p>Comparison gained at QRG and N&amp;M huddles</p>	<p>To review model hospital reporting processes</p> <p>Use of Resources project reports on MH data and feeds into ETM monthly</p> <p>Determine how this will be included in Bi-annual board reports</p>

<p><b>9 An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence based toolkit where available) must be reported to the Board by ward or service area twice per year, in accordance with NQB guidance and NHSI resources. This must also be lined to professional judgement and outcomes.</b></p>	<p><b>Compliant</b></p> <p>N&amp;M establishment reviews take place Bi-annually and are presented to board</p> <p>Evidence based tools used and data to be formally used in July 2022</p> <p>Professional judgment</p> <p>Outcomes</p> <p>Monthly workforce review meetings to maintain live workforce plans, agreed establishments, evidence based data, professional judgment.</p>	<p>Review the structure of the nursing establishment review board paper in line with NHSI guidance.</p> <p>Utilise “What a good workforce plan looks like” to ensure development of quality workforce plans</p> <p>Ensure communication and involvement from executive level throughout establishment reviews.</p>
<p><b>10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the</b></p>	<p><b>Compliant</b></p> <p>Workforce reviews based on data from approved evidence-based tools</p>	<p>ED tool to be used from 2022</p>

recommended establishment figures derived from the use of the tool	<p>SNCT</p> <p>BR+</p> <p>BADGER</p> <p>BAPM</p>	
11. As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.	<p><b>Compliant</b></p> <p>Process in place for any skill mix change/service review</p>	
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	<p><b>Compliant</b></p> <p>Process in place for any skill mix change/service review</p>	

<p><b>13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.</b></p>	<p><b>Compliant</b></p> <p>Safe Staffing meetings in place in accordance with guidance</p> <p>Professional judgment applied and documented within SCL</p> <p>Daily escalation pathway up to Executive level via</p> <ul style="list-style-type: none"> <li>✓ Safe Staffing meetings</li> <li>✓ Heads of Nursing</li> </ul>	
<p><b>14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.</b></p>	<p><b>Compliant</b></p> <p>Risks to safety and quality form part of workforce business plans, workforce business plans agreed and in place for all care groups.</p> <p>Escalation to Executive Team of significant risks for action within QIAs and bi-annual workforce board report;</p> <ul style="list-style-type: none"> <li>• Bi-annual workforce board report</li> <li>• QIA process</li> </ul>	

	<ul style="list-style-type: none"><li>• Daily safe staffing escalation process</li></ul>	
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## Care Group Summary – Healthy Lives

## Appendix 2

Wards	funded beds	Level 0 - average number of patients	Level 1a average number of patients	Level 1b average number of patients	Level 2 average number of patients	Level 3 average number of patients	Total budgeted wte	Recommended SNCT wte	Suggested over/under establishment wte	Average CHPPD required	Average CHPPD actual	CHPPD variance	Total number of falls	Total number of pressure ulcers
Paediatrics	20	14.52	1.81	7.04	1.52	0	50.19	52.48	-2.29	9.69	7.68	-2.01	0	0
SCBU	10	3.9	0	5.76	0.33	0	20.17	21.97	-1.8	10.99	12.16	1.17	0	0

**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 most recent Birth rate plus data analysis took place in 2019, and so the next review will take place in 2022. Both the Delivery Suite and Ante/Postnatal Ward currently have the full establishment of Midwives required. In order to maintain skills sets and to establish clear succession planning there is a fluid rotation of staff from the community coming into the ward settings. There are no proposals for a change to the workforce models as they meet the current demands of the service. There will however be further expected changes in workforce requirement in the near future in line with the national move towards the Continuity of Care model (CoC) and better births. There is a full project plan in place with identified work streams to support the CoC model throughout 2021/22.

**The Maternity Assessment Unit** is situated within the women's out patients department, sees over 650 women per month, and is also fully established with Midwives. As the Unit Matron will potentially retire in the next year there is a succession plan in place to further develop existing midwives

The **Community Midwifery** team is distributed across three bases in Stockton, Hartlepool and Peterlee and includes an on call rota to support the escalation policy and the home birth service. The team currently has a 0.4 WTE RM Band 6 vacancy with no proposals to change the current workforce model, again in line with the movement towards the CoC model. All newly recruited midwives are appointed on the basis they will work within the CoC model going forward.

The **Rowan Team** is a midwifery led unit within the community hub based in the University Hospital of Hartlepool. Team members are practice assessors and a Specialist Lead Midwife for CoC oversees the management of the unit.

**Paediatric Services.** The Paediatric Day Unit at the University Hospital of Hartlepool continues to provide pre and post-operative services for children undergoing elective surgery. Staff rotate across the department creating flexibility in the staffing across Inpatient, Children's and young person's emergency department (CYPED) and Out Patient services. There are 20 paediatric in-patient beds (flex to 26 during winter months to

accommodate surges with increased respiratory acuity and occupancy) and a further 15 beds in the CYPED which is now co-located within the Trusts Paediatric Emergency Department and Integrated Urgent Care Centre (IUUC). The unit have zero RN vacancies. Recruitment into this area is usually very successful with final year paediatric nursing students. Staff between paediatric services have merged to create a fluid workforce rotating across all areas to develop and maintain specialist skills. Succession planning continues to be high on the agenda and the services continues to provide development opportunities to all staff to ensure a highly skilled workforce is in place. This includes investing and supporting trainee paediatric nurse practitioners, trainee advanced neonatal nurse practitioners, trainee play specialists, recruitment of a paediatric clinical educator and a transitions coordinator. Proposals to enhance the workforce due to an increase in the complexity of the children and young people accessing services and the higher acuity needs is currently under discussion within the care group. Scoping the requirements to change the workforce and uplift the band 5 team leads to band 6 team leads to ensure visible leadership 24 hours per day will support the provision of safe and effective care as well as responding to the emerging needs of our local population.

**Special Care Baby Unit (SCBU)** is a level 1 service with workforce based on the British Association of Perinatal Medicine standards (BAPM) at an 80% occupancy level, which is 1 nurse to 4 babies within the unit. There is also the addition of a Nurse Practitioner (ANNP) being on the unit 24hrs per day, this role is required to maintain BAPM standards. There are no RN vacancies and the area is popular with student nurses as they near the end of their training. The current workforce model at present meets the demands of the service however the unit is currently an outlier in regards to BAPM requirements as the unit does not have a supernumerary team lead on each shift.

**District Nursing Stockton** delivers care to individuals in their own homes or residential care homes. The service is made up of Four Primary Care Networks (PCNs) in Stockton, which include Billingham/Norton, Stockton North, Stockton and BYTES (Billingham, Tennant Street, Lawson Street and Eaglescliffe Medical Centre). The PCNs provides complex care, palliative care and provide support to families and carers. Registered nurse vacancy is currently 4wte and unregistered nurse vacancy is 1.64wte with plans in place for recruitment into all posts. There is an RN sickness absence rate of 5.8%, which is higher than the trust recommended average; additionally there is pressure to cover unfilled shifts within rosters due to there being zero planned headroom built into the nursing establishment. To support the current 6.1% RN and 5.1% unregistered parental leave the team very successfully recruited into fixed term posts. The team are very experienced at supporting newly registered nurses and by September 2021, they will have seven new nurses across the PCNs with succession plans in place to prepare for some experienced District Nurse planned retirement. Advanced skills acquisition is in place across the team with RNs registered to complete non-medical prescribing and others planned to commence District Nursing Specialist Qualification from September 2021 onwards.

**District Nursing Hartlepool** have three PCNs in Hartlepool, including Hartlepool Health, One Life Hartlepool and Hartlepool Network. Registered nurse vacancy is currently 2.26wte and unregistered nurse vacancy is 1.2wte with plans in place for recruitment into all posts. There is an RN sickness absence rate of 6.3%, which is higher than the trust recommended average; again, additionally there is pressure to cover unfilled shifts within rosters due to there being zero planned headroom built into the nursing establishment. To support the current 6.1% RN and 9.7% unregistered parental leave the team successfully recruit into fixed term posts. Similarly, to the Stockton teams, there is a clear focus on the development of newly registered nurses and plans in place for constant succession planning through completion of the non-medical prescribing

and the District Nursing Specialist Qualification. The current workforce model meets the demands of the service, although there are plans to over recruit band 5 posts, which will support the planned secondments throughout the year.

**District Nursing Out of Hours** is a small team and is a popular area to work so have few vacancies (0.33wte RN and 0.09wte HCA). Two RN sit within the 55-70yr age group but have no plans at present to retire and when this time does come it is agreed that 1.0wte band 6 role will likely be skill mixed to band 5 to further support the out of hours service. There are no proposals to change the current workforce model as it meets the demands of the service.

**Macmillan Carers** is also a small team of 3.6wte band 3 unregistered nurses that support patients and their families within their own homes in Hartlepool. There are no plans to change the current workforce model as it meets the demand of the service although recently the band 3 job description has been reviewed which would enable future staff to support across the whole locality and not just Hartlepool.

**Rapid Response** is a crisis intervention team, providing health and social care to prevent hospital admission or to facilitate early discharge. The service works from two bases, one in Hartlepool and the other in Stockton and due to the previous merge of these teams, the current service consists of band 6 RNs. There is a requirement to carry out a skill mix review of the current workforce model, which will enable the model to change in the future when a proportion of band 6 RN retirement takes place (3wte). This service currently has 1.22wte RN (band 5) vacancies and 0.55wte HCA vacancies and active recruitment is in place.

The **Community Matron** team comprises of 20wte band 7 nurses and have a current vacancy of 2.22wte that are recruited to. Whilst there are 8wte staff in the 55-70yr age range, there are experienced community matrons moving into primary care based settings where the type of clinical work can be more attractive due to higher pay bands being offered. The service is encouraged to maintain a very slight over recruitment when suitable candidates present in order to maintain a sustained average of full recruitment.

**Community Dementia Liaison Service** is a very small service with only 1wte RN and 1wte Occupational Therapist, which naturally causes resilience issues when absence occurs. Currently the 1.0wte OT is on an agreed secondment to Tees, Esk and Wear Valley (TEWV) services meaning that the team have struggled to recruit into a fixed term post. There is however, a plan in place to acquire temporary therapy cover from other specialist services in order to meet the demands of the service.

**Single Point of Access Clinical Triage (SPA)** Clinical Triage nurses are co-located and are integral to the wider Integrated SPA (ISPA). The service is operational 24/7 and consists of 8wte band 6 nurses. There is a current vacancy of 0.47wte where recruitment plans are in place. Succession planning is in place with 5wte staff in the 55-70yrs age range at the end of this year.

### **Outpatients and Rheumatology**

This is a large service covering Lung Health, Medical Rehabilitation Day Unit (MRDU), Rheumatology, Orthopaedic outpatients, Women's outpatients and Main outpatients all set across three sites (North Tees, Hartlepool and Peterlee). Following the nursing workforce review that



took place within Outpatients Departments in January 2019; an effective workforce model met the demands of the service and an implementation manager was recruited to help drive forward the initiatives associated with the productivity plan that included the nursing workforce. In 2020, the team had 74% of their nursing workforce approaching the end of their career and there was a requirement to 're-brand' to attract the nursing workforce to the service. This figure has now reduced to 29% with seven RNs across all services now approaching the end of their career. The current RN vacancy of 0.84wte reflects the significant work from the team to address recruitment and retention challenges. Plans are in place to skill mix some of the RN posts following planned retirement to create band 6 training posts in Rheumatology. This will allow career developmental opportunities across the services and succession planning for this speciality. Development of the unregistered workforce is also embraced by this service with 2wte staff due to complete their Nursing Associate (NA) training in September 2021 and another HCA planned to start their NA training. The accommodation of these roles within the workforce model has already been scoped.

### **Specialist Palliative Care Team (SPCT)**

SPCT delivers specialist palliative care advice and support to patients and professionals in their own homes and hospital settings. There has been a positive move to 7-day working within the team as an early response to Covid-19 escalation, which has proven to be an effective extension to the service providing support to patients and their relatives. The team continue to support band 3, band 5 rotations to upskill, and support the wider workforce. This service currently has no RN vacancies.

### **Home First**

The Home First service continues to develop to maximise admission avoidance, keeping people safely at home and supporting timely discharge from hospital. For this to be successful it is recognised that an appropriately resourced community infrastructure is required which includes, in addition to securing a sustainable Community Hub model, provision of clinical triage 24/7 and increasing the capacity of the Community Matron service. Further developments to increase frailty coordinator capacity and the potential for community teams to in-reach to acute areas to support timely transfers of care. A measure of success of this service is the positive impact for patients with a shift in some activity from an acute inpatient base to a community setting. Improved coordination of patient flow in hospital continues; achieved through greater integration of the Clinical Site Managers, Bed Management team and the Integrated Discharge Team, which includes a new leadership structure and shared governance through the combined Care Group Senior Management Team. An additional key development during 2021 included the progression of the Enhanced Care project and associated deliverables in line with the Home First Model.

The **Holdforth Hub** is based on ward 3 in the University Hospital of Hartlepool where the area is used as a community clinic and provides a 24/7 service. The team is made up of staff who previously worked within the in-patient Holdforth Unit who have adapted well to their new community setting. Community Matrons, part of a skill mixed team, provide direct clinical care, and support a home first model (delivering up to 7 days of enhanced care and support to patients in their own homes), support the service. There is currently no vacancy. There are currently 5.0wte RN in the 55-70yr age range and coupled with the current RN vacancy. To support succession planning, the team have requested that they take final year nursing students so that the service can be promoted as a preferred area to work. It is felt that students currently do not see the career opportunities within this area during their training.

## Care Group Summary – Responsive Care

Wards	funded beds	Level 0 average number of patients	Level 1a average number of patients	Level 1b average number of patients	Level 2 - average number of patients	Level 3 - average number of patients	Total budgeted wte	Recommended SNCT wte	Suggested over/under establishment wte	Average CHPPD required	Average CHPPD actual	CHPPD variance	Total number of falls	Total number of pressure ulcers
24	31	5.09	8.09	8.23	8.57	0	37.16	43.32	-6.16	8.15	6.26	-1.89	3	3
25	28	5.87	8.71	7.86	5.00	0	37.16	41.29	-4.13	8.65	6.89	-1.76	4	1
26	31	9.7	7.2	13.05	0	0	34.01	43.1	-9.09	7.1	5.68	-1.42	14	3
27	30	13.33	3.14	13.52	0	0	37.15	40.82	-3.67	7.01	5.06	-1.95	7	2
36	30	3.33	2.19	23.52	0.95	0	34.56	48.67	-14.11	7.76	4.48	-3.28	8	1
ACU/37	19	5.33	16.23	7	0.28	0	25.65	40.43	-14.78	6.69	4.68	-2.01	2	0
38	16	1.42	8.14	6.19	0	0	21.98	23.37	-1.39	6.93	6.16	-0.77	3	0
40	30	6.13	5.86	17.43	0	0	34.51	44.19	-9.68	7.11	5.63	-1.48	15	4
41	26	2.28	0.04	21.19	3	0	37.18	44.67	-7.49	9.27	6.32	-2.95	3	4
42	34	3.85	0.9	30.19	0	0	40.43	56.99	-16.56	7.66	5	-2.66	7	4
EAU	52	33.73	10.73	4.6	2.95	0	89.55	76.88	12.67	6.8	8.43	1.63	12	4

Responsive Care continue to have the highest number of vacancies with 39.63 (Dec 2021) with a forecast position of 39.12 (Jan 2022). A new cohort of newly registered nurses will take up positions in January 2022 but there has also been an increase in staff leaving the Care Group. The Care Group continues to strive for full recruitment of the nursing workforce; following some targeted work with performance and finance there is now pro-active measures to recruit to turnover rates in order to provide further resilience to safe staffing.

## Emergency Care

Significant changes to the Emergency Department (ED) nursing workforce model took place back in 2017 to reflect the challenges at that time in ensuring the workforce had the skills and capacity to deliver safe, efficient and innovative new models of patient care following the mobilisation of the Integrated Urgent Care service (IUCS). A further review of the workforce has been required in 2021 following the remodelling of the department and an increased capacity that included the expansion of the Resuscitation area. This workforce review reflected the challenges faced by the increased acuity of Type 1 attendances; recommendations from the Royal College of Nursing (RCN) and the Royal College of Emergency Medicine (RCEM) were included in that review. The proposals were presented to the Executive Team within a Business Case for further consideration, three cubicles within the department were closed until this review was completed. It was then agreed to recruit 10.8 WTE

registered nursing staff to increase allocation to the resuscitation bays to 3 registered nurses. We have now successfully recruited 9 wte registered nurses with further interviews planned to increase to the 10.8 wte planned. The Trust plans to utilise the appropriate national SNCT tool specifically for an ED to record the acuity and dependency levels of patients coming through the department, this will support future workforce planning. In the absence of this tool, colleagues at ECIST (Emergency Care Improvement Support Team) have supported with data analysis within the new workforce proposal.

### **Integrated Urgent Care Service**

The workforce model within the Integrated Urgent Care Service (IUCS) at North Tees and Hartlepool continues to meet the demands of the service. The level of administration support at the reception desk has been reviewed with 24 hour cover now in place at UHH. The IUCC manage recruitment separately to the other areas within the Care Group due to the requirement of an advanced skills set and the established collaborative working with the North East Ambulance Service (NEAS) as part of the alliance. The service has 0.3wte band 6 registered nursing vacancy and has recently fully recruited into band 7 practitioner posts. There are currently no unregistered nursing vacancy. Future opportunities lie in the introduction of the senior AHP role within the IUCC. Many senior physiotherapists have advanced skills in MSK and injuries that can be easily transferable to the service that makes alternative workforce modelling very appealing and there are currently 2 wte MSK practitioners supporting the service.

### **The Emergency Assessment Unit**

EAU is a 52-bedded level 1 admitting area including 10 beds to support a covid 19 admission pathway, and 2 assessment areas. The previous transport hub has now been integrated within a pilot of a discharge hub. Patient case mix includes those from paramedic, GP and ED acute medical admissions. EAU has seen significant changes throughout the Covid-19 pandemic, providing care for covid positive/negative patients. EAU currently has seen an increase in registered nursing vacancies and recruitment plans are in place, including offers for rotational posts within the Urgent and Emergency Care areas. EAU proves a popular place to work with newly registered nurses due to the fast pace and the wide range of speciality exposure. To support the registered nursing vacancies, over recruitment of 11.96 wte HCA posts was agreed with successful recruitment of 9.8 wte to date. With a workforce of 10.89 band 6 coordinator roles there are many opportunities for succession planning and staff progression into this role in addition to the advanced practitioner role within the unit. There are no current proposals to change the workforce model associated with EAU as the model meets the demands of the service following the workforce review in June 2020 where an uplift of RNs was agreed to support the area.

### **Ward 24 and Ward 25**

The Respiratory ward have seen changes in service provision over the last 18 months with an increasing demand for level 1.5 patients who have required non-invasive ventilation (NIV), tracheostomy care, chest drain insertion and management, high flow oxygen and more recently patients requiring continuous positive airway pressure (CPAP).

Significant estates work has recently been completed on both wards 24 and 25 to create a bespoke Respiratory Support Unit (RSU) following the demand and potential future demand from the Covid19 pandemic this work has allowed continuous patient monitoring, increased oxygen capacity, visibility and appropriate ventilation and air changes. The work was successfully completed by early December 2021. Both units have 28 beds each, of which 7 will accommodate level 1.5 patients in a bespoke monitored area. The ward has a nursing workforce model that will meet the demands of this service. In June 2020 the workforce model was reviewed to uplift both the registered and unregistered nursing workforce and to change the overall skill mix which ensured that the areas are both compliant with the national anaesthetic guidance for level 1.5 care which states that level 1 patients should be nurses with a ratio of 1:4 (registered nurse to patient). The Respiratory wards currently have 7.47 wte RN vacancies but with a forecast position of 5.47. Active recruitment continues with development opportunities to specialist Respiratory specialist nursing and planned rotation with Critical Care. There are currently no HCA or band 4 vacancies within Respiratory and we have planned over recruitment of 2.25 wte HCA to support registered nursing vacancies of which 0.6 wte has been successfully recruited. We are currently supporting 2 HCA s with the Trainee Nurse Associate programme. Work continues in relation to alternative workforce modelling and we have in place a band 6 senior therapist role within ward 24 RSU. There are no further proposals to change the workforce model at present as it meets the demands of the service. The 2 Respiratory wards allow appropriate isolation and segregation for our covid and non covid Respiratory patients.

**Ward 26** is a 31-bedded unit specialising in gastroenterology including pancreatic cancer, post endoscopy, palliative care and alcohol dependency. There is a band 5 RN vacancy of 6.5 wte with the concern that gastroenterology is not an attractive area to work. Further focus is required concerning advertising the speciality to new nurses, with successful social media postcard adverts promoting the development opportunities within the area.. There are a wide range of learning opportunities for staff including working alongside a vast MDT including various nurse practitioner and specialist nurse roles. During the Covid-19 pandemic, many of the staff from ward 26 have acquired additional respiratory skills to support the increasing demand for acute respiratory care. Plans are in place to maintain these skills to provide further support in this speciality if required in the future. There are no current proposals to change the workforce model associated with ward 26 as it meets the demands of the current service. We have had successful recruitment of a band 6 alcohol specialist nurse to support plans for alcohol detox facilitation. At present we have the additional support of a team support worker within ward 26.

**Ward 27** is a 30-bedded ward specialising in gastroenterology including liver disorders, alcohol dependency and eating disorders. Due to the complexity of nursing patients with eating disorders, there was an agreed uplift in the unregistered nurse workforce in June 2020. This uplift provides an additional unregistered nurse on a 24/7 basis to support the specialist 1:1 care that is required for these patients and by staff who have the right skills to provide this care. There is a long-standing service level agreement in place where a Nurse Practitioner is based on Birch Unit (West Park Hospital – TEWV) to provide registered nursing care. The Nurse Practitioner facilitates the safe transfer of care for patients between the mental health and the acute inpatient settings.

As part of the workforce review in June 2020, it was agreed to introduce an Occupational Therapist (OT) into ward 27 providing Monday to Friday cover. When recruited, the OT will be based on the ward and will become an essential member of the team by providing expert knowledge and skills to patients struggling with an eating disorder and alcohol and drug dependencies if appropriate. There is a current band 5 RN vacancy of 2

wte. There are currently 4 .0 wte team support workers providing support within ward 27. There are no further plans to change the workforce model as it meets the current demands of the service.

**Ward 36** is a 30-bedded ward specialising in acute medicine, diabetes, deliberate self-harm and care for some ITU step down patients. Due to the various specialities, there is a need to provide a highly skilled and resilient workforce to meet the demand of the patient need. The ward has a band 5 RN vacancy of 3.0 wte vacancy. There are 2.0wte band 4 AP/NAs within the area and 1.0wte unregistered nurse vacancy that will be. Due to the complexity and the high acuity of the patients on ward 36, the nursing workforce model currently does not meet the demands of the service. The use of the SNCT identifies a significant workforce review is required to uplift the nursing establishment to support the provision of safe, effective and efficient care to patients and to subsequently maintain the safety needs of all staff. There is significant opportunity to introduce an alternative workforce model into ward 36 given the diversity of the patient group including the nurse practitioner, AHP and mental health roles.

**Ward 38** specialises in haematology, oncology and acute general medicine and is a very popular speciality with no current vacancies. Staff work closely with both the Haematology and Chemotherapy Day Units and a number of the registered staff have completed chemotherapy training. The management of the Medical Day Unit (MDU) also falls under the same workforce model and is open Monday to Friday. Due to success of the MDU, the overall demand has increased with more patients being required to attend for support with a wide range of procedures. In June 2020, a second registered nurse was added into the MDU to provide a highly skilled and resilient workforce within this department, thus meeting the demand of the service. We have 1 wte team support worker within ward 38 There are no further plans to change the current workforce model.

**Ward 40** is a 30-bedded unit that provides all essential nursing care to the high number of frail and elderly patients. In 2019/20, a shift in the traditional 60/40 skill mix (registered nurse to unregistered nurse) to a 40/60 was deemed as more appropriate to support this patient mix. A skill mix shift allows an increase in unregistered nurses in the workforce model to support safe and efficient care to meet the needs of the patients. Enhanced care requirements remain significant on Ward 40 due to the patient type, which continues to create an increase in unregistered temporary staff usage. Ward 40 have a band 5 RN vacancy of 2.0 wte with a forecast position of 1 wte and no unregistered nurse vacancy. There is an appetite for an alternative workforce model with scope to skill mix some under-utilised band 4 monies. A recent trial in this area saw therapy assistants starting their working day at 7:30am in line with the nursing team and all staff have found this has greatly benefited the delivery of direct patient care and plans are in place to continue with an alternative workforce model. Ward 40 has 1 wte team support worker.

**Ward 41** is a 26 bedded admitting acute stroke unit, which incorporates the thrombolysis service and TIA assessment and supports the safe and efficient transfer of patients for thrombectomy service to the Royal Victoria Infirmary, Newcastle. The vision is that the unit has a workforce model that reflects a hyper-acute unit. In June 2020, there was an agreed uplift to the registered nurse workforce to reflect an acute level 1 admitting area to provide a safe and efficient workforce model to meet the demands of the service. There is a stroke coordinator available 24/7 in addition to the ward-based workforce model that is in line with national guidance. There is 3.0 wte band 5 RN vacancy and successful recruitment of a further 1.0wte for January 2022.. There are many opportunities in place for staff career progression and subsequent succession planning such as stroke simulation training, and the 'managing a patient with stroke' academic course which is accredited by Sunderland University and supports progression into the stroke coordinator role. To support with the current registered nursing vacancy we have plans to recruit an additional 5.62

wte Health Care Assistants of which 4.68 are successfully recruited. There are early discussions taking place to review the banding of the Stoke co-ordinator role.

**Ward 42** An alternative workforce model has been in place on **ward 42** since 2018. The model created a 40/60 registered/unregistered nurse skill mix. This provides a safe and efficient workforce model that meets the needs of the service. In June 2020 the care group increased the night shift provision to 3 x RNs to support a more suitable registered nurse to patient ratio. Enhanced care requirements remain significant on ward 42 due to the dependencies of the patients; this creates an increase in unregistered temporary staff usage. There is minimal band 5 RN vacancy of 1.0 wte with a forecast for January 2022 of no registered nurse vacancies. There are currently 3 team support workers in place on the ward. There is recognised potential to introduce bespoke roles such as AHP, Community and mental health nurses into the ward 42 model in the future to support patient pathways from hospital to home. There are no proposals to change the workforce model at present as it meets the demands of the service.

**Acute Cardiology Unit (ACU)** a 19 bedded unit that specialises in acute level 1 cardiology that requires a telemetry trained nurse each shift to manage the needs of the service and of the safe transfer of patient to James Cook University Hospital. The unit has 2.0 wte band 5 RN vacancy but remains a popular area for recruitment. There no unregistered nurse band 2 vacancy and 4 team support workers supporting the area. As part of this review, the unit would benefit from a slight uplift in the B2 unregistered nurse workforce to further support with the personal care needs of the more dependent patients. Due to the nature of the speciality, the unit benefits greatly from experienced cardiology nurses of whom 3wte are approaching the final years of their career. To support succession planning junior staff are provided exposure to specialist services and education. ACU has 10 beds that are utilised in times of increased acuity and activity, to support senior nurse visibility during times of surge we have successfully recruited an additional band 6 senior nurse over the winter period.

The **Endoscopy unit** is compliant with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation standards and will be due an on-site review in September 2022. The department is required to have adequately training and sufficient staff numbers to ensure that patients receive access to the best possible pathway from referral to diagnosis and or treatment by correctly trained, efficient, safe and caring staff. As such, staff are competency trained in line with national recommendations by the British Society of Gastroenterology (BSG) and British Thoracic Guidelines. Throughout the covid-19 pandemic, many of the elective endoscopy pathways were paused and staff were redeployed to other areas to work. Throughout 2021, the team are actively managing the recovery phase to allow services to continue. The unit does require a full workforce review to ensure that the workforce model meets the needs of the current service which, following the pandemic has seen a significant increase in activity particularly within the field of therapeutic intervention. A workforce review options paper is being drafted within the care group that will require significant consideration by the Trust.

**Haematology Day Unit** can deliver treatment to up to 24 patients at one time for haematological malignance, blood transfusions, venesection, various infusions, bone marrow biopsy and the administration of complex injection regimes. The nurses in the unit are highly skilled with on-going study requirements to remain up to date with the various speciality treatment. The unit has minimal vacancies and is a popular place to work given the professional development opportunities available to the team.

**Chemotherapy Day Unit** delivers treatment and supports patients with a variety of cancer diagnosis and can see up to 34 patients per day although face to face care has reduced over this past year due to the pandemic and the requirement to maintain social distancing within the unit. Similarly, to the Haematology unit it is a popular place to work and subsequently have zero vacancy. An element of skill mixing has already been completed which supports the demands of the service.

### Care Group Summary – Collaborative Care

Wards	funded beds	Level 0 average number of patients	Level 1a average number of patients	Level 1b average number of patients	Level 2 average number of patients	Level 3 average number of patients	Total budgeted wte	Recommended SNCT wte	Suggested over/under establishment wte	Average CHPPD required	Average CHPPD actual	CHPPD variance	Total number of falls	Total number of pressure ulcers
9	14	7.76	1.95	4.28	0	0	20.91	17.75	3.16	5.82	9.26	3.44	1	1
28	31	13.75	0	17.23	0	0	34.79	43.25	-8.46	6.96	5.36	-1.6	8	1
30/SDU	20	4.86	10.71	4.38	0.05	0	40.24	33.17	7.07	11.48	10.2	-1.28	0	0
31	20	3.52	3.85	7.19	6.04	0	35.4	33.1	2.3	8.03	6.72	-1.31	1	5
32	30	8.9	2.47	18.61	0	0	45.26	44.25	1.01	9.04	6.38	-2.66	0	4
33	22	10.09	4.8	10.03	0	0	25.48	33.91	-8.43	6.43	4.8	-1.63	1	0
ITU	16	1.8	0.52	0	3.8	9.85	83.45	68.7	14.75	24.35	18.56	-5.79	0	4

**Ward 32** is a 30 bedded in patient ward specialising in fragility fractures and emergency trauma. The patients within this area are very dependent due to their frailty and there is a continuing reliance on enhanced care and temporary staffing. Registered nurse recruitment to this area remains challenging and the current vacancy position is 4.18wte, but the area has been successful in terms over recruitment of Health care assistants in support of the current dependency, which is reflective of the current vacancy position of 0.8wte. A full refresh of the adverts associated with this specialty have been completed and shared across all social media platforms and the team now have a clear place at the recruitment centres in an attempt to successfully recruit. Ward 32 provides future opportunities in the introduction of an alternative workforce model. Many senior therapists have advanced skills in relation to fragility, fracture and rehabilitation, which makes alternative workforce modelling very appealing in this area.

**Ward 33** is a 22 bedded ward specialising in Orthopaedic trauma, diabetic foot post-surgery, and some complex elective revision surgery inclusive of spinal. This usually creates a mix of short and long stay patients depending on the complexity of their needs. There is a 1.6wte band 5 RN vacancy; recruitment plans are in place and an element of band 2 unregistered nurse over recruitment by 1.52wte to support long-term sickness.

There are approximately 4wte RN approaching the end of their career so succession planning is a priority. Various opportunities are available to the team to support career progression and the area has 1.0wte NA on the registered nurse training course at Teesside University. There are no proposals to change the workforce model at present as it meets the demands of the service, although this area is regularly flexed to 30 beds in times of surge within the organisation.

**Ward 31** is a 20-bedded area comprising of 15 level 1 beds and 5 level zero. Ward 31 cares for patients who have undergone major emergency and some elective surgery. The skill sets of nursing staff in this area are advanced to support the acuity needs of patients and there are plans to progress to a rotational model whereby staff will move through ward 31 and into Critical Care whilst completing the national level 1 competencies. There is currently a 0.4wte band 5 RN vacancy and 2.7wte HCA, which have recently been appointed to. There are no proposals to change the workforce model at present as it meets the demands of the service although there have been some significant demands in regards to the elective programme and this is being closely monitored.

**Ward 28** is a 31-bedded unit and cares for a combination of long and short stay patients following surgery (urology, gynecological and gastro intestinal), occasional orthopaedic surgery and some medical patients. The ward has 1.0 vacancy but by January, this will have increased to 3.0wte. In support of the wards flexibility and as part of surge over the next few months a further 2.0wte Band 6 posts have been appointed to this area with a combination of surgical and medical experience. This will support the leadership and clinical expertise over a 7-day period. The ward always embraces the development of newly registered nurses, supports career progression. By the end of this year, the ward will have 8wte RNs in the 55-70yr age range (approx. 40% of the RN workforce). To mitigate this, a robust succession-planning model is in place, which is managed via the annual appraisal process. There are no proposals to change the workforce model at present as it meets the demands of the service.

**Ward 9** is a 14 bedded nurse-led service, which manages the elective `green` pathway for lower limb, general and breast surgery and provides resilience for unplanned day case unit admissions. There is a current 0.2wte band 5 RN vacancy and an unregistered nurse vacancy of 1.6wte. Over the next 5 years, it is anticipated that 5wte RN will come towards the end of their careers; this is factored into the recruitment and alternative workforce model discussions within the care group. The current workforce model meets the service demand.

**Surgical Decisions Unit (SDU)** now comprises of 20 beds, 3 triage trolleys and 2 clinical trolleys with the ability for patients to return to the unit into either diary slots or hot clinics. This area also has a well-established Mid-line service, which is nurse-led and supports all specialties throughout the trust. The team care for patients on a short stay basis where their needs can range from all surgical specialties. SDU is usually a popular area to work given the wide range of experience that staff can gain in this area with little band 5 RN vacancy (1.96). This vacancy rate increases in January to 6.88wte due to staff gaining promotion or moving into the community setting. The unit embraces the development of newly registered nurses and supports career progression and this is evident as the area is now supporting 2 members of staff through Teesside university. Following the previous review the specialty now reflects that of the Medical Emergency Assessment unit model and there is 1 band 6 coordinator on duty per shift which was achieved through the ability to skill mix part of the existing band 5 establishment to support this. There



are no proposals to change the workforce model at present as it meets the demands of the service although there is a significant increase of ward attenders, which supports the reduction in length of stay across the ward areas but will need monitoring very closely.

**Day Case and Access Lounge** are based across both sites and staffing levels are planned around theatre list provision. There has been a recent external recruitment of a new band 7 with plans to review current workforce and potential skill mix changes for future provision. Due to the current Elective recovery programme there is continued demand in this area to support 7 days working to reduce the number of long waiters and achieve an improved position.

The **Pre-assessment** team also provide cross-site working and although the current workforce model meets the demand of the service it has been agreed that there is scope to carry out skills matrix work to ensure the right tasks are carried out by the right roles. This is similar to that of the day case and access lounge team and may result in an element of appropriate skill mixing. There are 7wte RN (68% of the total RN workforce) who are approaching the 55-70yr age range providing an added pressure. With a lack of final year student nurses placed in this area, there is a recognised risk that the area is not well promoted to those who are due to register.

### **Theatre Anaesthetics, Recovery and Scrub**

The anaesthetic and theatre services provide pre, intra and post-operative services. The services require a specialised, flexible, and highly skilled nursing workforce. Complex planning and continual monitoring of skills against lists and procedures is required within the care group and to ensure the workforce model meets the demands of the service. Theatres staffing workforce is complex and there is no nationally agreed workforce tool to determine how theatres should be staffed. This is a large workforce where the skill set required of theatre staff is significant due to the increasingly changing sub specialities. Further training, post registration, can take up to 18 months depending on the level of complexity to ensure full competence and to provide staff the opportunity to rotate across all aspects of the role. The most recent challenge has been the RN/ODP band 5 vacancy of 5.0wte across the three teams. In addition to this vacancy, there are 7.47wte band 5 RN on parental leave. The team have been advised to recruit into permanent position as minimal financial risk due to the overall size of the teams and the planned turnover. To mitigate the short-term risk, there are plans to utilise some agency workers to provide the required skills set across the teams. There is a positive succession planning process in place with consistent opportunities for band 5 staff to act up into team leader posts, development of band 7 posts have been introduced for 6-month periods and the Theatre Support Worker role is offered opportunities to complete Operating Department Practice (ODP) training. The team recognise the importance in maintaining the training and development of staff both to meet the demands of the service and to support retention of staff. Band 6 staff currently carry out theatre education and training for theatre staff when capacity to do so which is becoming more challenging so the care group have recently recruited a full time Clinical Educator for this area which is making a significant difference.

**Critical Care** is a 16-bedded unit with a high level of training and support needed to produce a skilled workforce that can safely manage the acuity and dependency needs of patients. Due to the dynamic nature of this specialty, the nursing establishment accommodates changes in the level of patient care and flexes the nurse to patient ratio in accordance with national standards. The establishment in Critical Care is based on 100% occupancy of the unit. The Critical Care unit has an effective workforce model that meets the demands of the service, which continued

during covid-19 pandemic with the redeployment of staff and investment in additional training for those staff new to the critical care environment. The unit has 1.0wte band 5 RN vacancy with an additional 5.44wte RN (8.3% of the B5 workforce) on parental leave. Unfilled shifts are covered within the team due to the advanced skill set required; recruitment into permanent and fixed term posts in critical care is usually very successful. Approximately 5wte RNs are approaching the end of their careers, the unit maintains a robust succession planning process creating opportunities for all staff to have exposure to higher band role and responsibilities including critical care outreach. National standards (GPICS) recommend that for every unit with 75 or more staff members should have a designated clinical educator. Following the workforce review in June 2020, to comply with this standard, the unit has recruited a 1.0wte clinical educator who will take forward the training and development needs of this large team. The Critical Care Unit is also embracing the introduction of new roles including the Advanced Critical Care Practitioner (ACCP), with 3wte who have now commenced training in September 2021. Due to the current increased occupancy, there are proposals to change the workforce model at present to meet the current demands of the service.

**Critical Care Outreach** (CCO) team is comprised of band 6 RNs and is led by a newly appointed band 7 RN who is refining the concept of CCO. The skills set required by the team is significant and over the past 12 months, they have supported many clinical areas at the height of the covid-19 pandemic. There are no vacancies within the team but it is noted that with a collective workforce of 5.62wte there is only ever one nurse on duty at any given time, which includes the band 7 lead, resulting in little capacity to carry out management duties. Although there are no immediate concerns over the need to succession plan, there is a clear succession-planning programme in place to provide band 5 staff with at least six shadow shifts to enable them to support the team if unfilled shifts occur and allows for a seamless transition into outreach recruitment when required. Future opportunities lie in the introduction of the senior AHP role within the outreach team which currently is 100% nursing. Many senior physiotherapists have advanced respiratory and Critical Care skills, which makes alternative workforce modelling very appealing.

**SNCT Clinical descriptors – a summary of criteria**

<b>Acuity Level</b>	
<b>Level 0</b>	<p>Patient requires hospitalization</p> <p>Patient needs are met by the provision of normal ward care</p>
<b>Level 1a</b>	<p>Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate</p>
<b>Level 1b</b>	<p>Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living</p>
<b>Level 2</b>	<p>May be managed within clearly identified/designated beds, requiring resources with the required expertise and staffing levels OR may require a transfer to a dedicated level 2 area</p>
<b>Level 3</b>	<p>Patients needing advanced respiratory support and/or therapeutic support of multiple organs</p>

# Appendix 4

Ward/Dept	Average total patients	Average total Level 0	Average total Level 1a	Average total Level 1b	Average total Level 2	Average total Level 3	Average of total WTE nurses recommended by multipliers	Budgeted total WTE nurse establishment	Variance total recommended v total budget
9	14	5.59	3.47	4.94	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		5.53	4.82	8.50	0.00	0.00	18.85	20.91	2.06
9	14	7.76	1.95	4.28	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		7.68	2.71	7.36	0.00	0.00	17.75	20.91	3.16
24	30	11	4.1	10.5	4.3	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		10.89	5.70	18.06	8.47	0.00	43.12	37.16	-5.96
24	30	5.09	8.09	8.23	8.57	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		5.04	11.25	14.16	16.88	0.00	47.32	37.16	-10.16
25	28	9.2	7.3	7.1	4.2	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		9.11	10.15	12.21	8.27	0.00	39.74	37.16	-2.58
25	28	5.87	8.71	7.86	5.00	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		5.81	12.11	13.52	9.85	0.00	41.29	37.16	-4.13

<b>26</b>	31	10.75	7.2	13.05	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		10.64	10.01	22.45	0.00	0.00	43.10	34.01	-9.09
<b>26</b>	31	10.75	7.2	13.05	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		10.64	10.01	22.45	0.00	0.00	43.10	34.01	-9.09
<b>27</b>	30	15.8	0.3	13.9	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		15.64	0.42	23.91	0.00	0.00	39.97	37.15	-2.82
<b>27</b>	30	13.33	3.14	13.52	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		13.20	4.36	23.25	0.00	0.00	40.82	37.15	-3.67
<b>28</b>	31	22.9	0.15	8.4	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		22.67	0.21	14.45	0.00	0.00	37.33	34.79	-2.54
<b>28</b>	31	13.75	0	17.23	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		13.61	0.00	29.64	0.00	0.00	43.25	34.79	-8.46
<b>30/SDU</b>	17.1	6.15	10.3	3.9	0	0			
<b>Multiplier - EAU</b>		1.27	1.66	2.08	2.26	5.96			
<b>Output - Mar21</b>		7.81	17.10	8.11	0.00	0.00	33.02	40.24	7.22

30/SDU	20	4.86	10.71	4.38	0.05	0			
Multiplier - EAU		1.27	1.66	2.08	2.26	5.96			
Output - Oct21		6.17	17.78	9.11	0.11	0.00	33.17	40.24	7.07
31	20	3.9	5.45	4.35	6.3	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		3.86	7.58	7.48	12.41	0.00	31.33	35.4	4.07
31	20	3.52	3.85	7.19	6.04	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		3.48	5.35	12.37	11.90	0.00	33.10	35.4	2.30
32	20	6.55	1.55	11.95	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		6.48	2.15	20.55	0.00	0.00	29.19	45.26	16.07
32	30	8.9	2.47	18.61	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		8.81	3.43	32.01	0.00	0.00	44.25	45.26	1.01
33	22.0	10	1.85	10.1	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		9.90	2.57	17.37	0.00	0.00	29.84	25.48	-4.36
33	22	10.09	4.8	10.03	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		9.99	6.67	17.25	0.00	0.00	33.91	25.48	-8.43
36	30	5.5	3.4	19.3	1.8	0			

<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		5.45	4.73	33.20	3.55	0.00	46.91	34.56	-12.35
<b>36</b>	30	3.33	2.19	23.52	0.95	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		3.30	3.04	40.45	1.87	0.00	48.67	34.56	-14.11
<b>ACU/37</b>	19.0	1	13.75	3.45	0.95	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		0.99	19.11	5.93	1.87	0.00	27.91	25.65	-2.26
<b>ACU/37</b>	29	5.33	16.23	7	0.28	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		5.28	22.56	12.04	0.55	0.00	40.43	25.65	-14.78
<b>38</b>	16	3.65	3.25	10.1	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		3.61	4.52	17.37	0.00	0.00	25.50	19.98	-5.52
<b>38</b>	16	1.42	8.14	6.19	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Oct21</b>		1.41	11.31	10.65	0.00	0.00	23.37	19.98	-3.39
<b>40</b>	20	6.6	1.55	11.87	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			
<b>Output - Mar21</b>		6.53	2.15	20.42	0.00	0.00	29.10	34.51	5.41
<b>40</b>	30	6.13	5.86	17.43	0	0			
<b>Multiplier</b>		0.99	1.39	1.72	1.97	5.96			

Output - Oct21		6.07	8.15	29.98	0.00	0.00	44.19	34.51	-9.68
41	26	2.35	4.6	18.7	0.3	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		2.33	6.39	32.16	0.59	0.00	41.48	37.18	-4.30
41	26	2.28	0.04	21.19	3	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		2.26	0.06	36.45	5.91	0.00	44.67	37.18	-7.49
42	34	4.7	0.2	29.15	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Mar21		4.65	0.28	50.14	0.00	0.00	55.07	40.43	-14.64
42	34	3.85	0.9	30.19	0	0			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output - Oct21		3.81	1.25	51.93	0.00	0.00	56.99	40.43	-16.56
EAU/Ambu	46.5	27.6	12.3	9.25	2.85	0			
Multiplier - EAU		1.27	1.66	2.08	2.26	5.96			
Output - Mar21		35.05	20.42	19.24	6.44	0.00	81.15	89.55	8.40
EAU/Ambu	52	33.73	10.73	4.6	2.95	0			
Multiplier - EAU		1.27	1.66	2.08	2.26	5.96			
Output - Oct21		42.84	17.81	9.57	6.67	0.00	76.88	89.55	12.67
Paediatrics	20	14.4	1.1	4.1	0.3	0			
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89			



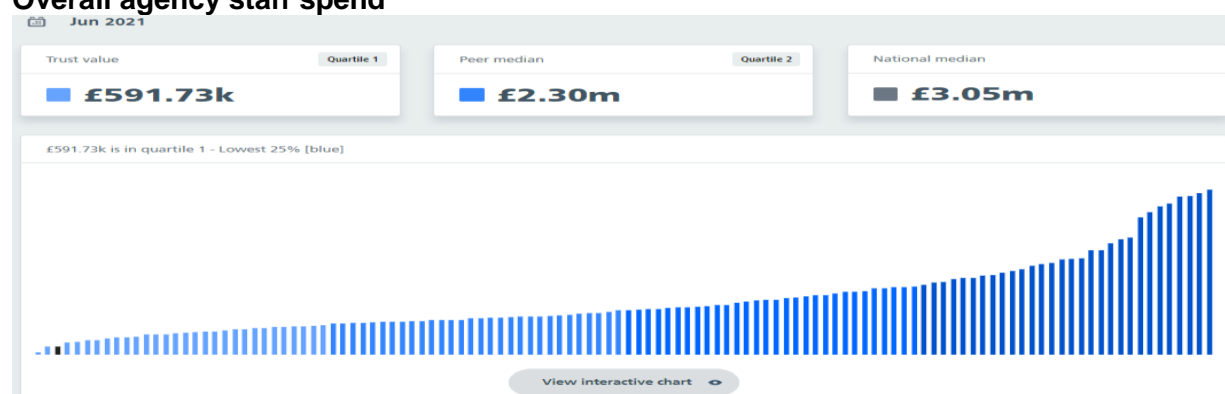
Output - Mar21		27.36	2.55	9.76	0.78	0.00	40.45	50.19	9.74
Paediatrics	24	14.52	1.81	7.04	1.52	0			
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89			
Output - Oct21		27.59	4.20	16.76	3.94	0.00	52.48	50.19	-2.29
SCBU	10	1.5	0	7.4	1.05	0.05			
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89			
Output - Mar21		2.85	0.00	17.61	2.72	0.29	23.48	20.17	-3.31
SCBU	10	3.9	0	5.76	0.33	0			
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89			
Output - Oct21		7.41	0.00	13.71	0.85	0.00	21.97	20.17	-1.80
ITU	16	3.5	0.15	0.5	3.85	8			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output		3.47	0.21	0.86	7.58	47.68	59.80	64.73	4.93
ITU	16	1.8	0.52	0	3.8	9.85			
Multiplier		0.99	1.39	1.72	1.97	5.96			
Output		1.78	0.72	0.00	7.49	58.71	68.70	64.73	-3.97

## Overall Bank Staff Spend



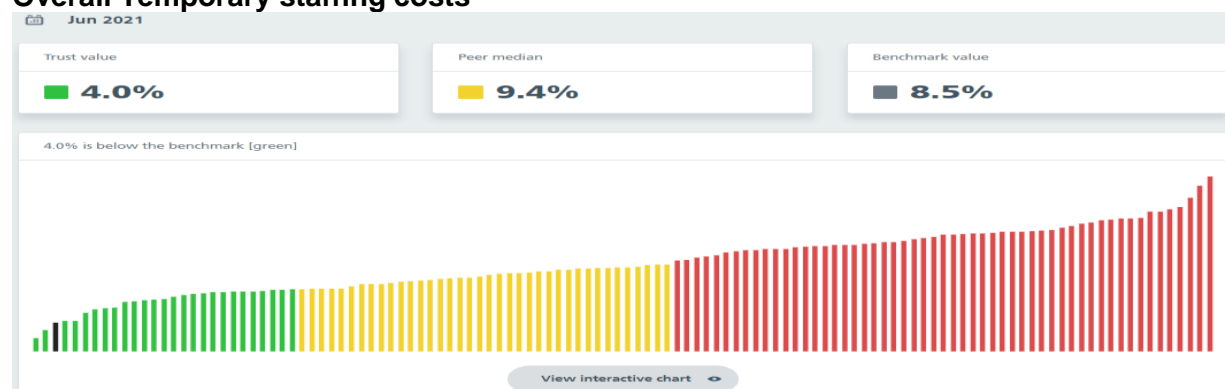
The Trust has the second lowest YTD spend on Bank Staff nationally. Each blue bar represents an NHS Trust, with the black bar representing North Tees and Hartlepool.

## Overall agency staff spend



This chart illustrates the Trust's excellent position nationally as third lowest provider Trust for Agency Staff spend YTD.

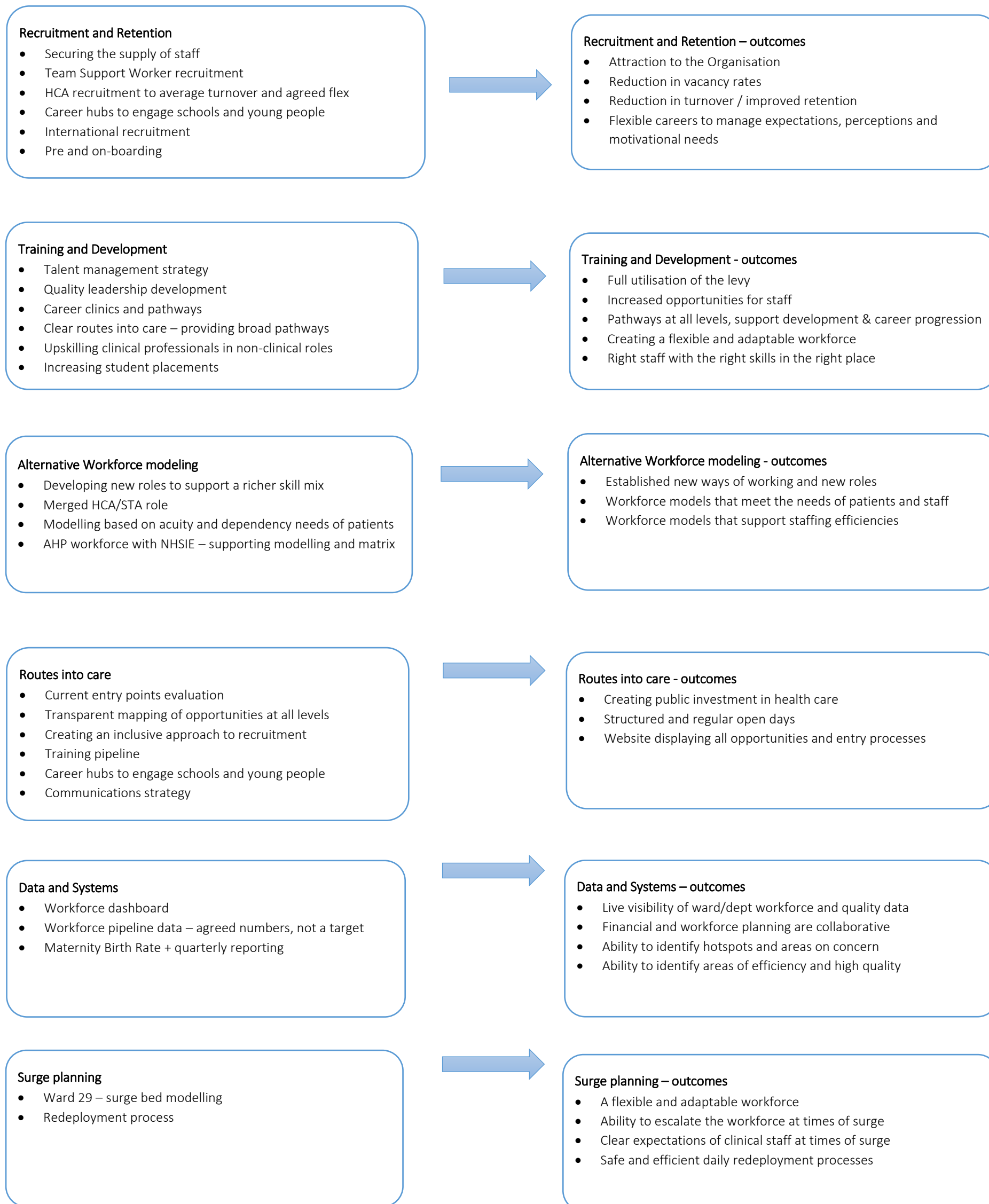
## Overall Temporary staffing costs



The Trust is positioned in the lowest quartile for overall temporary staffing spend as a percentage of total spend.

**Aim:**

**A collaborative approach to ensure that North Tees and Hartlepool Trust has the necessary supply of a highly skilled workforce that can work in a flexible way to deliver high quality, safe and efficient care with respect and compassion.**



## Board of Directors

Title of report:	Capital Programme Performance Q3 – 2021/22									
Date:	27 January 2022									
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 2021 (Quarter 3) on the progress of delivering the 2021/22 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			Valuing our People		Transforming our Services	X	Health and Wellbeing		
Which CQC Standards apply to this report	Safe	X	Caring		Effective	X	Responsive	X	Well Led	X

### Executive Summary and the key issues for consideration/ decision:

#### Capital Programme Delivery 2021/22

- The Trust has an overall capital programme of £30.010m for 2021/22. This plan has increased by £8.4m since the end of Q2 (South Tees Hospitals NHS Foundation Trust Community Diagnostic Hub £5.6m, Target Investment Fund £2.4m, Imaging & Endoscopy Academy Funding £0.2m and Cyber £0.2m).
- At the end of month 9, the Trust incurred capital spend of £9.1m, which is £0.8m behind the 21/22 plan.

#### **Estates Backlog Maintenance/Infrastructure**

- Lift Replacement at UHH:** this involves the replacement of the three ageing lifts in the acute block at UHH and due to be completed by the end of Q4.
- Theatre 1 Refurbishment and Future Proofing UHNT:** Theatre 1 refurbishment was planned with Care Group 3 in Q1 to minimise disruption to theatre services. Theatre 1 refurbishment is a high priority from a backlog maintenance point of view as the theatre plant is shared by theatre 1 2 & 3. Any faults or downtime on this end of life plant risks affecting 3 theatres. The scope of the refurbishment works includes a dedicated ventilation plant for theatre 1 (reducing the above risk), installation of IPS / UPS to improve patient safety and future proofing enabling works to facilitate the theatre becoming an integrated theatre in the future. The design and procurement of the plant has now been completed with work on site due to be completed in Q4.
- Roofing Repairs UHH:** A multi-year programme continues to progress, awarded to Group Tegula Ltd following a mini-competition in 2020/21. The contract value is capped at £2m and includes flexibility to address the high risks roofs and other roofs in dilapidated conditions with a number of urgent roofing repairs planned to be completed by 31<sup>st</sup> March 2022.

- **Intrusive Structural Surveys – North Wing / Tower block / South Wing UHNT:** In response to concerns raised by Faithful and Gould/WS Atkins in the 6 Facet Survey, further more detailed intrusive surveys are being carried out to assess the extent of any additional remedial works to ensure the building remains safe and operational for the remainder of its 10 year life. The survey report is expected to be completed by the end of Q4.
- **Replacement Flooring UHNT:** The works to replace the main entrance flooring have commenced. Breast Screening down to North Wing and the Dining Room to the Cashiers Office have been completed, with the lift lobby and Porters Lodge in Tower Block due to commence January 2022.

### Digital

- Significant work remains ongoing relating to digital, with an ongoing scheme to upgrade and replace end of life hardware; ongoing scheme to replace the remaining legacy fibre cabling for both (North Tees and Hartlepool) data networks; ongoing scheme to maintain and replace UPS devices throughout the Trust that are used to provide uninterruptable power for ICT services; ongoing scheme to replace end of life server hardware and add additional services.
- **CareScan+** - CareScan+ has now replaced TrakCare as the primary data capture source for surgical implants and instrument trays so staff no longer need to run a dual process. Development of the “Delta” release of software continues, with initial testing successfully complete. Subject to no unforeseen issues, the updated software is scheduled for Q4 21/22. The Time, Cost and Scope categories have slipped due to delays accessing NHSX funds to assist with piloting CareScan+ in other hospitals as this affects agreement of what deliverables are in the immediate plan and what potentially may need to be re-scoped.

### Medical Equipment Replacement (MER)

- Delivery against the MER continues to progress well, with capital equipment delivered in Q3 relating to patient monitors, examination lights, endoscopes, operating tables and theatre equipment.

### Forecast

A robust capital forecast has been completed in January 2022, relating to Q3 and the Trust is forecasting slightly ahead of the £30.010m plan.

### Other Bids

The following schemes are now approved and PDC will be received in 2021/22:

- Community Diagnostic Hub – North Tees £2.843m
- Community Diagnostic Hub - South Tees £5.565m
- Pathology LIMS £1.752m
- Target Investment Fund £2.363m
- Cyber £0.25m
- Imaging & Endoscopy Academy Funding £0.213m

The total PDC additional funding is £12.986m and is included within the annual plan and forecast.

**Full details of the capital programme progress to Q3 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, however, the significant challenge of the scale, complexity, time constraints and market conditions placed reliance upon sub-contractors and supply chain.

Committees/groups where this item has been discussed	Capital and Revenue Management Group
Recommendation	<p>The Board is asked to;</p> <ul style="list-style-type: none"> <li>• Note the contents of the report;</li> <li>• Note the increase in the capital programme to £30.010m at M9, which has increased by £8.4m since the end of Q2 (South Tees Hospitals NHS Foundation Trust Community Diagnostic Hub £5.6m, Target Investment Fund £2.4m, Imaging &amp; Endoscopy Academy Funding £0.2m and Cyber £0.2m);</li> <li>• At the end of month 9, the Trust incurred capital spend of £9.1m, which is £0.8m behind plan;</li> <li>• The capital plan is forecasting to overspend by £0.3m at year-end.</li> </ul>

# **North Tees and Hartlepool NHS Foundation Trust**

## **Meeting of the Board of Directors**

**27 January 2022**

### **Capital Programme Performance Q3 2021/22**

#### **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 2021 (Quarter 3) on the progress of delivering the 2021/22 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 has an overall capital programme of £30.010m for 2021/22. This plan has increased by £8.4m since the end of Q2 (South Tees Hospitals NHS Foundation Trust Community Diagnostic Hub £5.6m, Target Investment Fund £2.4m, Imaging & Endoscopy Academy Funding £0.2m and Cyber £0.2m).

At the end of month 9, the Trust incurred capital spend of £9.1m, which is £0.8m behind the 2021/22 plan.

#### **2.2 Estates**

Total expenditure on Estates schemes is £6.1m at the end of December 2021 (including Respiratory Support Unit development) against a year to date budget of £6.1m and is on plan.

#### **2.3 Medical Equipment**

Total expenditure on Medical Equipment schemes is £1.7m at the end of December 2021, against a year to date budget of £2.1m and is behind plan by £0.4m.

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

Total expenditure on IT&S schemes is £1.1m at the end of December 2021, against a year to date budget of £1.4m, so behind plan by £0.3m.

#### **2.5 Contingency**

There is a contingency of £0.2m and an actual VAT saving relating to previous years of £0.1m, resulting in an uncommitted contingency of £0.3m. The budget for this is phased to match the NHSE/I plan. Contingency at the end of December 2021 is behind plan by £0.1m.

## 2.6 Donated Assets

Total expenditure on donated/grant funded assets is £0.2m at the end of December 2021 against a year to date budget of £0.3m, so behind plan by £0.1m.

## 2.7 Forecast 2021/22

A robust capital forecast has been completed in January 2022 and the Trust is forecasting slightly ahead of plan for the year at December 2021.

It must also be noted that there is a risk to the delivery of the capital programme by year-end both internally to ensure all orders are raised on a timely basis and subsequently receipted, but also externally as the Trust is reliant upon the efficiency and effectiveness of supply chain and sub-contractors who will be under significant pressure.

## 2.8 Capital bids and PDC 2021/22

The following schemes are now approved and PDC will be received in 2021/22:

- Community Diagnostic Hub - North Tees £2.843m
- Community Diagnostic Hub - South Tees £5.565m
- Pathology - LIMS £1.752m
- Target Investment Fund - £2.363m
- Cyber - £0.25m
- Imaging & Endoscopy Academy Funding - £0.213m

The total PDC additional funding is £12.986m and is included within the annual plan and forecast.

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

2.10 The overall financial summary for the period to 31 December 2021 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 2021.

**Neil Atkinson**  
**Director of Finance**

**Prof. Graham Evans**  
**Chief Information and Technology Officer/SIRO**



## Appendix 1 - Work Stream Reports

### 1. Estates Backlog Maintenance Programme

The 21/22 backlog maintenance capital allocation was broken down into categories and specific projects to target high and significant risk backlog issues. 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 allowed for monthly reporting against time and cost for the overall programme (as required by NHSI). £5.3m has been allocated to Backlog Maintenance and £2.5m has been allocated to the development of the Ward 24 Respiratory Support Unit (RSU).

**Theatre 1 Refurbishment and Future Proofing UHNT:** Theatre 1 refurbishment was planned with Care Group 3 in Q1 to minimise disruption to theatre services. Theatre 1 refurbishment is a high priority from a backlog maintenance point of view as the theatre plant is shared by theatre 1 2 & 3. Any faults or downtime on this end of life plant risks affecting 3 theatres. The scope of the refurbishment works includes a dedicated ventilation plant for theatre 1 (reducing the above risk), installation of IPS / UPS to improve patient safety and future proofing enabling works to facilitate the theatre becoming an integrated theatre in the future. The design and procurement of the plant has now been completed with work on site due to be completed in Q4.

The 5-year backlog plan includes the refurbish of two theatres per year for the remaining years of the 5-year programme. Discussions are ongoing to agree the programme with the elective care group to minimise disruption to catch up services.

**Lift Replacement UHH:** Replacement of the 3 ageing lifts in the acute block at UHH is due to be completed by the end of Q4.

**Roofing Repairs UHH:** A multi-year programme continues to progress, awarded to Group Tegula Ltd following a mini-competition in FY20/21. The contract value is capped at £2m and includes flexibility to address the high risks roofs and other roofs in dilapidated conditions. The project is anticipated to deliver further urgent roofing repairs within FY 2021/22. During Q4 work is planned for OPD department roof and the acute block on the UHH site to maintain buildings in a safe and operational manner.

The project relates to the roof replacement of Hartlepool Main Ward Block. The project is proposed to be split into two phases to ensure continuity of resources and prevent costly demobilising at the end of March and remobilisation in FY22/23;

Phase 1 - £170k - This will commence in February and be complete prior to March 31st 2022

Phase 2 - £498k and extra £10k contingency for market fluctuations. Overall cost £508k and this will start 1st April 2022 and be complete in a couple of months.

A £30k contingency is also proposed to cover any unknowns. There will also be the removal and refitting of roof antennas to factor in which will be around £10k

Therefore Total proposed spend is £548k spread over FY21/22 and FY22/23.

Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

**Concrete Repair Works - Tower Block UHNT:** The scope of works will repair the damaged concrete, preventing further structural damage to the building and apply a coloured protective coating guaranteed for 10 years. The total cost of the works is £455k, split over 2 years (£195k in year 1 and £260k in year 2). Overall, the project is now complete, with the North, East and South elevations now finished. The year 2 works to the West elevation and roof top plantrooms were completed in Q2.

**Intrusive Structural Surveys – North Wing / Tower block / South Wing UHNT:** In response to concerns raised by Faithful and Gould/WS Atkins in the 6 Facet Survey, further more detailed intrusive surveys are being carried out to assess the extent of any additional remedial works to ensure the building remains safe and operational for the remainder of its 10 year life. The survey report is expected to be completed by the end of Q4.

**Fire door replacement UHNT / UHH:** The fire door replacement programme has begun 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 in Q2 including Central stores, Medical Records, Lung Health and the main circulation corridors around the lower ground floor and ground floor. Replacement fire doors for the UHH site were planned in Q2. The replacement works will continue on both sites throughout FY21/22.

**Fire Alarm Replacement UHNT:** Installation was completed in December 2020. The testing /commissioning of the system was completed in Q4 with the changeover at the end of July, once training was completed for fire response team members. Extensive briefing and communications were undertaken within Care Groups, Trust Resilience Forum and Executive team to ensure the changeover was successfully managed.

The old system will be decommissioned and removed during Q4.

**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 FY20/21 and the remaining spend in FY21/22. The installation is now 50% complete, with the majority of plantrooms and estates areas complete. The works has now extended into operational areas. The project team is working closely with the clinical teams to arrange access to clinical areas and using installation methods agreed with Infection Prevention and Control. The installation is planned to be completed by the end of Q4 FY21/22 / Q1 FY22/23 with staff training and change over to follow shortly thereafter.

**Endoscopy Scope Washer Replacement UHH:** The business case was approved in June 2021 to replace the ageing end of life endoscopy washers within the Rutherford Morrison Unit (UHH). The existing washers are 13 years old and were planned to be replaced as part of the Backlog Maintenance capital programme in the FY2021/22. However, the equipment was becoming unreliable and to prevent disruption to clinical services. The case was approved at Capital Revenue Management Group (CRMG) to replace the equipment in FY 2021/22 and fund the required £215k from the existing capital Backlog Maintenance allocation. The work was completed in November 2021.

**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 and waiting for completion of contract and PO.

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 the work will be completed by Q2 of FY22/23.

**Plate Heat Exchangers UHH:** The ageing heating and hot water calorifiers will be replaced with modern energy efficient plate heat exchangers providing improved resilience and progress our path towards net zero carbon. Anticipated completion date for this work is by end of FY21/22.

**Replacement Flooring UHNT:** The works to replace the main entrance flooring have commenced. Breast Screening down to North Wing and the Dining Room to the Cashiers Office have been completed, with the lift lobby and Porters Lodge in Tower Block due to commence January 2022.

**Patient Environment, Furniture and Equipment (PLACE):** 10 Redi Rooms have been ordered and delivered to assist with Covid pressures.

**X-Ray Replacements:** The 4 replacement x-rays for UHNT (x 2), Peterlee and UHH have been ordered with building enabling works due to commence in Q4.

**AHU Replacement:** Orders for the air handling units for Tower Block have been raised. Work is due to commence within Q4.

## 2. Other Estates Capital Developments

Ward 24 Respiratory Support Unit (RSU): The business case was approved in May to upgrade the existing ward 24 respiratory ward into an RSU unit with specific enhancements to support the care of patients with major respiratory illnesses such as COVID 19 or Influenza. The unit has been designed with three flexible areas within the ward with the ability to escalate care and dedicate further sections as the clinical need requires.

The ward includes:

- A 7 single bedroom specialist RSU area with 3 specific gowning lobbies for infectious patients, dedicated staff base, dedicated dirty utility and WC facilities for patients.
- The unit will have two dedicated ventilation plants providing 10 air changes / hour in line with the latest COVID 19 guidance and improving infection control standards.
- A significant increase in oxygen capability, increasing the existing 700l/m for the floor to 2000l/m for the floor.
- The design will significantly improve patient observation with the use of smart glass to all patient rooms.
- The design also includes the installation of specialist patient monitoring equipment in the RSU areas to allow staff to be provided with key information on the patients condition in real time.

The same design team and contractor were appointed, who successfully completed the recent A&E project on budget and under significant time pressures. This project came with significant time pressures, the work commenced on site on 12th July 2021 and Ward 24 was handed over on 17th November 2021.

This was followed by a short ward decant to prepare ward 25 for winter Covid pressures. This work included installing Mindray (patient monitoring equipment), redecoration, general maintenance and repair of medical gasses oxygen outlets. This work was completed and ward 25 was operational by 30th November 2021.

**3rd CT scanner (UHNT):** Provision of a new CT scanning area within the old Wheelchair Services department. The works were completed in Q3. The area is adjacent to radiology and main Outpatients and will be utilised mainly for outpatient clinics but will also provide important resilience for inpatient scanning.

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 are developing for spokes at UHH, Stockton (Lawson Street) and Redcar. The location of the main hub (Stockton or Middlesbrough) to be determined as part of an option appraisal being carried out by P+HS Architects. This will feed into the business case in February 2022, which is seeking further capital funding approval. The spoke delivering additional MRI scanning capability became operational on the UHH site at the end of September 2021.

Staff Recharge Hub Link Staircase From The Tees Dining Room (UHNT): As part of the 100 Leaders Challenge within the Trust and NTH Solutions, nominated candidates were asked to bring forward ideas to improve the estate for patients, visitors and staff. One of the early ideas that received significant support was to create a link from the Tees Dining room down to the staff recharge hub located on the floor below. This link would significantly improve access to the indoor and outdoor staff facilities within the recharge hub. The design team has been appointed (funded by LLP) to develop the design. The design is complete and work is due to commence in Q1 of FY22/23.

Endoscopy Academy: This project is funded from a successful TIF bid that applied for external funding in October 2021. The bid was approved by DH in December 2021 with the requirement to spend the money within the FY21/22. The money will fund a training endoscopy facility within the Endoscopy Department UHH used to train endoscopy staff from our Trust and potentially other Trust's in the Northern ICS.

The scope of works is to carry out internal alterations within the Rutherford Morrison Endoscopy Unit, which will create an endoscopy room and training room with appropriate audio visual equipment to allow observation of operations for training purposes. Work will commence in Q4.

### 3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against an initial allocation of £3m and an additional allocation of £0.4m, a total of £3.4m. Of this, £1.9m has been ordered and received to date. A further £1.3m is ordered but not yet received and £0.2m still to order, but is progressing. At this time we are still on track to receive before the end of March 2022

Since the last report we have taken delivery of:

- **Patient monitors** for Ward 23 Neonatal vital signs monitoring.
- **Patient monitors** for Rutherford Morrison UHH & Endoscopy UHNT vital signs monitoring.
- **Upper limb stack** for surgical procedures on upper limbs.
- **Zimmer tourniquet system** for surgery One Life Hartlepool Theatre.
- **Luxmed examination light** for Birthing centre UHH.
- **Resuscitaires** for Maternity for the care of new babies. They combine an effective warming therapy platform along with the components you need for clinical emergency and resuscitation.
- **Endoscopes** for Endoscopic surgery Surgery.
- **Treadmill** for heart function testing Cardiology.
- **Operating tables** for UHH General surgery.
- **Stryker video stack upgrade** to enable the system to be used for general surgery as well as breast surgery.
- **Pencil saw** Surgical power tool system.

Items currently in progress are:

- **TCI Infusion pumps** for Pain management.
- **Hoists** for assisting with patient manual handling.
- **Draeger Baby Incubators** to closely control the environment of babies monitoring temperature Oxygen and humidity.
- **Anaesthetic machines** to complete the upgrade of anaesthetic workstations on both sites.
- **Nerve Simulators** for use with anaesthetic monitors during surgery.
- **Trauma Chair** suitable for bariatric patient handling for ITU.
- **MRI Monitor** essential for use in MRI environment. Will replace existing obsolete equipment.
- **Sonosite Ultrasound scanner** for use in ITU to replace older machine that now falls short of the required image quality.

In addition, a trial of a transport baby incubator is due to be carried out week commencing 17<sup>th</sup> January 2022 for ward 23.

#### 4. Information and Technology Services (I&TS)

The current I&TS capital plan incorporates elements of the Trusts Information and Communications Technology (ICT) and broader Digital Programme capital projects.

**Desktop PC replacements:** Now complete this is a three-year contractual payment plan to replace ageing desktop computers to allow migration to Windows 10.

**Out of Hospital Services tablet replacement:** To replace Out of Hospital services equipment which is an ongoing project but has encountered some delivery delays due to the COVID pandemic.

**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.
- **Fibre Cable replacement** – Ongoing scheme 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).
- **UPS replacement** – Ongoing scheme to maintain and replace UPS devices throughout the Trust that are used to provide uninterruptable power for ICT services.
- **Firewall Switch replacement** – Ongoing scheme to upgrade and replace end of life firewall hardware.
- **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.

##### Servers & Storage

- **Server replacement** – Ongoing scheme to replace end of life server hardware and add additional 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.
  - **OPSWat –NAC** (Network Access Control) for Internet access to Horizon. Cloud based posture assessment that evaluates the security states of the connecting system.
  - **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.

## Telecomms

- VC expansion – Additional video conference facilities to support both Microsoft Teams and CMS (Cisco Meeting Service) collaboration.
- Switchboard Infrastructure – Revamp of switchboard facilities.

## 5. Digital Strategy – Electronic Patient Record

The 'Digital Hospital of Things' programme, was initiated following success of the Trust being announced within the second wave of NHS Digital pioneers or 'fast followers' to the first wave of Global Digital Exemplars (GDE) Trusts. The aim of the national fast follower programme is to support Trusts who have the potential to reach a higher level of digital maturity within an enhanced timescale, allowing them to benefit from work already undertaken by the Global Digital Exemplar (GDE) Trusts.

The GDE Fast Follower (FF) programme enabled NTHFT to receive £5m of Public Dividend Capital (PDC) funding on a matched funding basis over a three-year programme, the associated funding payments being split into multiple milestones, payable on delivery (and in arrears) of a specific set of outputs and outcomes being successfully delivered.

The Trust successfully completed the fifth and final milestone within the GDE programme in Q4 FY19/20. In delivering our planned digital ambitions outlined in our "Digital Hospital of Things" programme, the Trust achieved level 5-maturity status within the Healthcare Information and Management System Society (HIMSS) and Electronic Medical Record Adoption Model (EMRAM). It is our intention to move quickly toward an independently accredited HIMSS level 6/7 status. In August 2021, the Trust received formal recognition and was awarded as a 'National Digital Leader' by NHSX, for contributions and progress made within the GDE Programme.

FY21/22 allocation is £2.03m and this includes approved underspend from 20/21 carry forward. Acknowledgement that the majority of spend being outside of the Digital Programme team control.

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

**Maintenance Upgrade** – The upgrade of TrakCare vT2017 to T2020 on 8th September 2021 went in as planned and with minimum disruption to service. Post go live, following a number weeks of being live, there were some significant issues identified, no harm was found as a result of these issues but the fixing and data cleansing activities that was required was excessive and time consuming for all involved. Once issues were identified and replicated, fixes were provided swiftly by the supplier and applied with support from the Trust teams. A full lessons learned is to take place as part of the project closure phase.

**The Great North Care Record (GNCR) HIE** - The regional Health Information Exchange (HIE), a core module of the GNCR continues to expand wider. The HIE was made live on 9th March 2020 with data being shared from GPs and Community units in the North East and North Cumbria. A number of Trusts (North Tees included) are now contributing data to the HIE for sharing purposes. The remaining Trusts to share data include South Tees, Northumbria, North Cumbria Integrated Care and TEWV. The GNCR team are working with the local authorities to agree a deployment schedule of a standalone 'Viewer' or an in-context Viewer.

**My 'GNCR' aka PEP – (Patient Engagement Platform)** - delays encountered around the development of the PEP, the revised go live date for the host organisation (Newcastle) is Q4 21/22. Build of Sandbox, AOS and Production environments in Azure hosting is complete. Deployment of code from Enigma into Azure is underway and scheduled to complete on 8th November 2021. Four Trusts (CNTW, NCIC, Gateshead and NuTH) continue to progress with interface development and testing of their connection to PEP. Work within the NHS App development team has commenced to move PEP into their sprint cycle to allow jump off points to be enabled within NHS App. Registration to NHS app continues to increase across the region.

**Nursing Handover/Doctors Weekend Handover** – due to additional functional requirements being highlighted in design/development, design has now commenced on integration with core EPR rather than a questionnaire.

**Closed Loop Medicines Administration (CLMA)** – Draft Business Case awaiting approval before any further progress can be made.

**Closed Loop Blood** - An end-to-end demo will be arranged for all key Trust stakeholders in February 2022 when clinical pressures will hopefully have decreased a little. The Business Case is being finalised by Pathology and will be submitted and considered as part of the key strategic digital business cases for FY21/22.

**Clinical Communication system** – The Business Case providing options for Vocera (and another) is complete and is waiting for approval before any further progress can be made.

**HealthCall** – North Tees and Hartlepool NHS Foundation Trust are delighted to have received full shareholdings in HealthCall along with four other Trusts in the region. **Prostate Cancer Stratified Follow Up** - With the upgrade to T2020 now in place, the team have been able to complete the build of the required configuration for the PSAFU pathway into BASE and this has now successfully passed regression testing. The configuration has been pushed through to TEST2020 ready for UAT which is scheduled for 16th December 2021 with the Prostate Nurses and Cancer Coordinator. Next steps are to develop the interfaces between TrakCare, HealthCall and ICE. System Admin are currently building an extract to pull the PSA recall date through to the TIE for HealthCall to intercept and pull through to the patients app, the same report once built will be able to feed into yellow fin so we have a dashboard to view the patients on the stratified list. **Digital Outpatients** – request made to move this into the Trust's SANDPIT environment to start reviewing. **Long COVID** - DPIA approved and user acceptance testing commenced.

**A&E Observation machines** – this is a two phased approach, (a) central monitoring system to be installed and linked to the Mindray observation devices, (b) to provide an Interface between Mindray and TrakCare. First phase is now complete with the service being able to monitor observations centrally. Options are being explored with suppliers and clinical staff for how best to develop the functionality required for storing the data gained from the machines and viewing that data for assessment.

**ITU TrakCare + Hardware** – Business Case still under construction in readiness for approval.

**Imprivata phase 2** – Difficulties in recruitment has led to significant delays in rolling out.

**Ascribe/TrakCare Interface** –Ward 24,25,26,27,32 & 33 all up and running however further roll out paused until the Drug Database (FDB) is upgraded, initially due in December 2021 but now scheduled 10 January 2022.

**EPMA Phase 2** (includes Infusions and will remove all remaining cardex) Build group 1: remaining items are in TEST ready to be progressed into LIVE. Full re-planning session held.

#### **Active Clinical Notes (ACN)**

**Nursing Admission Documentation** - Design is ongoing with relevant service areas and time in motion studies complete to support the hardware request, a Business Case is being finalised and will require approval before any roll out can take place.

**Clinical Pathways** – design of PE / DVT pathway ongoing. All other work streams are progressing to plan. A&E - Hip Injury Assessment Pathway went live successfully on 7 December 2021, ED Paeds, CYPED (Paeds Assessment Unit) and Children's Ward ACN redesign is now complete in BASE. Service testing is underway and a go-live date to be led by service due to current pressures. Adult Asthma Immediate Assessment has been amended by the service with further improvements. Go-live date to be led by service due to current pressures.

**Critical Care Admission** - Draft designs of both Admission and Daily Assessment are now ready to be shared with relevant services.

**EDM2** – The project is back on track, recovery plan signed off at Project Board on 8 December. A compensation package for the delay has been shared and this will be reviewed and signed off at January Project Board. Technical go live will take place March 2022, MediViewer will be rolled out speciality by specialty from May 2022, piloting in Obs & Gynae. The bespoke QA module development has commenced and on track to deliver to the Trusts requirements, three additional scanners delivered so scanning capability no longer at risk.

**CareScan+** - CareScan+ has now replaced TrakCare as the primary data capture source for surgical implants and instrument trays so staff no longer need to run a dual process. Development of the “Delta” release of software continues, with initial testing successfully complete. Subject to no unforeseen issues, the updated software is scheduled for Q4 21/22. The Time, Cost and Scope categories have slipped due to delays accessing NHSX funds to assist with piloting CareScan+ in other hospitals as this affects agreement of what deliverables are in the immediate plan and what potentially may need to be re-scoped.



## Appendix 2 – Capital Programme Financial Position as at 31<sup>st</sup> December 2021

### Capital Plan, Actual and Commitments

Reporting period: 1st April 2021 to 31st December 2021

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Total actual and forecast 2021/22 £'000's	Commitments 2021/22 £'000
<b>INTERNALLY AND EXTERNALLY FUNDED CAPITAL SCHEMES AGREED BY ICS</b>						
<b>Estates Backlog</b>						
Building Sub Structure	678	483	451	32	1,138	949
Compliance	1,685	1,200	1,098	102	3,381	2,058
Energy Conservation	580	413	76	338	340	18
Patient Environment	1,497	1,066	1,645	(578)	2,970	478
Service Developments	872	393	724	(331)	1,305	0
<b>Estates Backlog Total</b>	<b>5,311</b>	<b>3,555</b>	<b>3,994</b>	<b>(439)</b>	<b>9,134</b>	<b>3,503</b>
<b>Medical Equipment</b>						
Medical Equipment	3,000	2,068	1,762	306	3,400	1,372
<b>Medical Equipment Total</b>	<b>3,000</b>	<b>2,068</b>	<b>1,762</b>	<b>306</b>	<b>3,400</b>	<b>1,372</b>
<b>IT</b>						
ICT	1,155	911	840	71	1,155	209
<b>IT Total</b>	<b>1,155</b>	<b>911</b>	<b>840</b>	<b>71</b>	<b>1,155</b>	<b>209</b>
<b>Respiratory Ward Configuration</b>						
Respiratory Ward Configuration	2,500	2,500	2,103	397	2,500	167
<b>Respiratory Ward Configuration Total</b>	<b>2,500</b>	<b>2,500</b>	<b>2,103</b>	<b>397</b>	<b>2,500</b>	<b>167</b>
<b>Service Developments</b>						
Theatres Robot	0		0	0	1,700	0
Contingency	202	53	(91)	144	2	0
<b>Service Developments Total</b>	<b>202</b>	<b>53</b>	<b>(91)</b>	<b>144</b>	<b>1,702</b>	<b>0</b>
<b>GDEFF</b>						
GDEFF	2,013	468	182	285	484	47
<b>GDEFF Total</b>	<b>2,013</b>	<b>468</b>	<b>182</b>	<b>285</b>	<b>484</b>	<b>47</b>
<b>Carescan</b>						
Carescan	74	31	61	(30)	74	17
<b>Carescan Total</b>	<b>74</b>	<b>31</b>	<b>61</b>	<b>(30)</b>	<b>74</b>	<b>17</b>
<b>Cyber</b>						
Cyber	250	0	0	0	250	0
<b>Cyber Total</b>	<b>250</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>250</b>	<b>0</b>
<b>Regional Digital Radiology</b>						
Regional Digital Radiology	768	10	(9)	20	768	617
<b>Regional Digital Radiology Total</b>	<b>768</b>	<b>10</b>	<b>(9)</b>	<b>20</b>	<b>768</b>	<b>617</b>
<b>Community Diagnostic Hub</b>						
Community Diagnostic Hub - North Tees	2,843	0	33	(33)	1,600	1,133
Community Diagnostic Hub - South Tees	5,565	0	0	0	5,565	2,508
<b>Community Diagnostic Hub Total</b>	<b>8,408</b>	<b>0</b>	<b>33</b>	<b>(33)</b>	<b>7,165</b>	<b>3,642</b>
<b>Targeted Investment Fund</b>						
TIF	2,363	0	21	(21)	1,493	402
<b>Targeted Investment Fund Total</b>	<b>2,363</b>	<b>0</b>	<b>21</b>	<b>(21)</b>	<b>1,493</b>	<b>402</b>
<b>Service Developments</b>						
Imaging & Endoscopy Academy Funding	213	0	0	0	213	0
<b>Imaging &amp; Endoscopy Academy Funding Total</b>	<b>213</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>213</b>	<b>0</b>
<b>Pathology LIMS</b>						
Pathology LIMS	1,752	0	0	0	0	0
<b>Pathology LIMS Total</b>	<b>1,752</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>ICS AGREED CONTROL TOTAL (£28.009m)</b>	<b>28,009</b>	<b>9,597</b>	<b>8,895</b>	<b>701</b>	<b>28,338</b>	<b>9,976</b>
<b>SCHEMES OUTWITH ICS AGREED CONTROL TOTAL</b>						
<b>Donated</b>						
Donated	399	289	244	45	399	23
<b>Donated Total</b>	<b>399</b>	<b>289</b>	<b>244</b>	<b>45</b>	<b>399</b>	<b>23</b>
<b>Digital Pathology</b>						
Digital Pathology	1,602	0	0	0	1,602	1,424
<b>Digital Pathology Total</b>	<b>1,602</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,602</b>	<b>1,424</b>
<b>EXTERNALLY FUNDED SCHEMES TOTAL</b>	<b>2,001</b>	<b>289</b>	<b>244</b>	<b>45</b>	<b>2,001</b>	<b>1,447</b>
<b>GRAND TOTAL</b>	<b>30,010</b>	<b>9,886</b>	<b>9,139</b>	<b>747</b>	<b>30,339</b>	<b>11,423</b>

# North Tees and Hartlepool NHS Foundation Trust

## Board of Directors

Title:	Integrated Compliance and Performance Report									
Date:	27 January 2022									
Prepared by:	Lindsey Wallace, Deputy Director of Planning and Performance									
Executive Sponsor:	Linda Hunter, Interim Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Alan Sheppard, 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:										
<p>The report outlines the Trust's compliance against key access standards in December 2021 including quality, workforce and finance.</p> <p><b>Summary</b></p> <ul style="list-style-type: none"> <li>December saw continued pressures that affected patient flow with the impact of the omicron variant evident with a surge in admissions. The Trust continues to manage Covid admissions, pre Covid levels of emergency care activity, alongside the elective recovery programme. Insourcing continues to support both in week and weekend lists.</li> <li>Performance and Quality 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.</li> <li>DNA rates are seeing an increase trend which is to be reviewed within the re-established Outpatient Transformation Group.</li> <li>Ambulance handover delays are evident, linked to the sustained pressure on beds affecting flow.</li> <li>A flexible bed base continues to be adapted accordingly as staffing resource allows.</li> <li>Staff sickness continues to remain a key challenge.</li> <li>Work continues to review recruitment and retention rates, including alternative workforce models to meet current organisational pressures.</li> <li>The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI and infection control measures.</li> <li>At Month 9, the Trust is reporting an in-month surplus of £0.316m against a planned deficit of £0.961m, which is £1.27m ahead of plan. The Trust is reporting a year to date surplus of £4.812m against a plan of £2.399 based on the plan of a breakeven position at year-end).</li> </ul>										

How this report impacts on current risks or highlights new risks:	
<p>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 pressures, recovery, winter and staffing resource.</p> <p>Associated risks are outlined within the Board Assurance Framework</p>	
Committees/groups where this item has been discussed	<p>Executive Team Meeting</p> <p>Audit Committee</p> <p>Planning, Performance and Compliance Committee</p>
Recommendation	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> <li>• note the performance against the key operational, quality and workforce standards; and</li> <li>• acknowledge the significant on-going operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that is being undertaken to address these going forward.</li> </ul>





# Integrated Corporate Report



*January 2022*

# Responsible Directors

**Linda Hunter**

Interim Director of Planning & Performance

Single Oversight Framework

Efficiency & Productivity

**Lindsey Robertson**

Chief Nurse and Director of Patient Safety & Quality

Safety & Quality

**Alan Sheppard**

Chief People Officer

Workforce

**Neil Atkinson**

Director of Finance

Finance

# Introduction



Performance highlights against a range of indicators including the Single Oversight Framework (SOF) and the Foundation Trust terms of licence remains. The report is for the month of December 2021 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

## Statistical Process Control (SPC) Charts

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

A **Step Change** occurs when there are 4 or more consecutive points above or below the *mean*. The Trust chose 4 data points as opposed to the general rule of 7 points to enable a more timely response to variance in performance.

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





# Contextual Information



North Tees and Hartlepool  
NHS Foundation Trust

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December saw continued operational pressures that impacted on patient flow. The impact of the omnicron variant started to be seen with an increase in the number of patients admitted to the trust compounded by the number of staff who were away from work due to Covid issues.

In addition to this, the national 2022/23 Planning Guidance was released (24<sup>th</sup> December 2021), with consideration of its implications to the Trust underway.



# Executive Summary



North Tees and Hartlepool  
NHS Foundation Trust

## SOF and Efficiency & Productivity

'Insourcing' continues to support additional weekend lists with consideration of supporting in week lists to maintain recovery of elective waiting times.

The increased acuity of patients presenting to the Emergency Department, alongside gaps in staffing resources due to higher sickness and vacancy rates, have compounded the impact of increased activity and the pandemic. Despite these pressures, clinical teams are working hard to maintain business as usual, with strong oversight and management through the Trust's governance structures.

The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position, with a focus remaining on reducing the overall waiting list and in particular those waiting the longest. The Trust remains on target to deliver against the H2 requirements to date with a detailed dashboard under development to allow executive high level oversight.

Operational efficiency and productivity remains a focus ensuring outcome measures across Outpatients, Theatres and Emergency pathways continue to be monitored and managed closely with additional high-level narrative outlined within the individual sections of the report.

Briefing sessions for all MOC/DOC including Clinical Leads held throughout December including:

- Operational Resilience
- Full Capacity Plan
- Ambulance Handover Guidance
- Roles and Responsibilities

## Safety & Quality

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

The latest HSMR value is currently reporting at 91.19 (November 2020 to October 2021) which has increased from the previous rebased value of 88.80 (October 2020 to September 2021). The latest SHMI value is 99.16 (August 2020 to July 2021) continues to remain 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 complaint in all stages (Stage 1, 2 and 3) have decreased during December 2021. The number of complaints received this month continues to support the return to the pre-Covid status.

# Executive Summary



North Tees and Hartlepool  
NHS Foundation Trust

## Workforce

A review of vaccination status is underway across the Trust to understand the implications of those staff who remain unvaccinated pending the release of a mandated requirement. The vaccination campaigns for covid-19 and flu remain the focus to encourage uptake amongst staff. Pressures have increased within the covid support line as the number of infection rates increased across the Trust. Additional resource was provided to help manage the surge and ensure staff received the required support to ensure all guidelines were adhered to and staff could return to work safely. Lateral Flow Kits are now provided to staff in response to the national shortage.

Sickness absence and management is a priority given the increasing rate. The development of a specific training programme on the effective management of sickness absence is underway with the aim of ensuring cases are managed appropriately and consistently across the Trust.

A Wellbeing Pack, providing key information to staff in relation to supporting their wellbeing, along with a number of Trust-branded items, was delivered to each member of staff in the Trust in December as one of the initiatives in the Trust's 100 Leaders Project which was well received. The Trust achieved the Better Health at Work Maintaining Excellence Award in December, demonstrating the commitment and collaboration of many teams across the Trust to ensure wellbeing support is at the heart of the Trust's approach to its staff. Work has begun on the NHS Health and Wellbeing framework, to produce a gap analysis, which will inform the Trust's health and wellbeing strategy going forward.

As at 31 December 2021, the number of active volunteers is 234, a small increase on the previous month. There are currently 29 applications in progress and a further advertisement will open late January/early February. Recruitment continues at pace and interest remains high with a further 100 expressions of interest. Three volunteers successfully gained employment with the Trust in December.

The volunteer service continues to work with areas across the Trust to place volunteers in both clinical and non-clinical areas. There has been an increase in students providing support within the wards, particularly in the pilot areas of the Active Hospital Project, whilst the number of volunteers within the Emergency Department is also increasing. There are now volunteer responders available at core times Monday-Saturday who support a range of activities and tasks including delivering patient belongings and medication, dropping items off at the lab or the movement of patients to the transport hub. Support is also planned for virtual visiting initiatives that will be re-introduced by the trust.

## Finance

As funding allocations for H2 have been concluded, the Trust is now reporting the financial position across the year and is forecasting a year-end surplus of £5.9m.

At Month 9, the Trust is reporting an in-month surplus of £0.316m against a planned deficit of £0.961m, which is £1.27m ahead of plan.

The Trust is reporting a year to date surplus of £4.812m against a plan of £2.399m (based on the plan of a breakeven position at year-end).

Total Group income in Month 9 is £30.385m (including donated asset income and ERF income).

Month 9 pay expenditure totalled £20.09m (including M1-6 ERF and removing the impact of the pay award) of which £0.350m is additional spend relating to the Covid-19 response and includes costs associated with Covid-19 testing.

Month 9 non-pay expenditure totalled £9.942m (including M1-6 ERF) of which £0.209m is additional spend related to the Covid-19 response and includes costs associated with Covid-19 testing.

The Month 9 year to date net contribution from Optimus is £0.217m against a plan of £0.083m (£0.134m ahead of plan) and the year to date net contribution from the LLP is £1.653m against a plan of £1.298m (£0.355m ahead of plan).

At Month 9, the Group cash balance is £64.0m, compared to a plan of £64.1m.

As at month 9, the Trust has spent £9.1m capital against a year-to-date plan of £9.9m, therefore behind plan by £0.8m.

At Month 9, key risks relate to: the identification and under-delivery of recurrent efficiency savings; under-delivery of non-recurrent plans; the impact of the reduction in the useful economic life of Trust buildings and the uncertainty relating to funding arrangements for 2022/23.

# Single Oversight Framework



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	Performance	Standard	2 Year Trend
New Cancer Two Week Rule	✗	Nov-21	86.57%	93.00%	
Breast Symptomatic Two Week Rule	✗	Nov-21	90.57%	93.00%	
28-day Faster Diagnosis	✓	Nov-21	80.83%	75.00%	
New Cancer 31 Days	✓	Nov-21	99.21%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Nov-21	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✓	Nov-21	100.00%	94.00%	
New Cancer 62 Days	✗	Nov-21	76.47%	85.00%	
New Cancer 62 Days (Screening)	✓	Nov-21	92.94%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✓	Nov-21	100.00%	85.00%	

### Cancer

The increased demand created additional pressures across the system with increased outpatient and diagnostic appointments needed. As a result, the two week rule standard reported at 86.57% (1141/1318 seen within 14 days) and the breast symptomatic two week rule standard reporting at 90.57% (240/265 seen within 14 days). Gynae, breast and lower GI have struggled to accommodate patients within 2 weeks this month.

Urology, Colorectal and Gynaecology remain key areas of pressure with increased 2ww referrals now experienced in Breast (535 in October, up from 504 in September and 440 in September). The Trust remains committed to a collaborative approach through the South Cancer Cell initiative alongside South Tees- ensuring equitable access to treatment for all patients.

Whilst the number of patients waiting over 62 days has seen an increase, so too has the number of two week rule referrals, with numbers highest seen to date (12.4% increase on previous month (n=175) and 16.4% on same period last year (n=223)).

The Trust reported an improved position to October, reporting at 76.5% (52/68 patients treated within a 62 day timescale compared to 61/83 – 73.4% last month). Breaches were due to diagnostic delays, elective capacity and complex diagnostic pathways. The regional average for November reported at 67.4%, with performance ranging from 52.9% to 80.7%. No regional Trust achieved the 85% target; highlighting the continued challenges facing the region across most tumour groups. The national average for November reported at 67.5%.

Pressures continue to impact on the delivery of cancer standards with some delays to pathways unavoidable due to system capacity issues including diagnostics, complexity of presentations, patient choice and infection prevention and control (IPC) requirements influencing pathways.

# Single Oversight Framework



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	Performance	Standard	2 Year Trend	
Referral To Treatment Incomplete Pathways Wait (92%)	❌ Dec-21	83.06%	92.00%		<b>RTT</b> The elective recovery programme continues across the system. Latest national benchmark position (November 2021), indicates no trust in the region is reporting above the 92% standard with a regional average reporting at 65.5%, a reduction from 65.6% the previous month (range 61.65% to 89.18%) and the Trust ranks 2 <sup>nd</sup> reporting at 85.7%. Median waits saw a marginal increase to 8.14 days against the 7.20 standard.
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	✅ Dec-21	26.57	28.00		
Incomplete Pathways Wait (Median)	❌ Dec-21	8.14	7.20		
Incomplete Pathways Wait (>52 Week Wait)	❌ Dec-21	75	0		
Diagnostic Waiting Times and Activity	❌ Dec-21	85.04%	99.00%		
Community Information Dataset - Referral Information	✅ Nov-21	100.00%	50.00%		<b>Diagnostics</b> Patients waiting over 52 weeks is reporting at 75 compared to 67 last month with cancellations noted as a result of covid positive test results and patients not attending for pre procedure swabs. Theatre staffing and resource was problematic in November with a number of procedures reappointed as a result (see theatre section for detail). Regionally there are 8939 patients waiting over 52 weeks with a range of 27 to 4595.  Diagnostics is reporting an unvalidated position of 85.04% . Key areas of pressures continue to be Endoscopy, MRI, Ultrasound and Cardiology. In November, the regional average was 74.50% with a range of 53.44% - 99.69% with the Trust ranking in 4th position.
Community Information Dataset- Referral to Treatment Information	✅ Nov-21	97.62%	50.00%		
Community Information Dataset - Treatment Activity Information	✅ Nov-21	99.99%	50.00%		
Community Information Dataset - End of Life	✅ Nov-21	84.81%	50.00%		



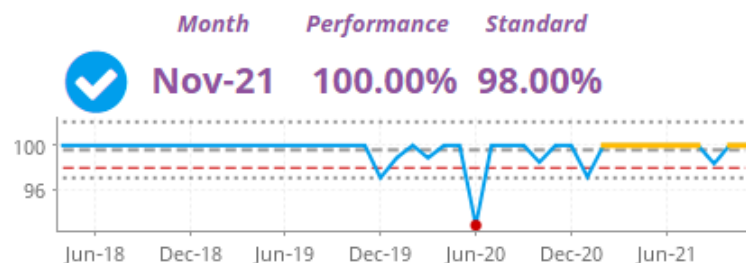
# Single Oversight Framework



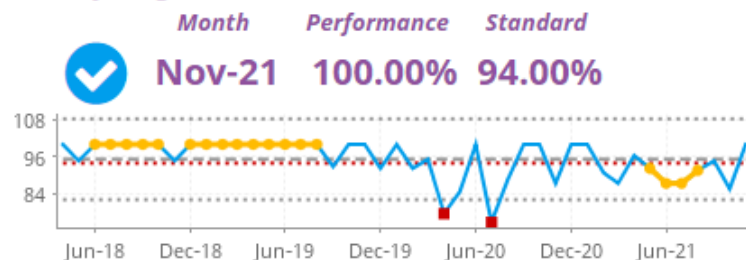
North Tees and Hartlepool  
NHS Foundation Trust

## Statistical Process Control (SPC) Charts

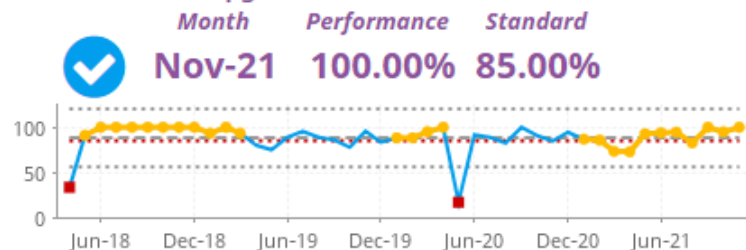
Cancer - 31 Day Drug Treatment



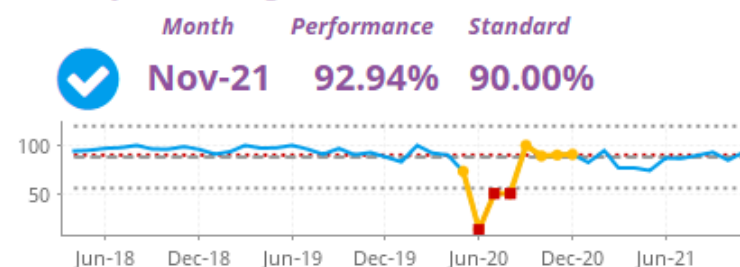
Cancer - 31 Day Surgical Treatment



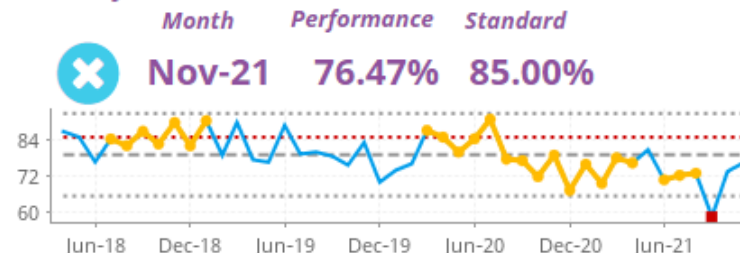
Cancer - 62 Consultant Upgrade



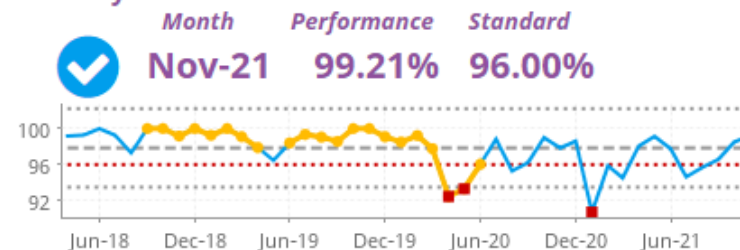
Cancer - 62 Days Screening



Cancer - 62 Days



Cancer - 31 Days



# Single Oversight Framework



North Tees and Hartlepool  
NHS Foundation Trust

## Statistical Process Control (SPC) Charts

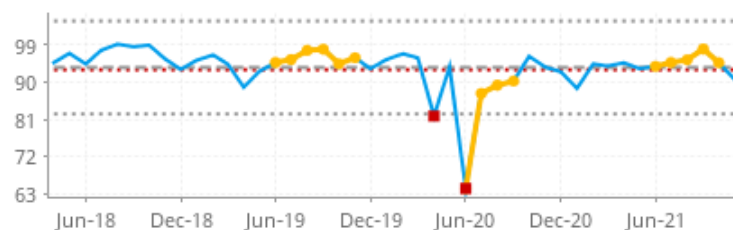
### Cancer - 2 Week Rule

Month **Nov-21** Performance **86.57%** Standard **93.00%**



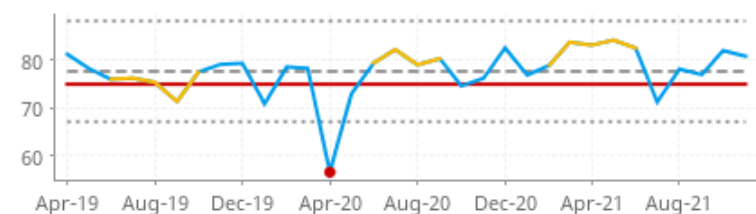
### Cancer - Breast Symptomatic

Month **Nov-21** Performance **90.57%** Standard **93.00%**



### Cancer - 28day Faster Diagnosis

Month **Nov-21** Performance **80.83%** Standard **75.00%**



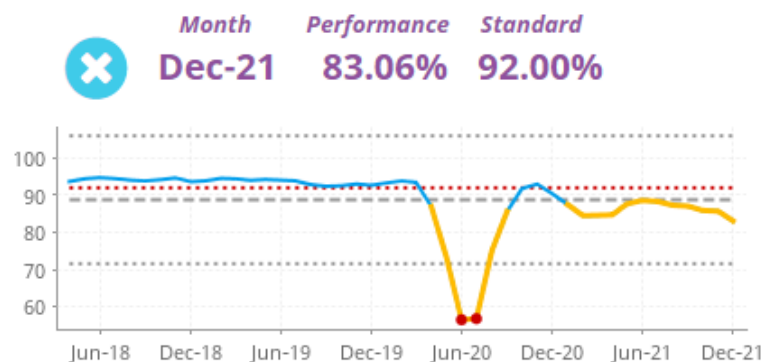
### Diagnostic Waiting Times

Month **Nov-21** Performance **88.91%** Standard **99.00%**

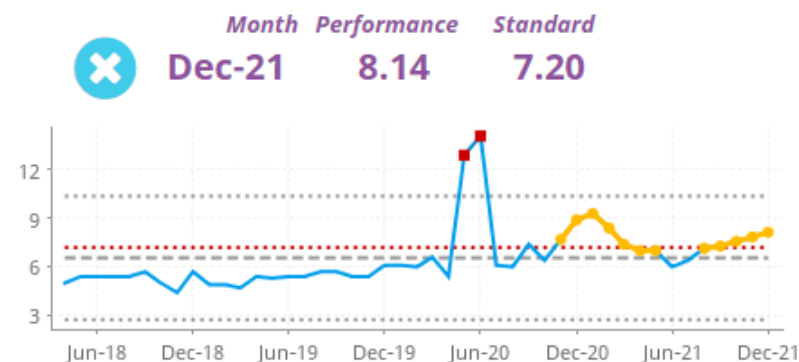


## Statistical Process Control (SPC) Charts

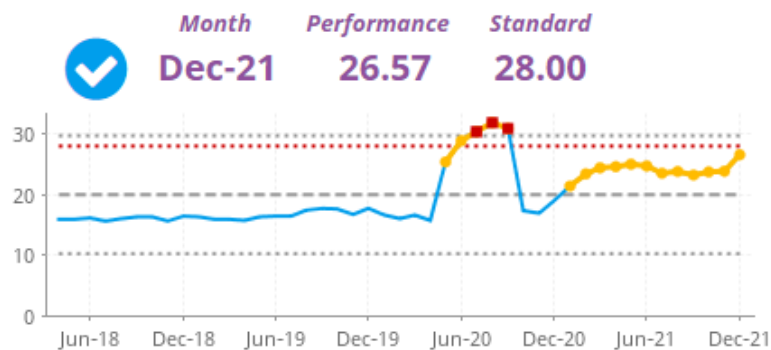
Referral To Treatment- Incomplete Pathways Wait (92%)



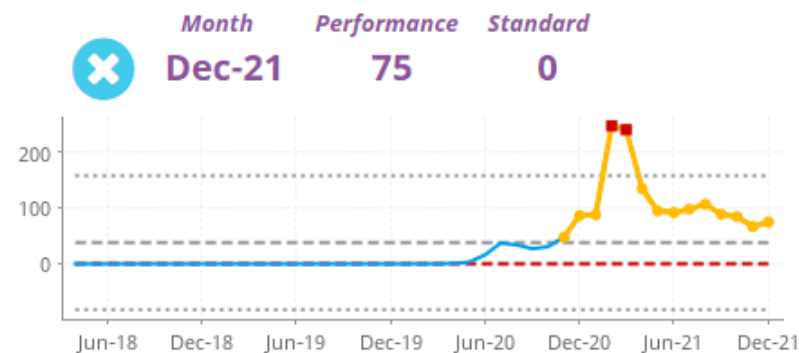
Referral To Treatment - Incomplete Pathways Wait (Median)



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



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



# Single Oversight Framework

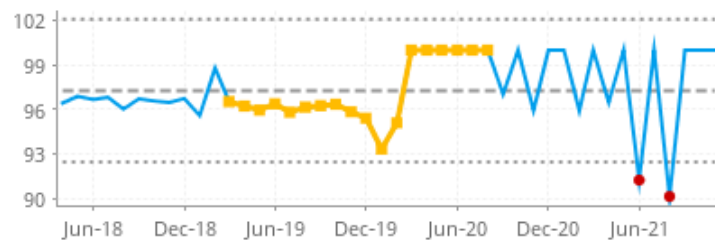


North Tees and Hartlepool  
NHS Foundation Trust

## Statistical Process Control (SPC) Charts

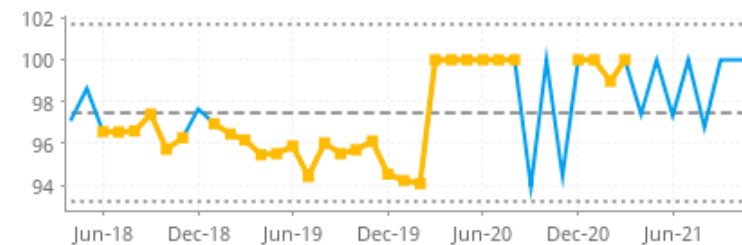
### Community Information Dataset - Referral Information

Month Performance Standard  
✓ Nov-21 100.00% 50.00%



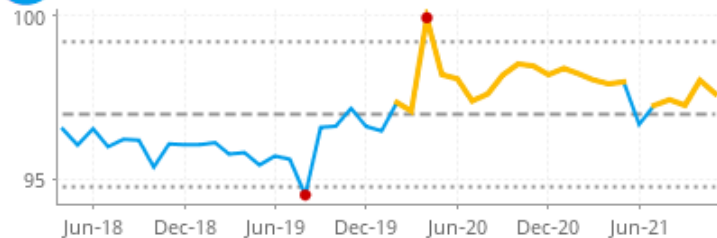
### Community Information Dataset - Treatment Activity Information

Month Performance Standard  
✓ Nov-21 99.99% 50.00%



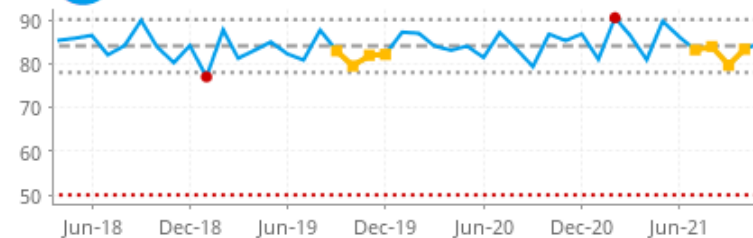
### Community Information Dataset - Referral to Treatment Information

Month Performance Standard  
✓ Nov-21 97.62% 50.00%



### Community Information Dataset - End of Life

Month Performance Standard  
✓ Nov-21 84.81% 50.00%





# Efficiency & Productivity



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	Performance	Standard	2 Year Trend	
Outpatient Did Not Attend (New)	✗ Dec-21	9.27%	7.20%		<b>Did Not Attend (DNA)</b> DNA rates for New, Review and Combined are seeing an increased trend. Trauma, Orthopaedics and Diabetes (low numbers) continue to see the greatest increase. The number of outpatient appointments has decreased in December possibly a result of the festive period however remains higher than previous years.  Virtual appointments continue in accordance with national guidance, with circa 25% of appointments offered via video/telephone with work ongoing to increase Patient Initiated Follow Ups (PIFU). Outpatient Transformation Group has been re-established to review all of the above.
Outpatient Did Not Attend (Review)	✗ Dec-21	9.45%	9.00%		
Outpatient Did Not Attend (Combined)	✗ Dec-21	9.37%	9.20%		
Average Depth of Coding	✓ Nov-21	6.12	3.01		<b>Bed Occupancy</b> Sustained high bed occupancy rates above 90% are evident alongside the management of increased acuity and covid and non-covid patients, with resilience supported through a flexible bed base as staffing allows. Covid related admissions saw a steady increase throughout the beginning of December with a surge over the festive period as predicted. This is continuing into January with rates closely monitored using a forecasting methodology.  Occupancy ranged from 75.6% (on 24 December) to 97.5% throughout the month of December with escalation beds open where able due to workforce constraints (max open 26).  Emergency admissions saw an increase in December compared to the same time last year, with a 15.6% (n= 483) increase. The largest increase in General Medicine (n=124) and Paediatrics (n=182)
Length of Stay - Elective	✓ Dec-21	2.27	3.14		
Length of Stay - Emergency	✓ Dec-21	2.93	3.35		
Day Case Rate	✓ Dec-21	87.22%	75.00%		<b>Readmissions</b> Readmissions continues to show an improved position albeit a marginal increase this month to 8.8% from 7.56%. This still brings the Trust in line with model hospital benchmarking data. Data cleansing and capture continues to be a focus. Main reasons for readmissions are respiratory disorders accounting for 8% though relatively small numbers, soft tissue disorders accounting for 2%, sepsis accounting for 2% and heart failure accounting for 2% although all have small numbers.
Pre-op Stays	✓ Dec-21	1.71%	4.50%		
Trust Occupancy	✗ Dec-21	90.71%	85.00%		
Re-admissions Rate 30 Days (Elective and Emergency)	✗ Oct-21	8.81%	7.70%		

# Efficiency & Productivity



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	Performance	Standard	2 Year Trend	
Electronic Discharge Summaries	✗ Dec-21	85.97%	95.00%		<p><b>Cesarean -Section Rates</b></p> <p>A gradual increase is noted on SPC though within control limits, reporting at 18.4% against a target of 15.60%. This equated to 39, (34 last month) emergency C-sections out of 212 mothers, (200 last month), with 33% due to suboptimal foetal heart tracing (CTG) and 25% due to poor progress of labour.</p> <p><b>Decision To Admit (DTA) (over 12 hours)</b></p> <p>The significant pressures across the organisation resulted in 13 12-hour (DTA) trolley waits during December as a result of bed pressures. Additional pressure within ED increased as mutual aid requests, diverts and deflections from other Trusts were experienced on many occasions throughout the month, with a total of 25 patients received (18 in November). The Trust requested mutual aid from neighbouring organisations on 6 occasions all of which were declined; however 1 patient was deflected via NEAS.</p> <p><b>Ambulance handover</b></p> <p>Increased pressures across the emergency care pathway have continued with some ambulance handover delays noted, however kept to a minimum wherever possible.</p> <p>NEAS monthly handover report indicates circa 1878 (30-60 minute) ambulance handover delays across North East and Cumbria providers in December with 831 over 60 minutes (724 last month).</p> <p>NEAS reported the Trust at 35.4% ambulance turnaround times (valid) within 30 minutes, in comparison the North East's position at 38.3% with performance ranging between 24.8% and 54.6%.</p> <p>Engagement sessions in ED commenced in January including:</p> <ul style="list-style-type: none"> <li>• FCP</li> <li>• Ambulance Handover/Escalation/Roles and responsibilities</li> <li>• Operational Resilience</li> </ul> <p>&lt;30 min ED handover SOP reviewed and implemented - Jan 21 Overnight ambulance provision in place for ED discharges</p>
Cesarean -Section Rates	✗ Dec-21	18.40%	15.60%		
Decision To Admit (DTA) (over 12 hours)	✗ Dec-21	13	0		
Time to Initial Assessment (mean) Type 1 & 3	✓ Dec-21	13.27	15.00		
Number of Ambulance Handovers waiting more than 30 Mins	✗ Dec-21	58	0		
Number of Ambulance Handovers waiting more than 60 Mins	✗ Dec-21	36	0		
Super Stranded	✓ Dec-21	47	61		

# Efficiency & Productivity



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	Performance	Standard	2 Year Trend
Touch Time Utilisation	✗	Dec-21	70.68%	80.00%	
Overrun Sessions	✓	Dec-21	25.91%	36.00%	
Session Utilisation	✗	Dec-21	58.12%	92.50%	
Cancelled on Day of Operation %	✓	Dec-21	7.38%	8.80%	
Cancelled procedure - Non medical	✓	Dec-21	0.59%	0.80%	
Not reappointed within 28days	✗	Dec-21	7	0	

### Theatre

The elective recovery programme has been impacted upon by increased staff absences for a variety of reasons including covid. 322 operations were cancelled during December for non medical reasons, 26 of which cancelled on the day.

Recovery is monitored on a weekly basis, including all activity taking place within the Independent Sector. 'Insourcing' of additional weekend lists continues with lists also taking place in week however this still does not provide full capacity to manage demand.

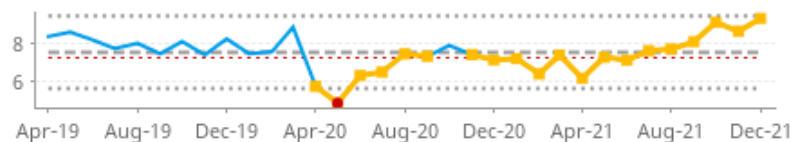
# Efficiency & Productivity



## Statistical Process Control (SPC) Charts

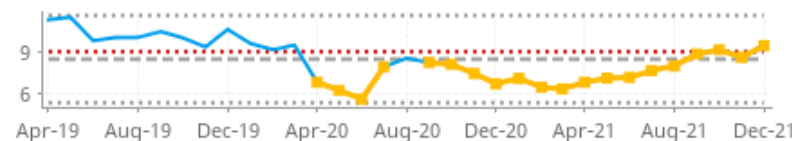
Outpatient Did not Attend (New)

Month Performance Standard  
**Dec-21** **9.27%** **7.20%**



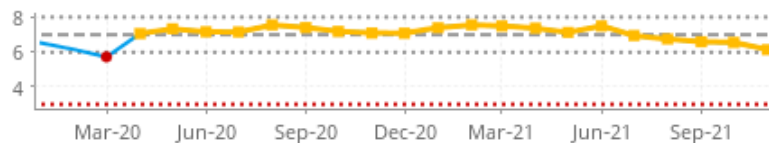
Outpatient Did Not Attend (Review)

Month Performance Standard  
**Dec-21** **9.45%** **9.00%**



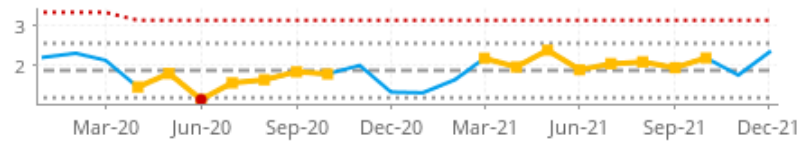
Average Depth of Coding

Month Performance Standard  
**Nov-21** **6.12** **3.01**



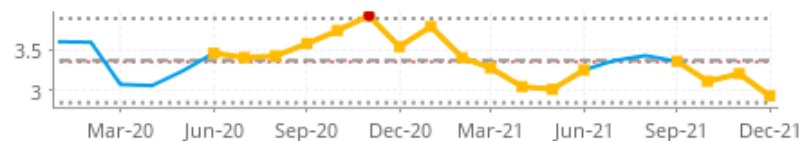
Length of Stay - Elective

Month Performance Standard  
**Dec-21** **2.27** **3.14**



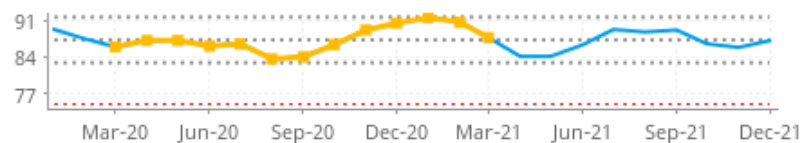
Length of Stay - Emergency

Month Performance Standard  
**Dec-21** **2.93** **3.35**



Day Case Rate

Month Performance Standard  
**Dec-21** **87.22%** **75.00%**



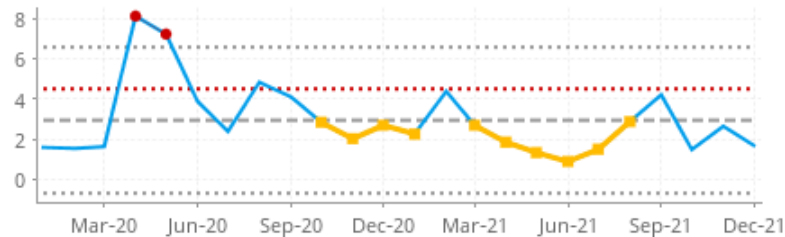
# Efficiency & Productivity



## Statistical Process Control (SPC) Charts

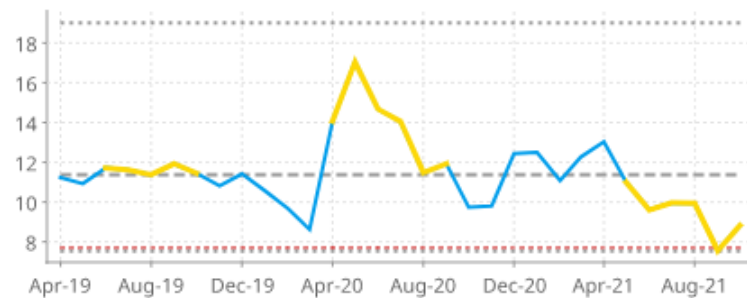
### Pre-op Stays

Month **Dec-21** Performance **1.71%** Standard **4.50%**



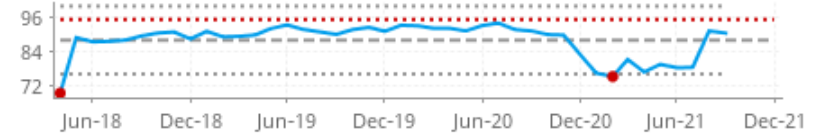
### Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month **Oct-21** Performance **8.81%** Standard **7.70%**



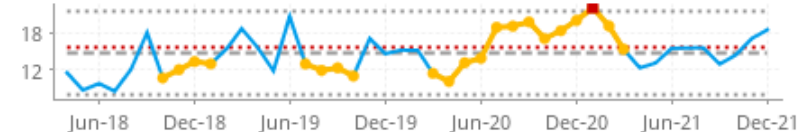
### Electronic Discharge Summaries

Month **Dec-21** Performance **95.00%** Standard **95.00%**



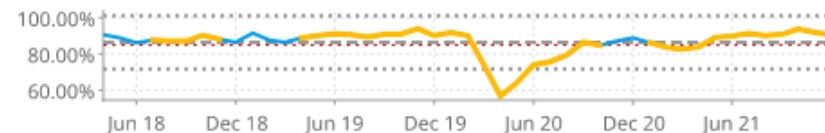
### Cesarean-Section Rates

Month **Dec-21** Performance **18.40%** Standard **15.60%**



### Trust Occupancy

Month **Dec-21** Performance **90.71%** Standard **85.00%**



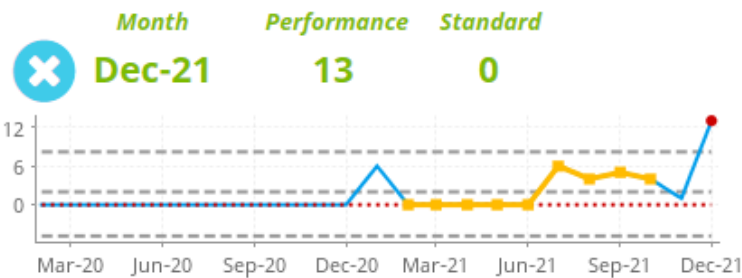


# Efficiency & Productivity

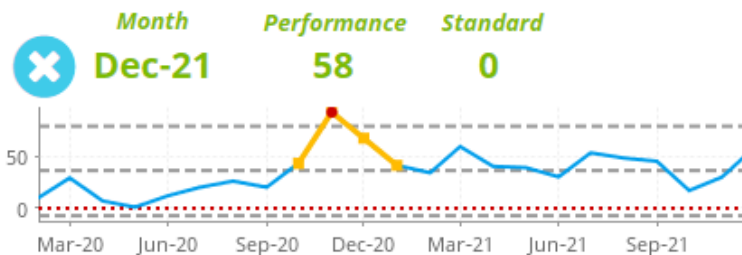


## Statistical Process Control (SPC) Charts

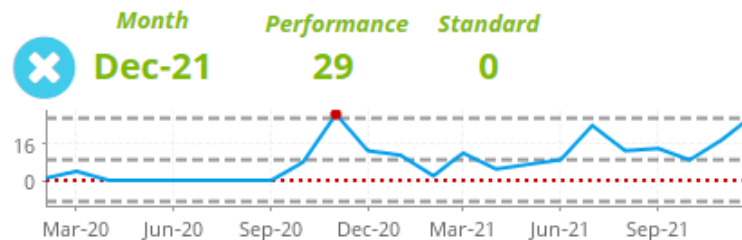
Trolley Waits over 12 hours



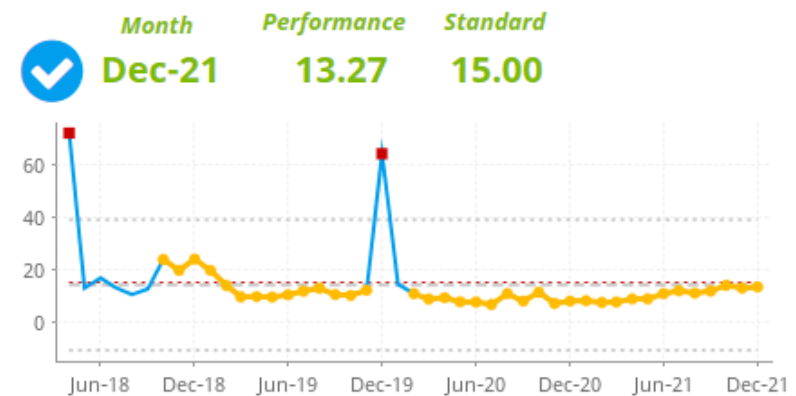
Number of Ambulance Handovers waiting more than 30 mins



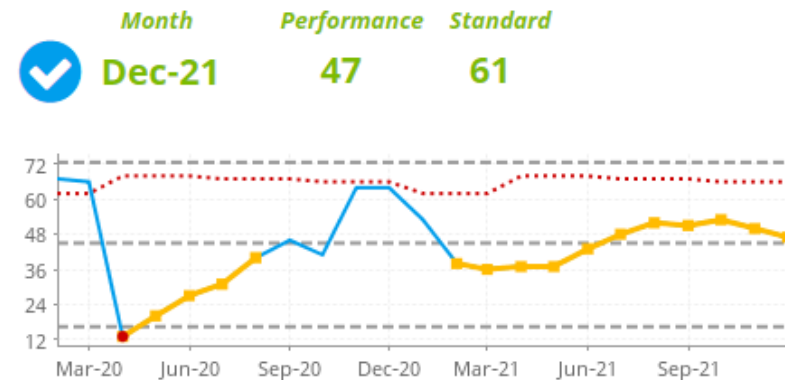
Number of Ambulance Handovers waiting more than 60 mins



Time to Initial Assessment (mean) Type 1 & 3



Super Stranded

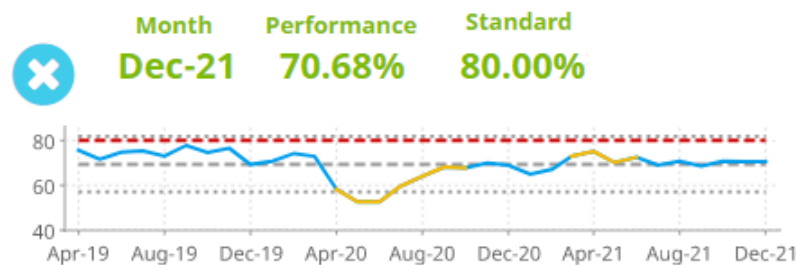


# Efficiency & Productivity

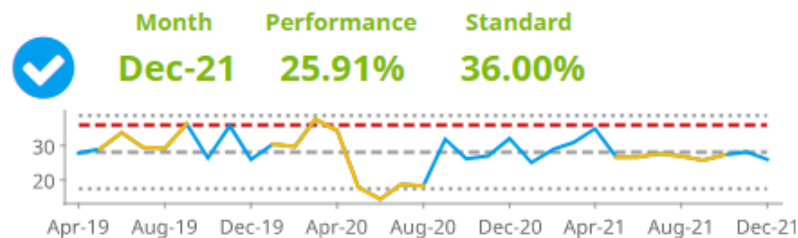


## Statistical Process Control (SPC) Charts

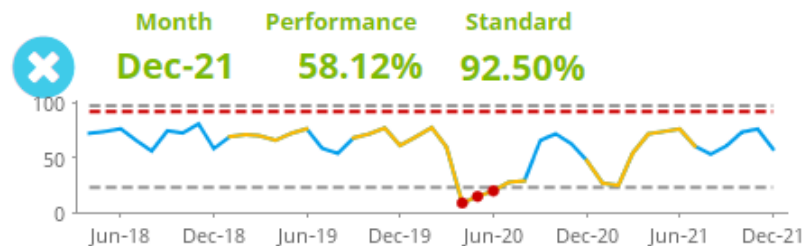
### Touch Time Utilisation



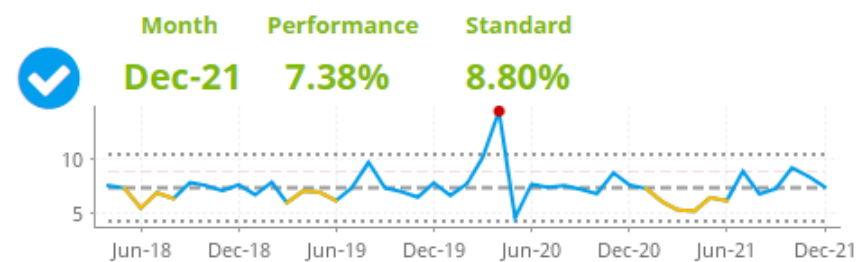
### Overrun Sessions



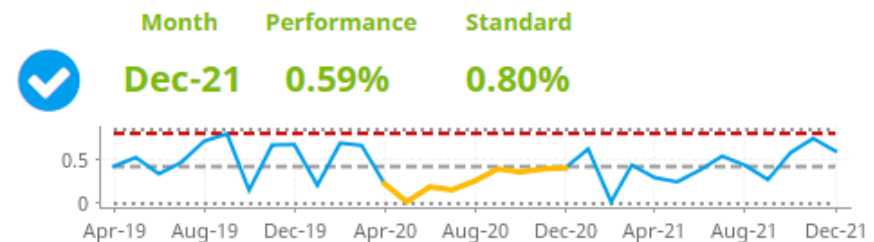
### Sessions Utilisation



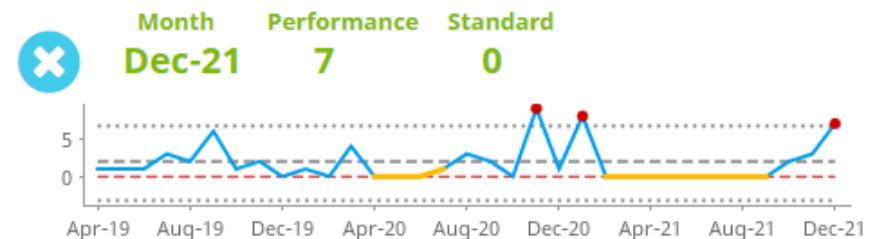
### Cancelled on Day of Operation %



### Cancelled Procedure - Non Medical



### Not reappointed within 28days



# Efficiency & Productivity



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	Performance	Standard	2 Year Trend	
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool	✓ Nov-21	97.69%	93.50%		<b>TCS Standards</b>  No change to TCS35b (Wheelchair referrals) with pressures around delays to electric wheelchairs delivery due supplier issues. The current contract is under review. The service has also experienced internal pressures due to Covid isolations, vacancy's and general sickness.
TCS35b - % of Wheelchair referrals completed within 18 weeks	✗ Dec-21	77.22%	90.00%		
Diabetic Retinopathy Screening	✓ Dec-21	97.12%	95.00%		
The % of Patients treated within 18weeks of referral to Audiology	✓ Dec-21	100.00%	95.00%		
Audiology non-admitted wait (92nd Percentile)	✓ Dec-21	6.00	18.30		



# Efficiency & Productivity



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	Performance	Standard	2 year Trend	
PHQ - Emergency Admissions for Acute Conditions that should not usually require hospital admission	Nov-21	130.25	100.74		<p><b>PHQ Indicators</b></p> <p>The PHQ indicators are a set of metrics, which monitor the impact of community services on avoidable admissions for a set of key conditions. A year on year improvement is monitored against these indicators as a measure of avoidable admissions.</p> <p>All indicators have been affected by seasonal pressures and expected at this time of year. Main reasons for admissions are Respiratory, Diabetes, Heart disease, Urine infection and acute Bronchiolitis.</p>
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Nov-21	24.47	22.00		
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Nov-21	76.50	63.74		
PHQ - Unplanned hospitalisation for respiratory tract infections in under 19s	Nov-21	63.40	21.40		
Stroke admissions - 90% of time spent on dedicated stroke unit.	Dec-21	94.12%	80.00%		
High Risk Trans Ischaemic Attack assessed and treated within 24hrs	Dec-21	60.00%	75.00%		

# Efficiency & Productivity

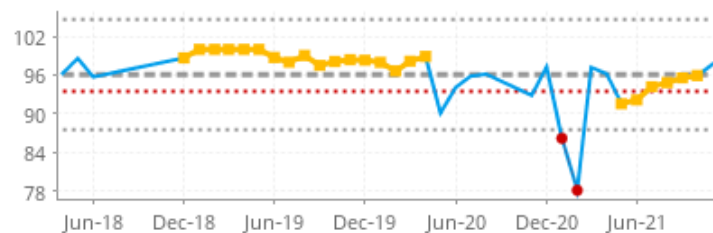


North Tees and Hartlepool  
NHS Foundation Trust

## Statistical Process Control (SPC) Charts

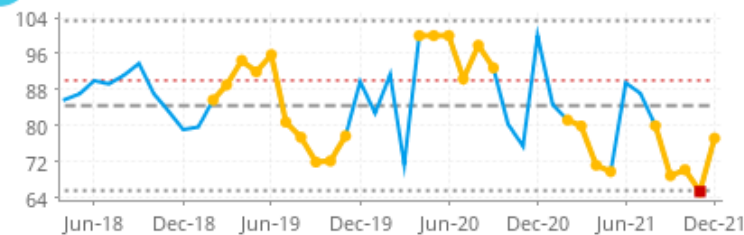
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool

Month Performance Standard  
✓ Nov-21 97.69% 93.50%



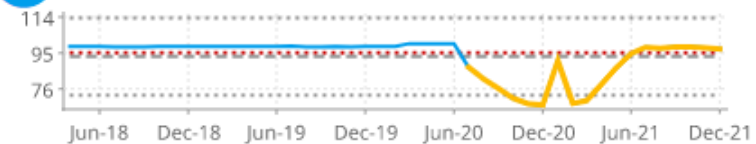
TCS35b - % of Wheelchair referrals completed within 18 weeks

Month Performance Standard  
✗ Dec-21 77.22% 90.00%



Diabetic Retinopathy Screening

Month Performance Standard  
✓ Dec-21 97.12% 95.00%



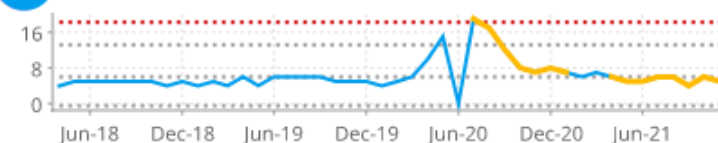
The % of Patients treated within 18 weeks of referral to Audiology

Month Performance Standard  
✓ Dec-21 100.00% 95.00%



Audiology non-admitted wait (92nd Percentile)

Month Performance Standard  
✓ Dec-21 6.00 18.30

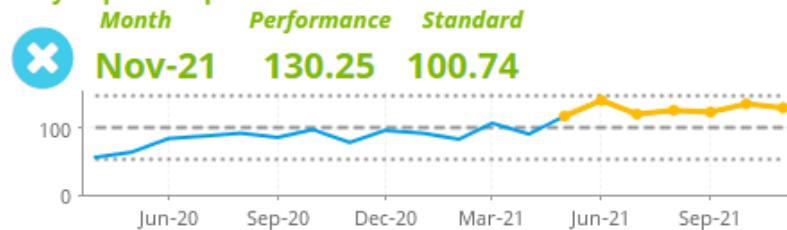


# Efficiency & Productivity

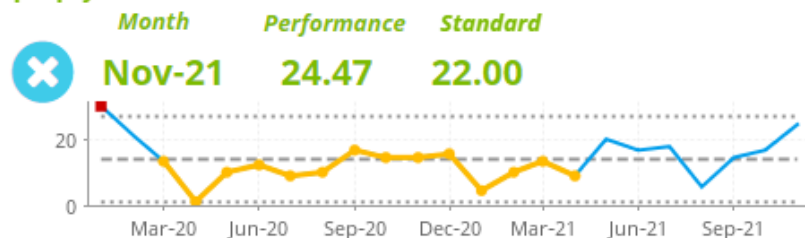


## Statistical Process Control (SPC) Charts

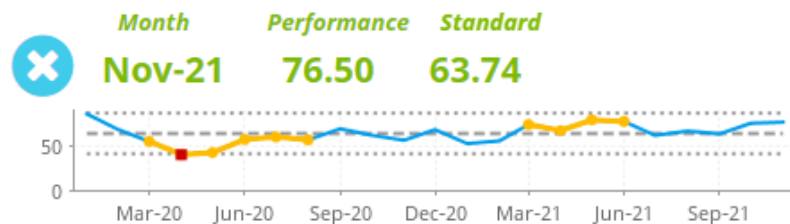
PHQ - Emergency Admissions for Acute Conditions that should not usually require hospital admission



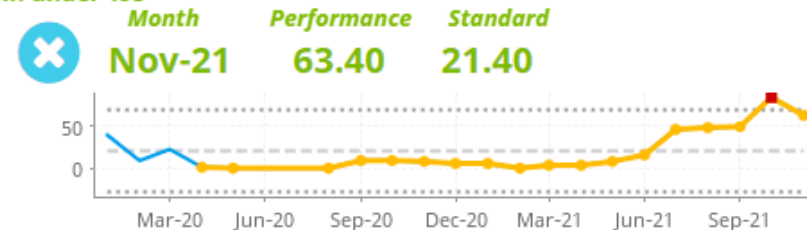
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in unders 19s



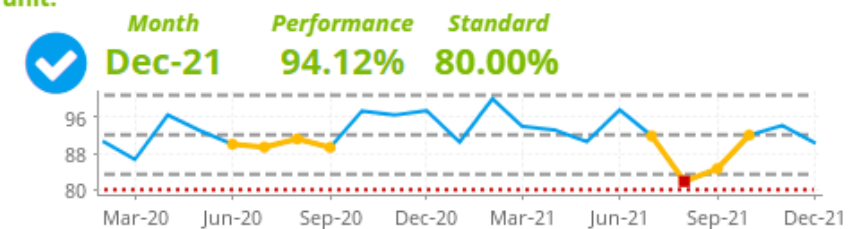
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)



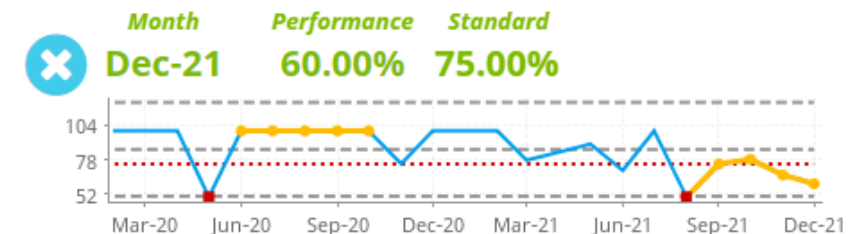
PHQ - Unplanned hospitalisation for respiratory tract infections in under 19s



Stroke admissions - 90% of time spent on dedicated stroke unit.



High Risk Trans Ischaemic Attack assessed and treated within 24hrs



# Safety & Quality



North Tees and Hartlepool  
NHS Foundation Trust

## Standard

## Standard Achieved

## Narrative

		Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Nov 20 - Oct 21	91.19	
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Aug 20 - Jul 21	99.16	

		Month	Performance	Standard	Trend
Stage 1 Complaint	✓	Dec-21	90	90	
Stage 2 Complaint	✓	Dec-21	3	5	
Stage 3 Complaint	✓	Dec-21	6	11	
Compliments	✓	Dec-21	328	247	

### Mortality

The latest HSMR value is currently reporting at 91.19 (November 2020 to October 2021) which has increased from the previous rebased value of 88.80 (October 2020 to September 2021). The latest SHMI value is now 99.16 (August 2020 to July 2021) which has decreased from the previous rebased value of 98.66 (July 2020 to June 2021).

### Complaints

The number of complaints in all stages have decreased compared to last 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 have been developed to support this process.

Limited visiting was in place during December 2021, however has now been paused due to the increase in the local Covid 19 infection rate, however families continue to be supported through John's Campaign and provisions for those patients at End of Life. During December 2021, communication was the highest reported main issue in concerns raised to the Trust, although it is noted this has decreased from the previous month. Complaint trends are discussed during weekly Safety Panel meetings and Senior Clinical Professional Huddles, supporting timely identification of the themes.

The communication plan introduced in January 2021 remains in place to ensure families receive a good level of communication. The plan incorporates regular telephone updates by ward staff. The plan also supports virtual visiting, property and letters of love drop off service. The number of relatives utilising the drop off service increased significantly during December 2021.

### Compliments

The Trust records the compliments received onto the Greatix platform. For December 2021 the number of compliments received is 328, which is significantly higher than the mean of 247 compliments. Compliments consistently remain higher than the number of complaints the Trust receives.

# Safety & Quality



North Tees and Hartlepool

NHS Foundation Trust

## Standard

## Standard Achieved

## Narrative

		Month	Performance	Standard	Trend
Red Risks	✓	Dec-21	4	4	
Never Events	✓	Dec-21	0	0	
VTE %	✓	Dec-21	95.16%	95.00%	
Fall No Harm	✗	Dec-21	110	77	
Fall Low Harm	✓	Dec-21	15	17	
Fall Moderate Harm	✓	Dec-21	1	1	
Fall Severe Harm	✓	Dec-21	0	0	

### Venous Thromboembolism Compliance %

The Trust is reporting that 95.16% of patients admitted to hospital were risk assessed for Venous Thromboembolism (VTE) during November 2021; this is above the National Standard of 95.00%.

The VTE working group, will review next month the obstetrics patient's data collection to provide assurance of the data quality. The group is working collaboratively to support improvement work in areas that have low compliance.

### Falls

There has been an increase in the overall number of falls in December 2021, with the majority resulting in no harm. There has been an increase of 31 in the number of no harm, an increase of 1 in low harm and moderate harm has remained the same at 1 case. The 1 fall categorised as moderate harm was for a fractured humerus. This is currently being investigated inline with the Trust policy.

Work is on-going with ward areas in terms of promoting risk mitigation strategies and providing appropriate education and support. The falls group has recently agreed a guidance for the use of non-slip slipper socks which has been disseminated to all ward areas and departments. This will provide a standardised approach.

The digital team continue to develop the falls documentation as well as the bed rails assessment. Improvements have recently been agreed by the working group. Digital solutions are also supporting the improvement work of lying and standing blood pressures.

# Safety & Quality



North Tees and Hartlepool  
NHS Foundation Trust

## Standard

## Standard Achieved

## Narrative

**Pressure Category 1**  
(inpatient)



Nov-21

2

6



**Pressure Category 2**  
(inpatient)



Nov-21

25

23



**Pressure Category 3**  
(inpatient)



Nov-21

5

2



**Pressure Category 4**  
(inpatient)



Nov-21

0

0



### Pressure Ulcers

In the November 2021 reporting period, all four categories of Pressure Ulcers fall within the control limits. A pressure ulcer assurance framework is currently under development to further support pressure ulcer management and the trust are in the process of rolling out the Purpose T evaluation tool.



# Safety & Quality



North Tees and Hartlepool  
NHS Foundation Trust

Standard	Standard Achieved				Narrative	
		Month	Performance	Standard	Trend	
Hand Hygiene	✓	Dec-21	99%	95%		<h3>Hand Hygiene</h3> <p>The overall Trust compliance score for hand hygiene is 99% for December 2021; this has increased from the previous reporting period, and remains above the trust standard of 95%. Clinical areas carry out monthly audits with a quarterly assurance check by the IPC team, areas have been encouraged to ensure submission or to notify the IPC team for support.</p> <h3>Infections</h3> <p>In December 2021, the Trust has reported 6 Trust attributed cases of Clostridium difficile infection (5 Hospital-onset Healthcare Associated and 1 Community-onset Healthcare Associated). This is in line with our projected trajectory for December and takes our total number of cases to 42 against a yearly target of 64. Common themes from early RCAs have identified delayed sampling, multiple antibiotic courses and increased frailty.</p> <p>In the same period, six E.coli case have been reported, taking the total number of cases to 62. Although the trust continues to perform well against our target of 117 for the period of 2021/22.</p> <p>There has been two reported pseudomonas cases identified in December 2021, which brings us over our target of 11 cases to 13 cases for the year. There have been no further cases identified linked to Critical Care.</p> <p>There have been three hospital associated cases of MSSA in the month of December, taking the total case number to 23, against an internal trust target of 25.</p> <p>The trust has reported only no cases of trust-attributed Klebsiella in December 2021 bringing us to a total of 12 cases against a target of 24.</p> <p>The trust continues to report 0 MRSA bacteraemias.</p> <p>Community prevalence of Covid-19 has increased significantly within the North East and the wider UK. There has been a steep increase in patients admitted with Covid-19, although admissions to ITU has reduced. An increase in hospital onset cases which are linked to community onset cases make up new Covid-19 outbreaks throughout the trust. This is mainly due to the Omicron variant and increased social activity over the festive period. There are currently nine open outbreaks of Covid-19 within the trust. The IPC team are currently working hard to monitor outbreaks and staff cases. Outbreak management in such high numbers remains challenging whilst maintaining patient flow. The IPC team continues to assist with advice for safe patient movement throughout the trust.</p>
Clostridium difficile	✗	Dec-21	7	6		
MRSA	✓	Dec-21	0	0		
MSSA	✓	Dec-21	1	2		
Ecoli	✓	Dec-21	4	10		
Klebsiella	✓	Dec-21	0	2		
Pseudomonas	✓	Dec-21	1	1		
CAUTI	✓	Dec-21	17	22		

Community prevalence of Covid-19 has increased significantly within the North East and the wider UK. There has been a steep increase in patients admitted with Covid-19, although admissions to ITU has reduced. An increase in hospital onset cases which are linked to community onset cases make up new Covid-19 outbreaks throughout the trust. This is mainly due to the Omicron variant and increased social activity over the festive period. There are currently nine open outbreaks of Covid-19 within the trust. The IPC team are currently working hard to monitor outbreaks and staff cases. Outbreak management in such high numbers remains challenging whilst maintaining patient flow. The IPC team continues to assist with advice for safe patient movement throughout the trust.

# Safety & Quality



North Tees and Hartlepool  
NHS Foundation Trust

## Standard

## Standard Achieved

## Narrative

		Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	✓	Dec-21	87.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	✓	Dec-21	90.00%	75.00%	
Friends and Family Test (FFT) - Maternity	✓	Dec-21	100.00%	75.00%	
UNIFY - RN Day	✗	Dec-21	77.16%	>=80% and <=109.99%	
UNIFY - RN Night	✓	Dec-21	82.53%	>=80% and <=109.99%	
UNIFY - HCA Day	✓	Dec-21	85.36%	>=80% and <=109.99%	
UNIFY - HCA Night	✓	Dec-21	120.57%	>=110% and <=125.99%	

### Friends and Family Test

For December 2021 the Trust received 1,006 FFT returns, this is down on the previous month, but does incorporate the Christmas period which generally produces lower numbers, the Very Good or Good response is 91.55%.

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 and a higher sickness absence than planned. The daily challenges have been safely managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse. The nursing fill rates presented in December 2021 show that these pressures are still evident and that the RN and HCA fill for December has decreased slightly from November 2021. Enhanced rate of pay shift continue to be offered to incentive staff for working additional hours to further support the safe staffing of the clinical areas and further incentive schemes have been commenced in January 2022 to further encourage staff to block book their additional hours worked in advance.

Minimum of 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.

The registered nurse vacancy level has increased in December 2021, due to staff seeking out professional development opportunities in new roles both internal and external to the Trust. An additional 18wte newly registered nurses are joining the trust from January 2022. Further RN and HCA recruitment is managed via monthly recruitment centres.

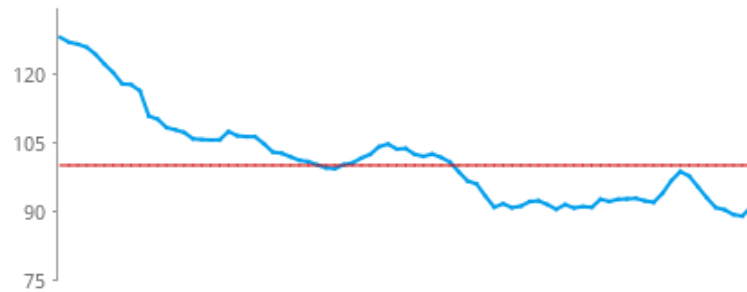
International recruitment is currently being planned which will further support increasing the shift fill rate and reducing the overarching nursing vacancy level from the summer 2022.



## Additional Detail Charts

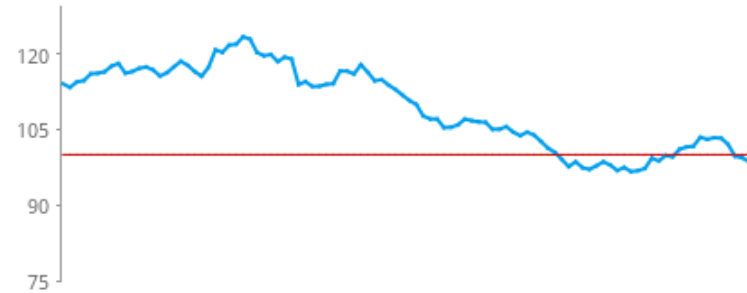
### Hospital Standardised Mortality Ratio

✓ *Month* **Oct 20 - Sep 21** *Performance* **90.85**



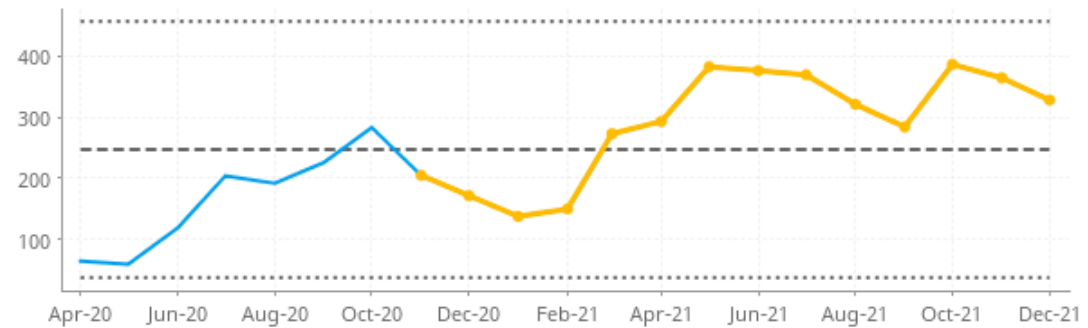
### Summary Hospital-Level Mortality Indicator

✓ *Month* **Aug 20 - Jul 21** *Performance* **99.16**



### Compliments

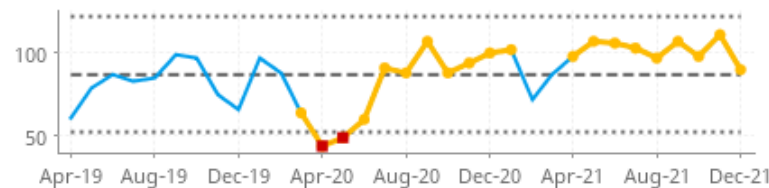
✓ *Month* **Dec-21** *Performance* **328** *Standard* **247**



## Statistical Process Control (SPC) Charts

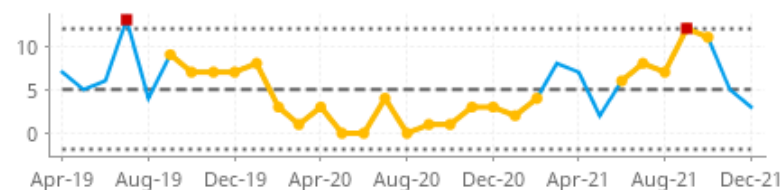
Stage 1 - Informal Month Performance Standard

✓ Dec-21 90 90



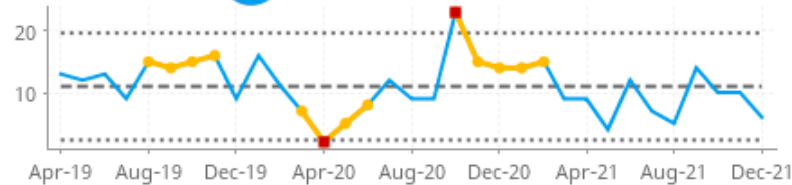
Stage 2 - Meeting Month Performance Standard

✓ Dec-21 3 5



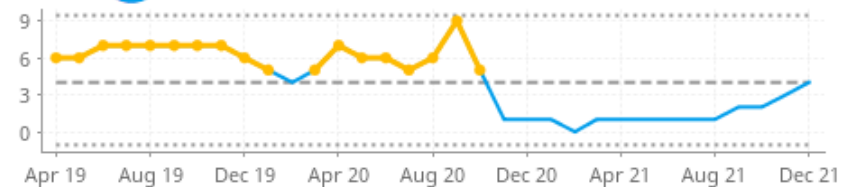
Stage 3 - Formal Month Performance Standard

✓ Dec-21 6 11



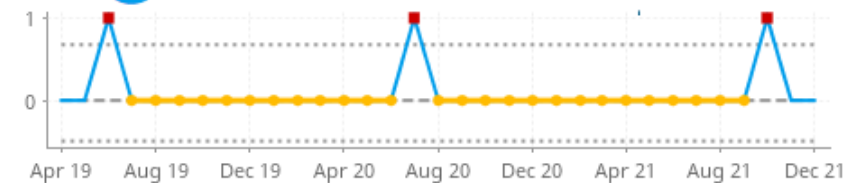
Red Risks Month Performance Standard

✓ Dec-21 4 4



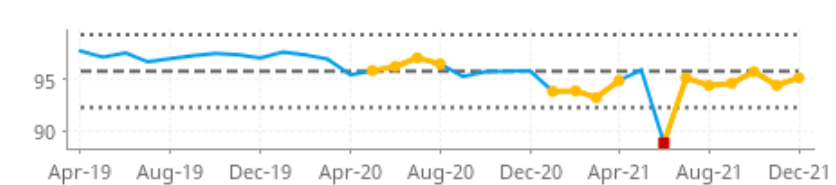
Never Events Month Performance Standard

✓ Dec-21 0 0

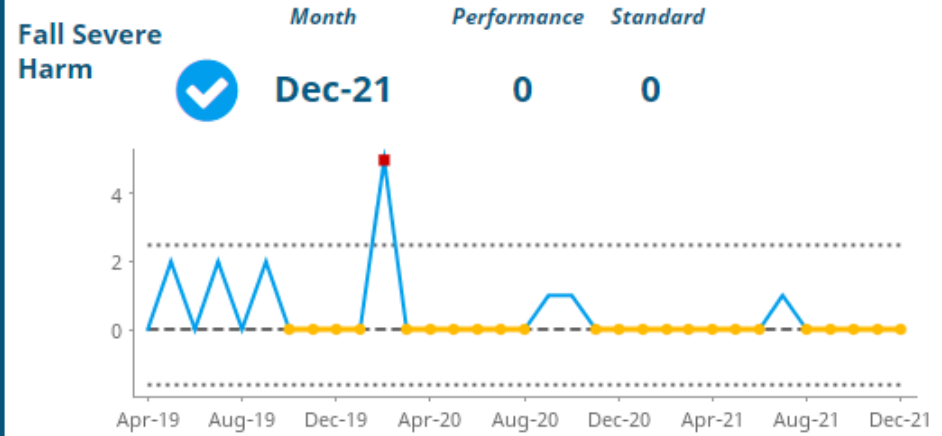
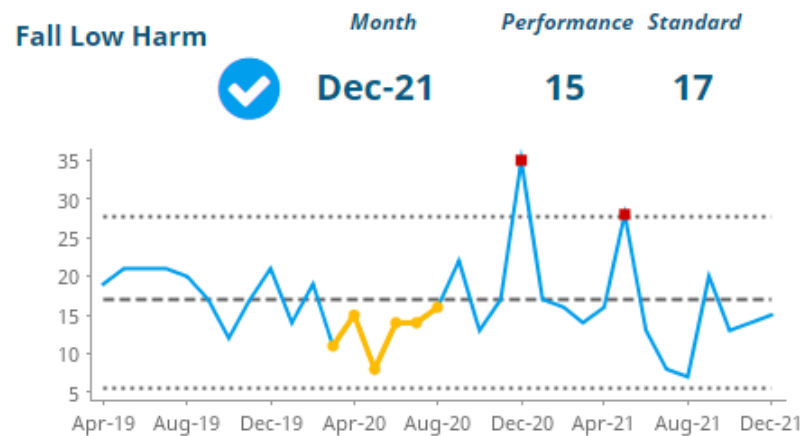
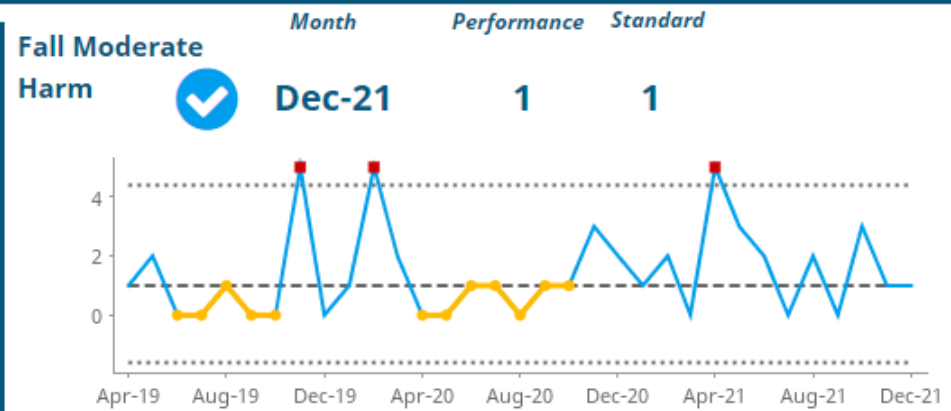
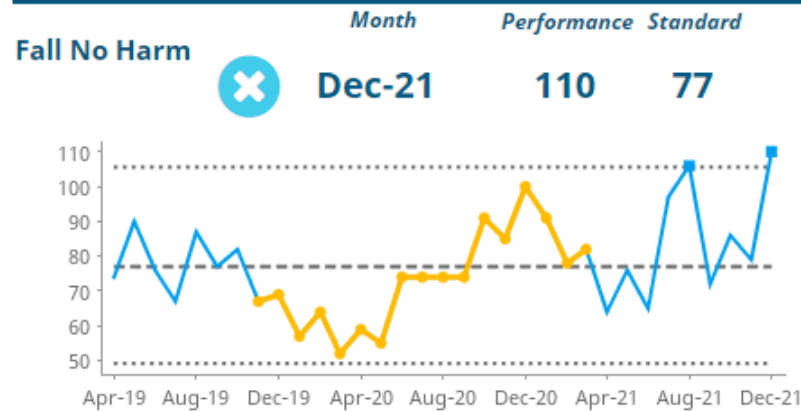


VTE % Month Performance Standard

✓ Dec-21 95.16% 95.00%



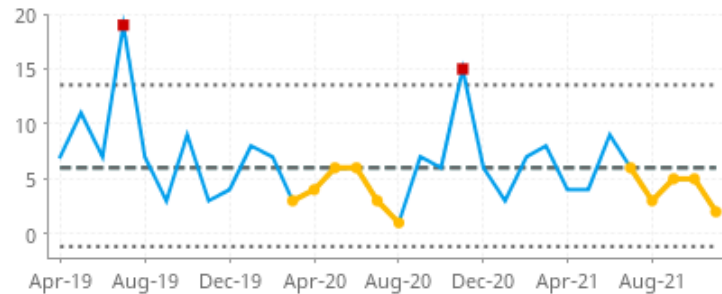
## Statistical Process Control (SPC) Charts



## Statistical Process Control (SPC) Charts

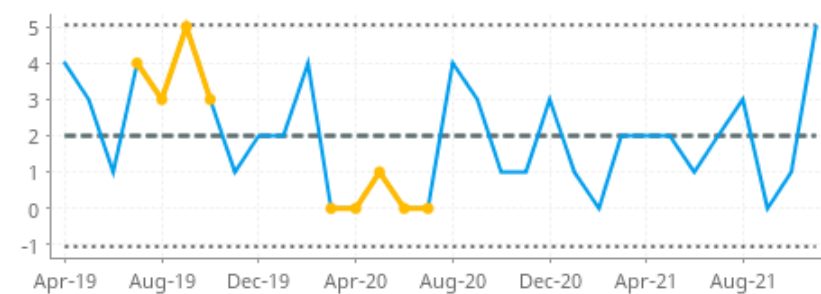
**Pressure Ulcer Cat 1**

Month	Performance	Standard
Nov-21	2	6



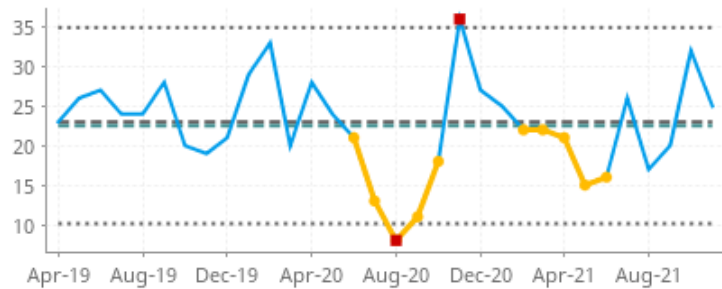
**Pressure Ulcer Cat 3**

Month	Performance	Standard
Nov-21	5	2



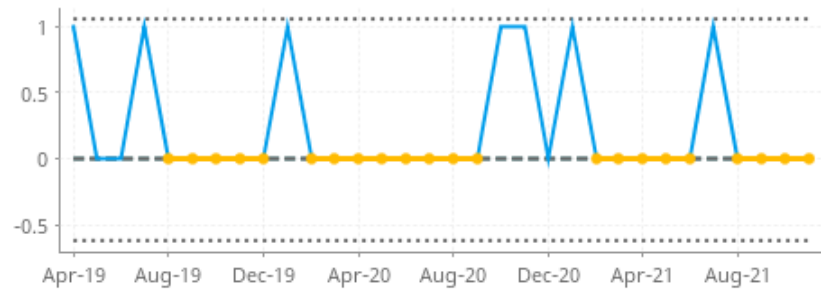
**Pressure Ulcer Cat 2**

Month	Performance	Standard
Nov-21	25	23



**Pressure Ulcer Cat 4**

Month	Performance	Standard
Nov-21	0	0



## Statistical Process Control (SPC) Charts

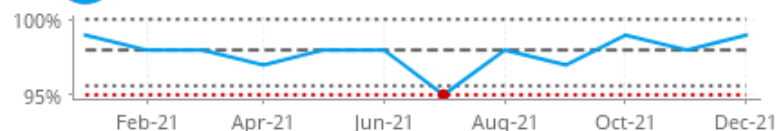
Hand Hygiene Month Performance Standard



Dec-21

99%

95%



Cdiff Month Performance Standard



Dec-21

7

6



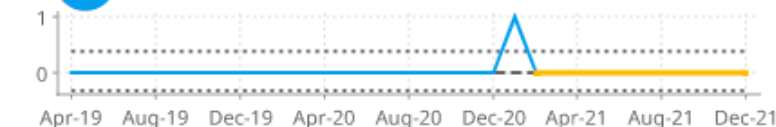
MRSA Month Performance Standard



Dec-21

0

0



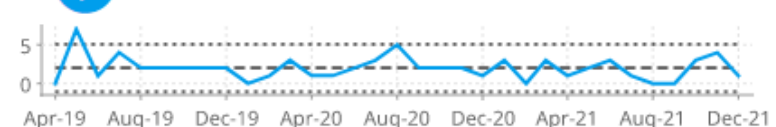
MSSA Month Performance Standard



Dec-21

1

2



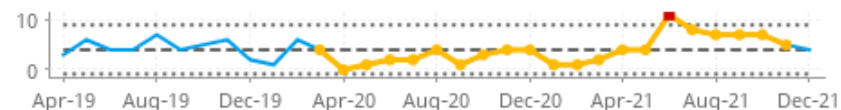
Ecoli Month Performance Standard



Dec-21

4

10



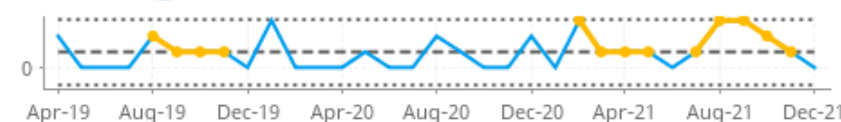
Klebsiella Month Performance Standard



Dec-21

0

2



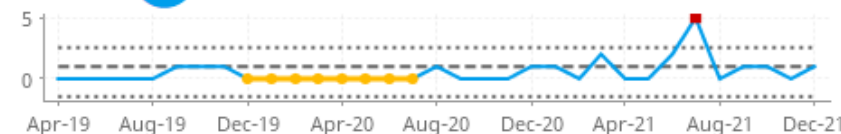
Pseudomonas Month Performance Standard



Dec-21

1

1



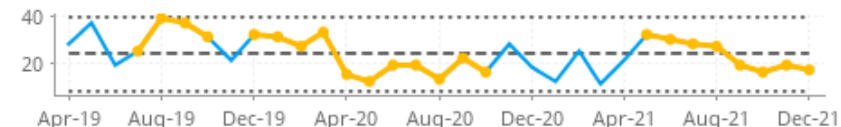
CAUTI Month Performance Standard



Dec-21

17

22



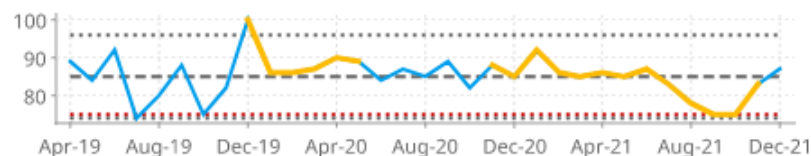
# Safety & Quality



## Statistical Process Control (SCP) Charts

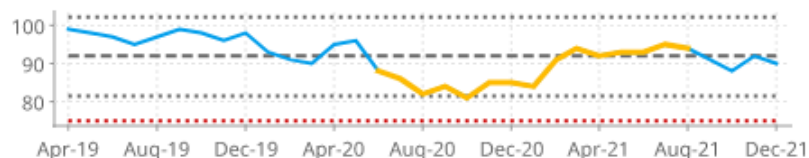
FFT Emergency Care

Month Performance Standard  
Dec-21 87.00% 75.00%



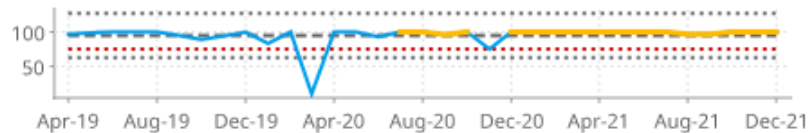
FFT Inpatient

Month Performance Standard  
Dec-21 90.00% 75.00%



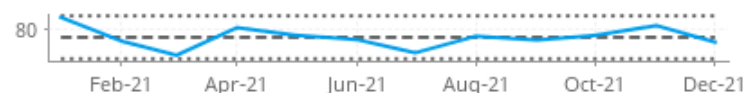
FFT Maternity

Month Performance Standard  
Dec-21 100.00% 75.00%



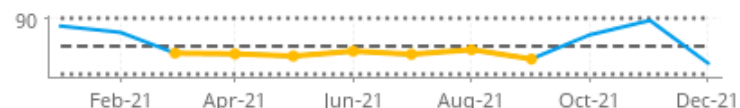
UNIFY RN Day

Month Performance Standard  
Dec-21 77.16%  $\geq 80\%$  and  $\leq 109.99\%$



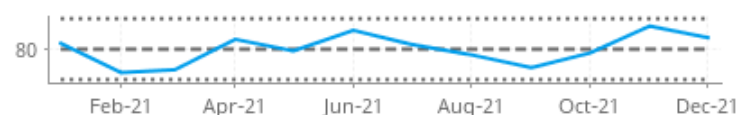
UNIFY RN Night

Month Performance Standard  
Dec-21 82.53%  $\geq 80\%$  and  $\leq 109.99\%$



UNIFY HCA Day

Month Performance Standard  
Dec-21 85.36%  $\geq 80\%$  and  $\leq 109.99\%$



UNIFY HCA Night

Month Performance Standard  
Dec-21 120.57%  $\geq 110\%$  and  $\leq 125.99\%$



# Workforce



North Tees and Hartlepool

NHS Foundation Trust

## Standard

## Standard Achieved

## Narrative

Month Performance Standard 2 Year Trend

### Sickness



### Appraisals



### Turnover



### Mandatory Training



The sickness absence rate for November 2021 is reported at 6.52%, a decrease of 0.14% compared to the previous month. This is broken down into 0.37% attributable to Covid-19 related sickness and 6.15% attributable to other sickness. The cost of sickness absence is reported as £576,134, an increase of £187,594 compared to October (£388,540). There were 262 cases of Covid-19 related staff absence in December 2021, broken down into 233 staff absent for 10 days and 29 who self-isolated for 14 days. Another 502 staff were absent for short periods while waiting for swab results.

'Anxiety/stress/depression' was the top sickness reason in November, accounting for 29% of all sickness absence during the month. The second highest reason was 'Other musculoskeletal problems' which accounted for 14% of sickness absence.

Other workforce metrics for December 2021 are:

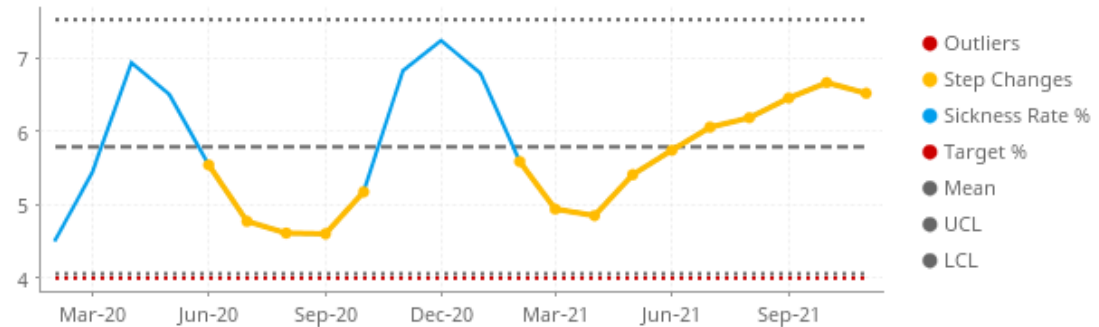
- Appraisal compliance reported as 84%, a decrease of 1% from the previous month
- Mandatory Training compliance reported as 87%, a decrease of 1% on the previous month
- Staff Turnover reported as 11.31%, an increase of 0.39% from the previous month



## Statistical Process Control (SPC) Charts

### Sickness

Month Performance Standard  
**Nov-21** **6.52%** **4.00%**



### Appraisal

Month Performance Standard  
**Dec-21** **85.21%** **95.00%**





## Statistical Process Control (SPC) Charts

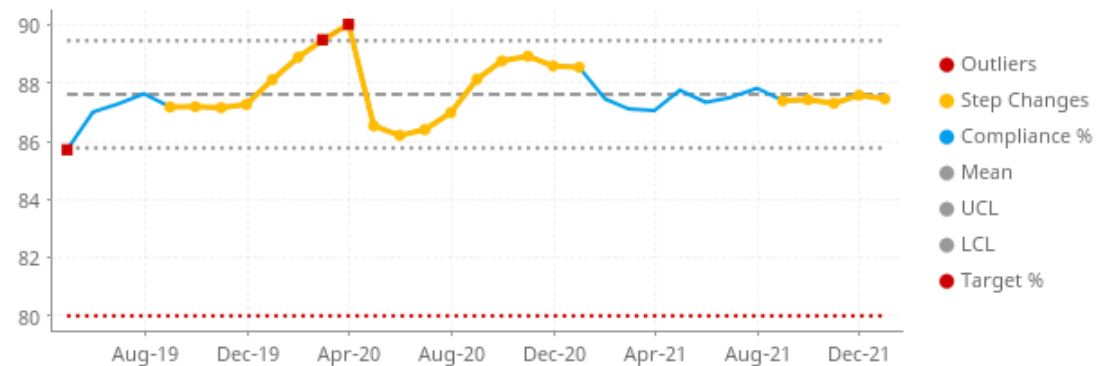
### Turnover

	Month	Performance	Standard
✗	Dec-21	11.31%	10.00%



### Mandatory Training

	Month	Performance	Standard
✓	Dec-21	87.47%	80.00%



# Finance



North Tees and Hartlepool  
NHS Foundation Trust



## Finance Overview - Month 9

	Plan (£000)	Actual (£000)	
<b>Income/Expenditure</b>			
<b>In Month</b>	<b>-961</b>	<b>316</b>	😊
<b>Year to Date</b>	<b>2,399</b>	<b>4,812</b>	😊

	£m
<b>Cash Actual</b>	<b>64.0</b>
<b>Cash Forecast*</b>	<b>64.1</b>

	Plan (£m)	Actual (£m)	
<b>Capital</b>			
<b>In Month</b>	<b>2.0</b>	<b>1.7</b>	😐
<b>Year to Date</b>	<b>9.9</b>	<b>9.1</b>	😐

<b>Use of Resources*</b>	
Capital Service Cover Rating	1
Liquidity Rating**	4
I & E Margin Rating	1
I & E Margin Distance from Plan	1
Agency Rating	1
Risk Rating After Overrides	3

\*UOR suspended in 2021-2022 - manual calculations

\*\* Rating will only improve with increased cash reserves



# Appendix 1

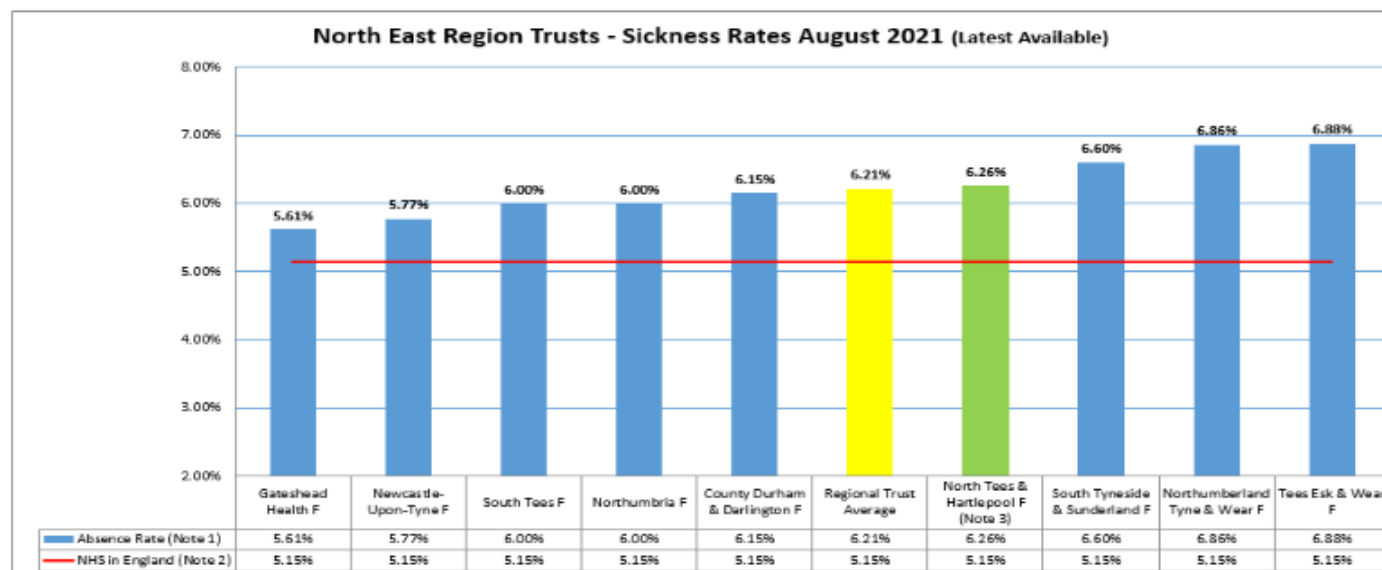
## RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
<b>RTT - November 21</b>										
Incomplete Pathways waiting <16 weeks	65.5%		85.7%	84.1%	61.6%	80.0%	70.8%	89.2%	66.4%	75.4%
Half of incomplete patients wait less than	12		7	7	13	8	10	8	11	8
Half of admitted patients wait less than	11		8	16	21	10	9	10	6	8
19 out of 20 admitted patients wait less than	67		40	38	91	48	68	39	67	56
Half of Non admitted Pathways waited less than	7		4	7	9	4	6	6	5	6
19 out of 20 non admitted patients wait less than	45		23	27	55	28	35	31	32	24
Incomplete Pathways waiting >52 weeks	8939		67	124	1366	27	4595	46	1769	945

Cancer Waiting times Summary	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals	94.35 (1320/1399)	82.16 (1027/1250)	76.17 (962/1263)	60.48 (1625/2687)	95.46 (1662/1741)	90.09 (1654/1836)	86.57 (1141/1318)	66.81 (1530/2290)	79.23 (1092/13784)
Breast Symptomatic Referrals	0 (0/0)	78.13 (75/96)	100 (11/11)	23.08 (24/104)	89.33 (134/150)	66.67 (4/6)	90.57 (240/266)	51.66 (116/225)	70.48 (604/867)
31 Day First Treatments	99.49 (194/196)	90.09 (101/111)	96.34 (158/164)	90.91 (450/495)	95.08 (167/174)	86.81 (204/235)	99.21 (126/127)	95.43 (188/197)	93.52 (1588/1698)
31 Day Subsequent Treatments - Drugs	100 (52/52)	100 (1/1)	100 (52/52)	97.84 (227/232)	100 (23/23)	98.65 (73/74)	100 (88/88)	100 (11/11)	98.95 (567/573)
31 Day Subsequent Treatments - Radiotherapy	0 (0/0)	0 (0/0)	0 (0/0)	98.5 (393/399)	0 (0/0)	93.69 (193/206)	100 (1/1)	0 (0/0)	96.86 (587/606)
31 Day Subsequent Treatments - Surgery	96.46 (21/22)	100 (13/13)	94.12 (32/34)	71.71 (109/152)	100 (7/7)	36.36 (4/11)	100 (12/12)	70 (21/30)	77.94 (219/281)
62 Day Target - 2WW	80.75 (86/106.5)	52.94 (40.5/76.5)	68.48 (63/92)	54.35 (103/189.5)	80.49 (99/123)	67.28 (109/162)	76.47 (52/68)	66.55 (92.5/139)	67.43 (645/956.5)
62 Day Target - Screening	100 (1/1)	83.33 (5/6)	93.82 (40/43)	82.36 (28/34)	100 (4/4)	66.66 (2.6/4.6)	92.84 (39.5/42.6)	0 (0/4)	86.33 (126/139)
62 Day Target - Upgrade	77.14 (27/35)	78.57 (11/14)	0 (0/1)	50 (11/22)	85.71 (12/14)	85.37 (17.5/20.5)	100 (8/8)	84 (10.5/12.5)	76.38 (97/127)
28 Day Target - 2WW	71.25 (100/140.5)	67.79 (78.5/115.8)	81.1 (96/118.5)	66.01 (143.5/217.4)	75.52 (134.5/178.1)	80.77 (121.4/158.3)	76.38 (88.3/115.6)	89.6 (178/199.0)	75.14 (940.5/1235.2)
28 Day Target - Breast Symptomatic	0 (0/0)	82.35 (84/102)	91.67 (11/12)	42.55 (40/94)	74.32 (138/183)	100 (7/7)	97.3 (252/259)	96.4 (214/222)	84.64 (744/879)
28 Day Target - Screening	50 (4/8)	33.33 (4/12)	64.42 (67/104)	80.12 (129/161)	66.07 (37/56)	22.22 (4/18)	85.02 (176/207)	57.14 (52/91)	71.99 (473/657)
28 Day Target - Overall	71.13 (100.5/141.3)	68.83 (87.3/127.2)	79.86 (103.9/130.1)	66.04 (160.4/242.9)	75.15 (151.8/202.0)	80.17 (122.5/152.8)	80.83 (131.1/162.2)	88.88 (204.7/230.3)	76.48 (106.22/138.88)

## Appendix 2

### Workforce



#### North East Region Trusts - Sickness Rates August 2021 (\*latest available)

The chart above shows the sickness absence figures for Acute and Mental Health Trust's in the North East region for August 2021.

North Tees and Hartlepool NHS Foundation Trust is represented by the green column. The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column.


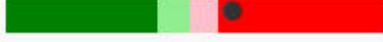








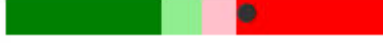


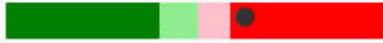








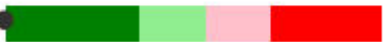











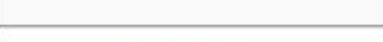













The red line is the average rate for the whole of the NHS in England (5.15%)

The sickness rate for North Tees and Hartlepool is 6.26%, just slightly higher than the Regional Trust (6.21%) average for this month.







































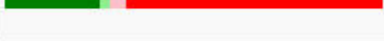











Gateshead Health NHS Foundation Trust report the lowest sickness absence rate for August 2021 at 5.61%.

Tees, Esk and Wear Valleys NHS Foundation Trust report the highest rate at 6.88%



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 2021)	ⓘ	9.50% <small>(Oct 2020 - Sep 2021)</small>	9.63% <small>(Sep 2020 - Aug 2021)</small>	-0.13 ↓ 	7.59%	7.71%		
	ⓘ	2.42% <small>(Oct 2020 - Sep 2021)</small>	2.49% <small>(Sep 2020 - Aug 2021)</small>	-0.07 ↓ 	2.28%	2.06%		
	ⓘ	5.30% <small>(Oct 2020 - Sep 2021)</small>	5.39% <small>(Sep 2020 - Aug 2021)</small>	-0.09 ↓ 	4.99%	4.41%		
	ⓘ	7.71% <small>(Oct 2020 - Sep 2021)</small>	7.78% <small>(Sep 2020 - Aug 2021)</small>	-0.07 ↓ 	7.24%	6.28%		
	ⓘ	10.67% <small>(Oct 2020 - Sep 2021)</small>	10.75% <small>(Sep 2020 - Aug 2021)</small>	-0.08 ↓ 	9.95%	8.51%		
Outpatient DNA rate (12 mth rolling) HES Outpatients (Dec 2021)	ⓘ	6.97% <small>(Nov 2020 - Oct 2021)</small>	6.92% <small>(Oct 2020 - Sep 2021)</small>	0.05 ↑ 	8.01%	7.33%		
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Dec 2021)	ⓘ	2.59 <small>(Nov 2020 - Oct 2021)</small>	2.60 <small>(Oct 2020 - Sep 2021)</small>	-0.01 ↓ 	2.35	2.22		
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Dec 2021)	ⓘ	0.00% <small>(Nov 2020 - Oct 2021)</small>	0.00% <small>(Oct 2020 - Sep 2021)</small>	No Change 	10.16%	9.84%		
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Jan 2021)	ⓘ	93.72% <small>(Nov 2020 - Oct 2021)</small>	93.79% <small>(Oct 2020 - Sep 2021)</small>	-0.07 ↓ 	78.34%	85.15%		
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Jan 2021)	ⓘ	96.61% <small>(Nov 2020 - Oct 2021)</small>	96.59% <small>(Oct 2020 - Sep 2021)</small>	0.02 ↑ 	94.55%	94.42%		
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Jan 2021)	ⓘ	72.96% <small>(Nov 2020 - Oct 2021)</small>	72.82% <small>(Oct 2020 - Sep 2021)</small>	0.14 ↑ 	72.63%	72.15%		
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Dec 2021)	ⓘ	74.75% <small>(Nov 2020 - Oct 2021)</small>	74.67% <small>(Oct 2020 - Sep 2021)</small>	0.08 ↑ 	69.25%	63.33%		
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Dec 2021)	ⓘ	87.95% <small>(Nov 2020 - Oct 2021)</small>	87.91% <small>(Oct 2020 - Sep 2021)</small>	0.04 ↑ 	85.55%	78.63%		
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Dec 2021)	ⓘ	87.56% <small>(Nov 2020 - Oct 2021)</small>	88.08% <small>(Oct 2020 - Sep 2021)</small>	-0.52 ↓ 	72.56%	61.34%		
Day case realisation rate (12 mth rolling) HES Inpatients (Dec 2021)	ⓘ	96.98% <small>(Nov 2020 - Oct 2021)</small>	96.99% <small>(Oct 2020 - Sep 2021)</small>	-0.01 ↓ 	95.99%	96.43%		
Day case rate (12 mth rolling) HES Inpatients (Dec 2021)	ⓘ	87.13% <small>(Nov 2020 - Oct 2021)</small>	87.14% <small>(Oct 2020 - Sep 2021)</small>	-0.01 ↓ 	85.14%	72.08%		



Average excess length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.12 (Nov 2020 - Oct 2021)	0.07 (Oct 2020 - Sep 2021)	0.05 ↑ 	0.34	0.41	
Average length of stay (12 mth rolling) HES Inpatients (Dec 2021)		3.27 (Nov 2020 - Oct 2021)	3.28 (Oct 2020 - Sep 2021)	-0.01 ↓ 	3.85	4.47	
Average elective length of stay (12 mth rolling) HES Inpatients (Dec 2021)		1.84 (Nov 2020 - Oct 2021)	1.84 (Oct 2020 - Sep 2021)	No Change 	3.47	4.42	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Dec 2021)		3.40 (Nov 2020 - Oct 2021)	3.41 (Oct 2020 - Sep 2021)	-0.01 ↓ 	3.90	4.47	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.20 (Nov 2020 - Oct 2021)	0.21 (Oct 2020 - Sep 2021)	-0.01 ↓ 	0.24	0.24	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.01 (Nov 2020 - Oct 2021)	0.01 (Oct 2020 - Sep 2021)	No Change 	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.35 (Nov 2020 - Oct 2021)	0.36 (Oct 2020 - Sep 2021)	-0.01 ↓ 	0.43	0.48	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.82 (Nov 2020 - Oct 2021)	0.85 (Oct 2020 - Sep 2021)	-0.03 ↓ 	0.95	0.92	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		0.18 (Nov 2020 - Oct 2021)	0.18 (Oct 2020 - Sep 2021)	No Change 	0.30	0.25	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2021)		1.27 (Nov 2020 - Oct 2021)	1.32 (Oct 2020 - Sep 2021)	-0.05 ↓ 	1.57	1.66	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Dec 2021)		36.44% (Nov 2020 - Oct 2021)	36.01% (Oct 2020 - Sep 2021)	0.43 ↑ 	38.09%	33.95%	
Elective stranded rate (12 mth rolling) HES Inpatients (Dec 2021)		5.07% (Nov 2020 - Oct 2021)	4.96% (Oct 2020 - Sep 2021)	0.11 ↑ 	12.00%	12.43%	
Emergency stranded rate (12 mth rolling) HES Inpatients (Dec 2021)		16.93% (Nov 2020 - Oct 2021)	17.01% (Oct 2020 - Sep 2021)	-0.08 ↓ 	18.06%	21.13%	
Elective super-stranded rate (12 mth rolling) HES Inpatients (Dec 2021)		0.43% (Nov 2020 - Oct 2021)	0.46% (Oct 2020 - Sep 2021)	-0.03 ↓ 	2.24%	3.18%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Dec 2021)		89.66% (Nov 2020 - Oct 2021)	92.65% (Oct 2020 - Sep 2021)	-2.99 ↓ 	74.26%	78.17%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Dec 2021)		0.17% (Nov 2020 - Oct 2021)	0.17% (Oct 2020 - Sep 2021)	No Change 	0.87%	0.96%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Dec 2021)		78.25 (Nov 2020 - Oct 2021)	78.14 (Oct 2020 - Sep 2021)	0.11 ↑ 	100.58	100.03	Low (>95%)

## Board of Directors

Title of report:	Elective Recovery Position										
Date:	27 January 2022										
Prepared by:	Eoin Carrol, 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 an update of the current elective recovery position within the Trust and ensure that the Board of Directors is aware of the arrangements that are in place to maximise elective capacity and provide support at a system level.										
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:											
<p>The Trust is delivering against the submitted activity plans in respect of trajectories for &gt;104 and &gt;52 week waits. There are clear plans for continuing to deliver the elective trajectories as well as providing some capacity and support to the wider system.</p> <p>There continue to be challenges in respect of increasing referrals and conversions and services monitor and respond to this on a weekly basis to ensure proactive planning of elective capacity and to ensure effective theatre utilisation.</p> <p>Key challenges for the Trust and wider system continue to relate to workforce with plans to address recruitment and retention challenges in place.</p>											
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	Operational Management Team Executive Management Team										
Recommendation	The Board of Directors is asked to note the content of this paper.										

# North Tees and Hartlepool NHS Foundation Trust

## Board of Directors

27 January 2022

### Elective Recovery Position

#### 1. Introduction

The purpose of this paper is to provide an overview of the current elective recovery position within the Trust and brief the Boards of Directors on the current arrangements that are in place to both maximise the Trust's elective capacity and to provide additional support for partners at a system level.

#### 2. Current Position

##### Current Inpatient waiting lists

Table 1 below summarises the organisation's current waiting position by subspecialty, the average number of patients per subspecialty list and the number of lists required to reduce all subspecialties towards a 40 week position. The 'To Come In' (TCI) position is included for reference.

This level of detail is monitored, reviewed and available on a weekly basis and future capacity and demand planning is continuously refined in response to the internal and regional waiting list position to ensure theatre capacity is well utilised to meet the needs of patients.

The Care Group's analysis of this information reflects both qualitative and quantitative data to predict the percentage split between day case and inpatient activity. This information is then used to ensure the most appropriate use of resources including theatre utilisation, bed occupancy and any requirements for additional activity. This approach is fluid in nature and allows the service to be responsive to the needs of the organisation in providing high quality and timely care.

##### Inpatient Waiting List

	>104 week waiters	>52 week waiters	>40 week waiters
General Surgery	0	12 (8TCI)	18 (5TCI)
Colorectal	0	2 (2TCI)	1
Breast	0	6	8 (1TCI)
Urology	0	8	24 (9TCI)
Gynae	0	4	9
Pain	0	5	2 (1TCI)
Lower Limb	0	7 (3TCI)	14 (1TCI)
Spinal	0	10	22 (1TCI)
Upper Limb	0	0	0
<b>Total</b>	<b>0</b>	<b>54</b>	<b>98</b>

Table 1 – Waiting list position by sub-specialty (as at 18 January 2022) with TCI numbers

The current referral rates and additions to list continue to demonstrate an upward trajectory of waiting list additions. It continues to be unclear whether this rise in referrals and conversions



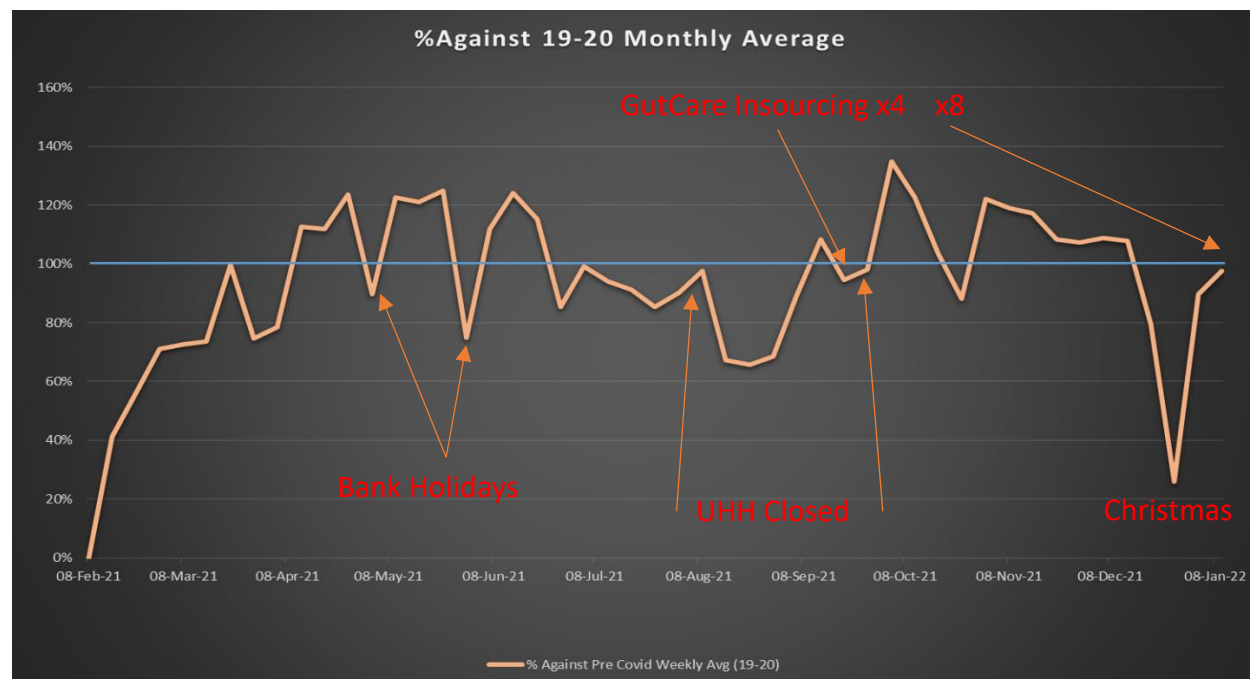
to list is due to delayed presentation by patients, in response to the pandemic, or whether this will be a sustained increase in referrals to services. Initial analysis by postcode and specialty has been undertaken in the Trust to review variation in referral patterns and support engagement with colleagues in primary care regarding future demand management and capacity planning.

As an example, three sub-specialties have seen a particular increase in both referrals and additions to lists. Some of the most recent figures are reflected below.

Gen Surgery – All	- Referral % Increase 48.4%
	- Additions % Increase 8.7% (Colorectal 20.89%)
Urology	- Referral % Increase 6.73%
	- Additions % Increase 19.53%
Orthopaedics - All	- Referral % Increase 19.76% (Spinal 49.47%)
	- Additions % Increase 8.93% (Lower Limb 12.55%)

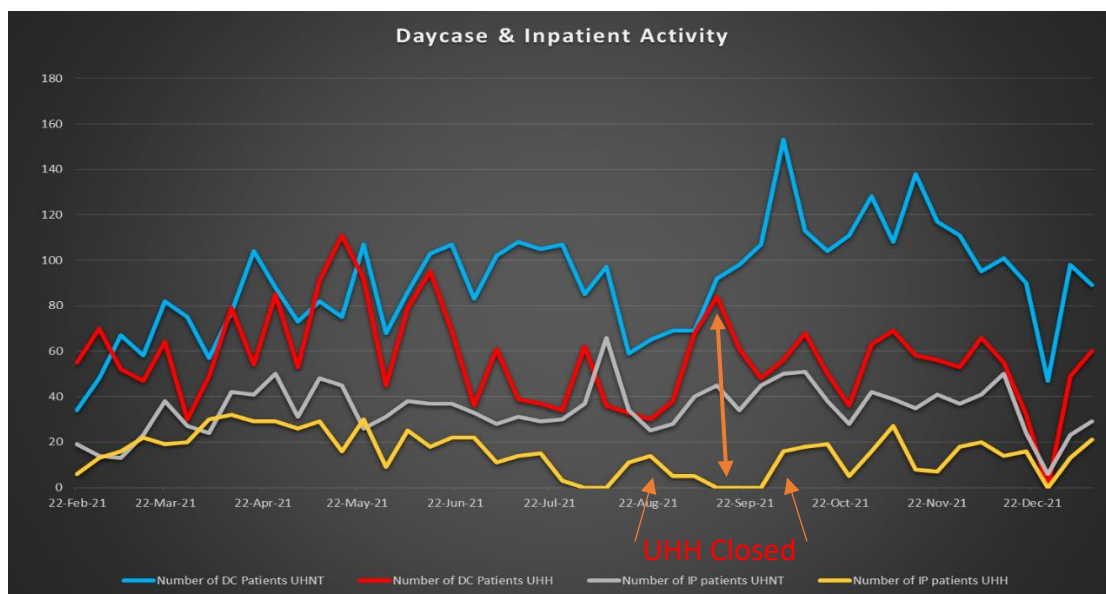
### Recovery progress

The graphs below demonstrate the Trust's positive recovery progress to date. Graph 1 below describes the elective recovery percentage compared with 2019/20 activity demonstrating repeated periods of combined elective activity over and above 2019/20 average activity levels. The data demonstrates the planned reduction in elective capacity over the festive period; the impact of patient cancellations and the planned theatre closure programme for capital works including the development of an integrated theatre. These levels of activity have led to the Trust being one of top three highest performing Trust in the region in terms of elective recovery.



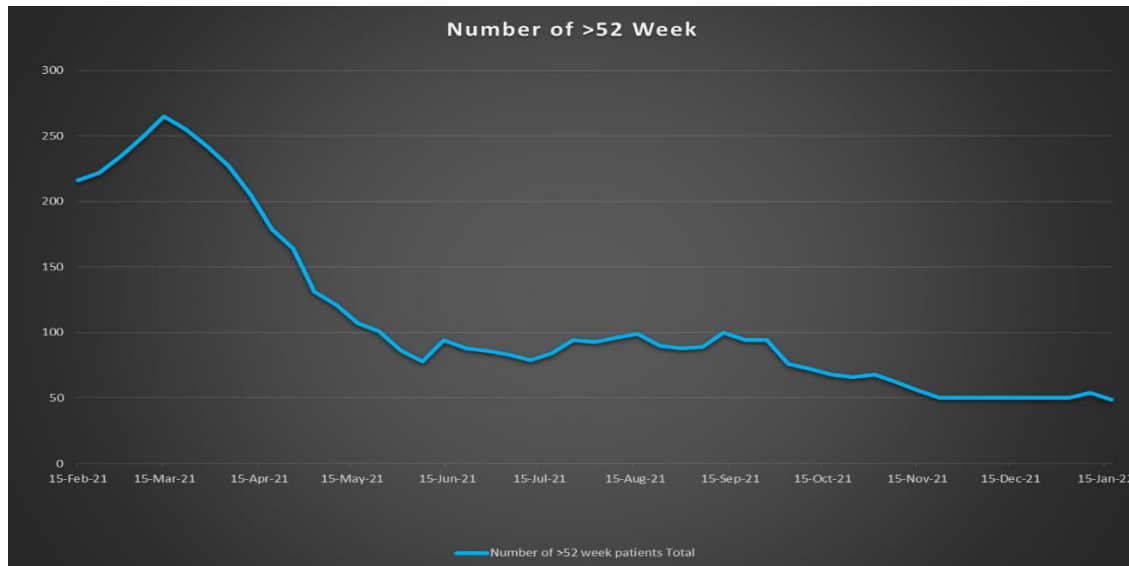
Graph 1 - Percentage elective activity 20/21 compared with 19/20 baseline average activity

Graph 2 below illustrates the relationship between day case and inpatient activity. Of key significance is the correlation between the two points of delivery when either one is negatively impacted by wider Trust pressures; i.e. when the temporary reduction of activity at University Hospital Hartlepool has occurred reducing inpatient activity, there has been a corresponding increase in daycase activity which demonstrates a fluid and responsive approach to the management of the theatre lists.



Graph 2 – Comparison of day case and inpatient activity

Graph 3 below shows the continuing downward trend of >52 week waits from a position of circa 260 in March 2021 down to the current position, as of 18 Jan. 2022, of 54 >52 week waits within Collaborative Care, 13 of whom already have a TCI date. It is the aim of the Care Group to ensure the continued significant reduction of >52 week waiters before the end of the current financial year in line with the trajectories developed through annual planning and internal elective recovery programme. The Care Group will also continue to drive towards to the internal stretch target of 40 weeks and under for some subspecialties.



Graph 3 – Actual >52 week wait position Jan 2022

### 3. Current Activity Plans

#### Planned in-week activity

The delivery of the routine theatre capacity is progressing well as is evident within the Integrated Performance Report and regional recovery data. However, there remain ongoing challenges within the Trust and across the region. Staff sickness absence continues to place significant pressures on the ability to plan and deliver against the activity plans. An added

complexity for the staffing resource is the sub specialisation of the operating teams which requires the right skill mix of clinicians to optimise outcomes and ensure consistent delivery of the available capacity.

Emergency and trauma activity always takes clinical priority over the elective priority 4 long waiters. However, the structure of the emergency and trauma theatre capacity provides sub specialised planned urgent theatre sessions, enabling unplanned activity to be managed with minimal negative impact on the elective programme. This approach to predicting emergency and trauma activity is well established in the Trust and supports minimal late cancellation of planned activity.

During winter, the Care Group has a long standing and effective approach to managing capacity and demand during times of sustained pressure whereby the case mix of planned surgery is flexed for the month of January to reduce the elective inpatient activity on the UHNT site and increase UHH activity wherever possible across both inpatient and day cases.

### **Additional Waiting List Initiatives (WLI)**

Pre-covid the Trust had a very low requirement for waiting list initiative work or the use of the independent sector. However, as a consequence of the pandemic there has been an increase in patients waiting over 52 weeks and therefore WLI and independent sector support has been utilised in the short / medium term. When WLI's were initially introduced there was minimal uptake from the workforce but interest improved with WLI's planned for the majority of weekends for the remainder of this financial year. The focus of these lists will primarily be at UHH and will focus on Lower Limb, Spinal, Gynaecology, General Surgery and Breast work.

### **Theatre Team Insourcing – GutCare**

In addition to introducing WLI using the internal workforce the Care Group has supported the insourcing of an external theatre insourcing company. This has utilised the national Elective Recovery Fund and initially delivered 4 additional weekend lists per week. The surgery and anaesthetic provision is provided by the Trust's consultant body with the nursing theatre provision being provided by the insourcing team. The provision started in mid-September delivering two lists initially but then quickly increased to 4 weekly lists. Since Jan 8<sup>th</sup> the use of GutCare has again increased to include 4 more full day lists, 2 additional in week lists on the UHNTs site and introducing 2 additional in week lists on the UHH site. The additional UHNTs lists will continue to support colorectal, general surgery, urology and gynaecology long waiters whilst the UHH lists will focus on orthopaedic and spinal long waiters. The current plan is to continue the utilisation of this GutCare model until the end of this financial year.

Utilising this approach there has been a positive impact on the backlog of 62 day colorectal cancer patients and urology cases. It has delivered 114 patients to date, made up of cancer patients and long waiters. This has had a significant impact on the waiting lists, particularly within general surgery and colorectal recovery. There continues to be the ability to alter the skill mix of the insourcing teams to ensure the service is targeting the longest waits within each subspecialty thus ensuring parity in the overall reduction of all waiting lists. It is projected that by the end of financial year there is the ability to deliver 96 more lists (excluding WLIs) which will further improve the Trust >40 week wait position.

### **Capacity versus Demand - Intelligent Forecasting**

The ability to forecast demand and being able to respond flexibly is the key to sustained improvement. The Care Group works in partnership with the Business Intelligence (BI) team to develop dashboards using the BI tool, YellowFin, to provide the Care Group with live data relating to the weekly RTT position, additions to list and theatre throughput. Whilst some of

this work is still in the development stage, significant progress has been made with 'additions to list' having just been added to YellowFin. This enables the service to be responsive to the changing demands of the local population. The BI Team will also support a review of the waiting lists to fully understand any peaks or troughs in activity, allowing the service to flex resources accordingly.

### **Independent Sector (IS)**

As noted above, the Trust continues to maximise the utilisation of any additional independent capacity made available through the ICP commissioning functions. Each month the waiting lists are reviewed in line with a rigid inclusion/exclusion criteria and all appropriate patients are transferred to the Nuffield, Stockton. In recent months the Trust has seen a reduction in the number of appropriate patients identified due to the general reduction in this type of patient but the Care Group will continue to maximise this capacity wherever possible. The situation with the IS will continue to be closely monitored given the potential nationally to request the IS to revert back to the national contract if required to ensure clinical prioritisation of cases in extremis.

## **4. System Recovery**

Although the Trust is cognisant of internal elective recovery challenges, it recognises that historic performance places the Trust in a comparatively stronger position compared to other providers across the ICS. The Trust wishes to continue supporting a levelling up of service provision, whilst not allowing an unacceptable deterioration of the waiting times for the Trust's own catchment population. Work continues with colleagues at South Tees FT in particular to support wider system recovery.

Two key work streams currently under development are spinal pathways and the foot and ankle pathway. The plan is for long waiters (>104 week) from across the system to be seen and treated on both the UHNT and UHH sites. Funding for these initiatives has been supported through the Targeted Investment Fund (TIF). The funding is limited to this financial year, which also causes challenges in terms of sustainability of workforce provision to improve the waiting times at system level beyond 31<sup>st</sup> March 2022. The Spinal work consists of both local anaesthetic and general anaesthetic lists, the local anaesthetic lists have already commenced with the first general anaesthetic list due to take place Thursday 20<sup>th</sup> January 2022. As part of this development there has been investment in a spinal microscope ensuring a system approach to the management of patient waiting lists.

With regards to the foot and ankle pathway there has been some workforce challenges outside of the Trust's control as this pathway was being supported by an external insourcing company, however there are now plans in place to complete the same amount of lists originally planned but within a shorter time period. These lists will take place during Feb and March 2022.

## **5. Challenges and Risks**

Workforce remains the most significant challenge for providers, this has been significantly impacted further by the latest Covid19 variant. Regardless of this the Care Group remains determined to proactively tackle this both in the short and long term. In the short term there are currently additional overtime shifts offered to help bridge the gap however the Care Group is mindful of the impact on staff health and wellbeing and wishes to minimise the additional duties undertaken by the core team.

In addition to the insourcing arrangements described above the Care Group is currently exploring additional options in an effort to secure additional workforce to support both the

delivery of internal and system demand with the support of the TIF bids. This includes alignment with the Trust's overseas recruitment plans, internal training schemes and close alignment with University colleagues to review local work force development and training plans.

Sustainable growth, taking into account the increase in referrals and the additions to the waiting list is key to the continued success of the Trust in delivering the waiting time standards and continuing to support the wider system. Plans have been submitted to support this approach both internally and as a system response.

The Trust will undoubtedly face other challenges in the coming months including the impact of winter and potential surges in emergency and trauma demand but, as already highlighted, the Care Group has clear plans to minimise and mitigate this impact.

## **6. Conclusion**

The Trust remains in a strong position in terms of elective recovery and has clear plans to continue to deliver as far as possible on the elective recovery trajectories. There are opportunities to support both the internal waiting lists as well as supporting the wider system recovery by ensuring the system 'levels up' through collaborative capacity and demand planning, forecasting, managing combined waiting lists and clinical pathways.

Based on the revised current trajectories the Collaborative Care Group remains confident that the Trusts >52 week wait position will continue to improve and is working tirelessly towards the target of 0 >52 week wait as well as significantly reducing the >40 week wait position in line with internal plans and acting as a system enabler to address >52 week waits across the ICP.

**Levi Buckley**  
**Chief Operating Officer**

# North Tees and Hartlepool NHS Foundation Trust

## Board of Directors

Title	Vaccination as a Condition of Employment (VCOD)										
Date	27 January 2022										
Prepared by	Natalie McMillan, Strategic Lead for Workforce Tracy Squires, Deputy Chief People Officer										
Executive Sponsor	Levi Buckley, Chief Operating Officer										
Purpose of the report	The purpose of this paper is to provide an overview of VCOD phase two guidance and actions in progress to deliver the new regulations by 1 April 2022.										
Action required	Approve		Assurance	x	Discuss		Information				
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		Effective		Responsive		Well Led		x
Executive Summary and the key issues for consideration/decision											
<p>The key message for the Board is that vaccination as a condition of employment is now legislation and the Trust must comply. The latest guidance relates to implementing and complying with the VCOD Regulations and conducting formal processes for staff who will be unvaccinated on 31 March 2022. The Trust response, in terms of key employment-related aspects of the regulations, have already been developed and implemented to ensure compliance with VCOD by 1 April 2022.</p> <p><b>Current staff</b></p> <p>The Executive team have agreed (18 January 2022) VCOD Regulations will apply to all roles in the Trust and LLP. The regulations refer to staff 'in scope' as undertaking a CQC-regulated activity. This paper provides an update on how many staff are identified as declining to be vaccinated or where there is no current record and, therefore, quantifies the potential risk to the Trust in terms of staff who could be impacted by VCOD.</p> <p>The criteria regarding all roles being in scope, which could be categorised as out of scope if strictly in line with the legislation, will require a process for consideration of any such challenges raised by staff. This is addressed later in the paper in relation to review by an independent job scope panel.</p> <p>As all roles are in scope redeployment will not be a feature although a process is being developed to manage redeployment for those with medical exemptions. For staff with medical exemptions there is no requirement for redeployment but risk assessments will be a mandatory requirement for an individual to continue in a clinical role if clinically exempt.</p> <p>The Board are asked to note that further guidance may follow regarding the mandating of boosters but currently this applies to the two vaccinations.</p> <p><b>Recruiting new staff</b></p> <p>As it has been agreed VCOD will apply to all roles in the Trust all recruitment and pre-employment processes have already been reviewed. The work undertaken to date includes a new pre-employment declaration regarding vaccination status which will be used as part of the recruitment process. A process to establish an independent panel to approve any requests for roles to be categorised as out of scope to ensure consistency and parity alongside an audit trail.</p>											

**Key risks and actions**

The current focus for Workforce and senior operational management leads is those staff who have declared they will not take up the vaccination, require their first dose or second dose of vaccination and those where there is no record of vaccination.

Communication to staff has happened last week on 21 January, to explain the impact of not being vaccinated has been identified as a key priority to reinforce the regulations will be fully enforced by the Trust, it is a Government requirement and legal mandate, with support offered to those remaining unvaccinated to ensure they are fully aware of the reality that effective 31 March 2022 their employment could, within the law, be terminated.

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

The mandatory vaccination of all health and social care workers undertaking CQC regulated activities in England is a high priority and legal requirement which could impact on availability of resources and delivery of service to patients.

This could pose a risk to our ability to recruit and retain the workforce if other Trusts take a different approach in terms of the inclusion of roles in scope.

There are potential risks in employment law specifically claims of unfair dismissal although a robust process and evidence-based audit trail of actions will mitigate as far as is reasonably possible.

Committees/groups where this item has been discussed	Previous papers at ETM Clinical Decision Group
Recommendation	Board are asked to NOTE the decisions made at ETM: <ol style="list-style-type: none"><li>1. Staff who challenge 'in scope' of their role will be given every opportunity to state their position with an independent job scope panel to apply consistent principles for decision-making with consistent panel membership.</li><li>2. Note the comprehensive HR guidance and processes being developed and introduced to manage the introduction of VCOD both for employees and managers.</li><li>3. The final numbers of staff who are at risk of being dismissed will not be known until 4 February 2022.</li></ol>
Next steps for presentation e.g. Board Committee/Board meeting	People Committee February 2022.

## **Board of Directors**

### **Vaccination as a Condition of Deployment (VCOD)**

**27 January 2022**

#### **Introduction**

The purpose of this paper is to inform the Board of the work that is on-going regarding vaccination as a condition of deployment for healthcare workers (VCOD).

Phase two national guidance was issued on 14 January 2022. This confirmed the inclusion of front-line staff as well as non-clinical workers not directly involved in patient care but who may have face-to-face contact with patients, including ancillary staff such as porters, cleaners or receptionists. Phase two guidance is to support service providers with implementing and complying with the regulations and conducting formal processes for staff who will be unvaccinated on 1 April 2022. The guidance was referenced at ETM on 18 January to inform discussions relating to decisions for roles in scope and in considering the approach to the employment position for staff whose role is in scope and who remain unvaccinated.

The Board are asked to note that the regulations and the associated Workforce process and procedure decisions are moving apace given the timeline for the regulations to become law effective 1 April 2022. There is significant investment of time in joining local, regional and national VCOD HR calls to be able to engage, and inform the conversation, but it is highlighted that there are a variety of approaches being taken by Trusts to many aspects of the guidance. For example, some Trusts are strictly following the guidance and including those roles determined to be in scope by the regulations (some still trying to make the final determinations), others are including all in scope (noting the potential risks this presents) and others are allowing service managers to make decisions about those in scope or not in their respective areas. It is entirely possible there are other, alternative, approaches.

It is clear, whatever approach is taken, that there is some uncertainty about being outside of the regulations (related to whatever aspect of the guidance) and concerns about the potential, resulting scenario of unfair dismissal cases. The Trust must ensure it meets at least the minimum requirements of the regulations and provides every opportunity for those who have declared they will not take up the vaccination and where there is no record of vaccination to be afforded every opportunity to explore their situation in relation to determination of their role being in scope and, importantly, whether they as an individual have agreed exemption status.

#### **Background**

It has been determined all roles will be in scope unless the post holder has an exemption or a particular role is deemed to be out of scope and is, therefore, an 'exception'; it is expected that this will be the exception rather than the norm. Roles deemed to be an 'exception' are further expected to be reduced in terms of potential numbers in view of the Agenda for Change job evaluation assessment which requires a minimum score of one in relation to patient contact. The application of this to the LLP has been agreed to be aligned with the Trust and offer of support for Workforce to liaise with LLP HR Team to give visibility of agreed approach and process.

It should be acknowledged that there is the potential for staff to challenge a particular role as being in scope. The Trust will need to evidence that it has taken all such cases (as raised) into account and responded in a considered, fair and equitable manner. There is, and will



continue to be, a high priority focus on the recording of all individual informal and formal discussions that take place to provide evidence-based rationale as well as mitigation of risk around any potential, future legal challenge a role is not in scope in line with the regulations.

There has been a suggestion (this does not relate to staff-side) that for those staff who feel 'forced' to be vaccinated it could lead to a breakdown in the 'psychological contract' with the Trust as their employer. This to be considered, and the potential for the wider impact of this, to communicate and engage with affected staff now and beyond any vaccinated date; at least for a period of time to continue to acknowledge where cases of specific note are recognised.

## VCOD HR Process

It is highlighted that the process which is required by the Trust applies wholly to those currently unvaccinated and/or whose vaccination status is not known and recorded which purports to a minority of Trust staff. In this case, it is important to keep perspective noting that the overwhelming majority of staff received first and second doses in phase one of the vaccination hub campaign and by the end of 2021.

In relation to the regulations, the following key pieces of work are on-going:

- Clear communications regarding the VCOD regulations and the potential impact on individuals via general communications and individual correspondence.
- Validation exercise to analyse discrepancies between staff who have their vaccination recorded and those who have been vaccinated but details not recorded on ESR.
- Weekly meetings in place including with the COO and Strategic Workforce Lead to ensure continued high focus on data, reporting and validation to inform the process.
- Accessing NIVS to evidence vaccinations staff who advised us they were vaccinated.

Process review timelines, currently planned (subject to change as the process progresses) are detailed for reference below and to provide assurance that a robust plan and actions are in place to manage this HR process.

Date	Activity	Comment
31 January	1 <sup>st</sup> Formal Review Meetings	First meeting to take place with staff who have declared they will not take up the vaccination or where there is no vaccination record (and to identify potential exemptions)
1-2 February	1 <sup>st</sup> Formal Review Meeting (additional window of opportunity)	Meetings beyond this date will be out of time for staff to receive a first dose by 3 February
3 February	First dose	Final date for staff to ensure full vaccination
4 February onwards	2 <sup>nd</sup> Formal Review Meeting	Second meeting to take place from this date, Workforce representative attends, could include notice of dismissal
31 March	Dismissal on notice (in accordance with contractual notice)	Note (in accordance with contractual notice): <ul style="list-style-type: none"> <li>• Subject to notice period start date</li> <li>• Subject to notice period/PILON clause</li> <li>• Subject to notice period end date</li> </ul>
31 March	Dismissal date	Notice must not expire before 31 March

1 April	VCOD for Healthcare Workers	Regulations come into force legally
1 April onwards	Notice periods	<ul style="list-style-type: none"> <li>• Notice period continuing beyond 1 April (due to contractual notice)</li> <li>• Staff cannot continue in role, placed on paid leave until employment end date.</li> </ul>
	Dismissal appeals	

The additional points are noted as important for visibility:

- a record is being maintained of first and second formal meetings
- there is a further analysis of staff identified (who have declared they will not take up the vaccination and where there is no record of vaccination) to be invited to the first formal meeting by 31 January
- the contractual notice period will, for some staff, dictate the earliest date where notice can be given such that no effective contractual end date falls before 31 March
- if notice period is 60 days or more it is recognised that, whatever date notice is issued the applicable period will extend by 1 April 2022. In this case the Trust will be required to make all contractual payments up to and including the end date.

The Trust has determined that an independent job scope panel will consider roles deemed by an individual staff member to be out of scope. It is critical that the approach to the independent job scope panel provides a level of consistency (in approach and panel member continuity) as well as clear criteria, points of principles and assessment to inform a decision that can be substantiated both in terms of compliance and in defence should a subsequent claim arise.

In addition to the implications of the regulations on current staff, Workforce has reviewed all aspects in relation to recruitment including offers already made to planned new starters and individuals engaged in a recruitment process. This is as a priority to affect changes required both for employment offers made and for decisions in relation to recruitment offers either in progress or pending. Workforce are already in discussion with individuals (referred to above) to start the conversation regarding VCOD and to determine current vaccination status.

In addition to the above there are a number of additional exemptions to note:

- pregnant workers are exempt but they must be fully vaccinated within 16 weeks of birth
- staff who have been advised, on medical grounds, not to have the vaccines (this will become a matter for evidence of exemption on medical grounds)
- 

HR, specifically workforce business managers, continue to provide advice and support to managers to understand what on-going support is required during this process. It is recognised managers are being asked to conduct what could present as difficult, personal and sensitive conversations in order to enable staff to fully understand their employment position if they do not comply with the regulations. Whilst only attributable to a small number of cases, emotions can run high leading to difficult and uncomfortable positions including abuse.

## **VCOD Staff Communication and Engagement**

High levels of staff communication continues, including in relation to phase two guidance, to ensure full awareness of the requirements and implications on the individual. It is important the Trust is able to demonstrate the availability of information in relation to the regulations and the implications to every individual who have declared they will not take up the vaccination and where there is no record of vaccination. In addition individuals who have declared they

will not take up the vaccination have, in the majority of cases (if not all) have already had one or more informal discussions with their line managers and/or workforce business managers to engage, since first phase guidance, in informal discussions regarding vaccinations. The guidance refers to informal and formal reviews; the Trust is now in the formal review stage.

It is recognised the messaging now is, primarily, for staff who have declared they will not take up the vaccination and where there is no record of vaccination (or an individual has chosen not to disclose their vaccination status) and it needs to be 'directed accordingly'. It is also important to recognise the engagement and support to date from staff in taking steps for the protection of their own health and those of patients in receiving first and second doses of a Medicines and Healthcare products Regulatory Agency (MHRA) approved COVID-19 vaccine. This is subject to exemptions and conditions. It should be acknowledged that 95% of Trust staff received their first and second dose vaccinations before the end of 2021.

On 21 January a Trust-wide communication was circulated. Staff-side feedback noted the urgency for staff who have declared they will not take up the vaccination and where there is no record of vaccination to be made fully aware of the regulations and that these will be enforced as law. It was discussed that there could be a level of apathy from some of those remaining unvaccinated on the basis they do not believe the Trust will affect the regulations thereby not acknowledge or accepting the result will be dismissal from employment.

## **Risks**

To date there are 74 members of staff who have declined the vaccination and they are across a range of job roles with an assessment demonstrating that these posts would be categorised as 'in scope'. There would be a risk of employment litigation for any employee who believes their role is not in scope and have been unfairly dismissed. The proposal to establish an independent panel to assess any roles that are considered to be out of scope would mitigate this risk to a point with an audit trail demonstrating an objective decision-making process and parity across the Trust in their position and stance. Furthermore, the risk can be quantified further as an analysis of the 74 roles finds that there is the potential for just seven of these roles to be challenged as 'out of scope' which is a minimal risk given the size of our workforce and the mitigation in place to enable an independent panel.

There is the very real risk that there are staff who haven't taken up the vaccine but are not declining it will not have had both vaccinations before the deadline. This risk is being mitigated and addressed by the mobilisation of additional clinics which need to be targeted including shift handover times, different locations to ensure that the Trust is doing everything possible to enable staff to access and receive their vaccination. This group of staff are being monitored and discussions ongoing to ensure that they book an appointment and receive.

The Trust could be an outlier in the region. In view of the timing of receipt of phase two guidance, and the urgency to proceed in making determinations about policy and process, it has not been possible to determine formally what approach other Trusts are taking in terms of scope. It has been acknowledged on a range of regional calls that there could be a wide variety of different approaches taken not only in relation to scope of roles but also redeployment or 'alternative' treatment for staff who choose not to be vaccinated. However, this risk is minimal given that many staff are in scope and won't be able to secure employment in the same role elsewhere in the NHS. As stated above, mitigation is in place to manage the risk around employment tribunals. In respect to reputational risk, it could be the case that taking a firm stance on this is viewed positively especially by our patients and community around expectations to protect them.

The potential risk of disability discrimination claims has been discussed in regional VCOD HR calls. The guidance provides this should not be a considerable risk, however, notwithstanding this there is a further analysis of staff who have declared they will not take up the vaccination and where there is no record of vaccination to understand the extent of those in special protected characteristic groups.

Furthermore, in light of the lower uptake of vaccination in certain groups such as BAME colleagues it could be argued this is not supporting our strategic aims of inclusivity and reducing health inequalities. However, this needs to be balanced with our duty of care to our patients and we must demonstrate that we have proactively engaged with all our staff and made every reasonable attempt to encourage and enable their vaccination.

## **Recommendations**

The Board is asked to note:

1. The progress that has been across the Trust to respond to the legislation and the decision taken at ETM on 18<sup>th</sup> January to take a Trust approach of 'exception' and work on the basis all roles are in scope
2. To note that the risks exist around unfair dismissal but these are minimal in reality with a very small number of unvaccinated staff in roles that might be argued as being 'out of scope'.
3. To note and support the targeted approach to improve the vaccination uptake to minimise the risk of staff who want the vaccinations missing the deadline of 3<sup>rd</sup> February for their first vaccination.

## **Appendices**

1. *C1545 Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers 14 November 2021*

## Board of Directors

Title of report:	Learning from Deaths Report, Quarter 3, 2021-22										
Date:	27 <sup>th</sup> January 2022										
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:											
<ol style="list-style-type: none"> <li>1. The Trust HSMR value has decreased slightly to <b>91.19</b> (November 2020 – October 2021), the latest SHMI value is now this has decreased slightly to <b>99.16</b> (August 2020 to July 2021). Both statistics remain “within expected” ranges.</li> <li>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.</li> <li>3. During quarter 3, 99% of all deaths within the scope of the policy have been scrutinised or reviewed.</li> <li>4. There is summary information in the report relating to actions initiated as a result of learning from deaths in patients in relation to the Deteriorating Patient, surgical reviews, Community services and the Medical Examiners team.</li> <li>5. During 2021-22, to the end of quarter 3, there have been three mortality cases reported and investigated as serious incidents, two of these are also be going through Coronal processes.</li> </ol>											
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	<ul style="list-style-type: none"> <li>• Trust Outcome Performance, Delivery and Operational Group</li> <li>• Patient Safety &amp; Quality Standard Committee</li> <li>• Clinical Quality Review Group (following Board presentation)</li> </ul>										
Recommendation	<ol style="list-style-type: none"> <li>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 in order to maintain the reduction in the Trusts mortality rates.</li> <li>2. The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation.</li> <li>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.</li> </ol>										

# **North Tees and Hartlepool NHS Foundation Trust**

## **Meeting of the Board of Directors**

**27<sup>th</sup> January 2022**

### **Learning from Deaths Report, Q3, 2021-22**

#### **Report of the Medical Director**

## **1. Introduction/Background**

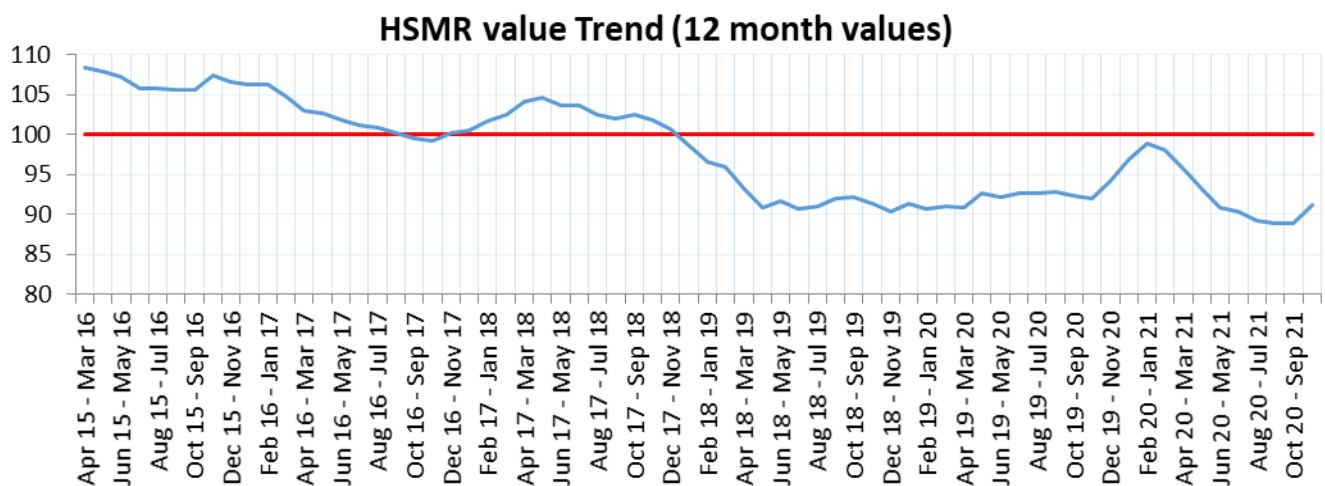
- 1.1 In March 2017, the National Quality Board (NQB) published national guidance “Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”. The guidance provides requirements for Trust to implement as a minimum 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.

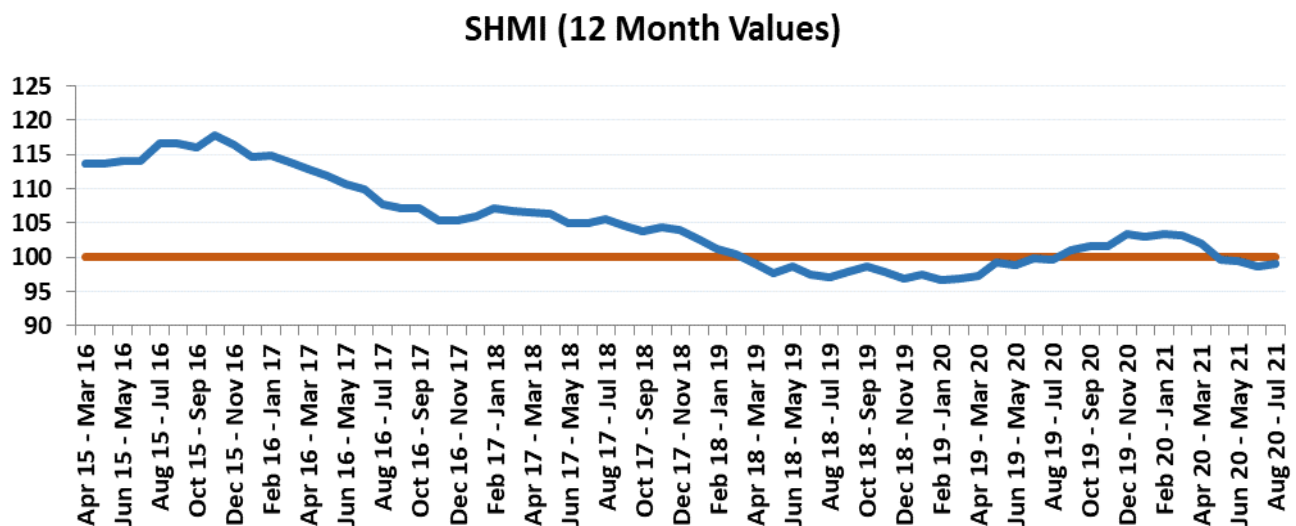
- 2.2 The latest HSMR value is now **91.19** (November 2020 – October 2021), this has decreased from the previously reported **91.97** (July 2020 to June 2021).
- 2.3 The value of 91.19 continues to remain inside the ‘as expected’ range. The following chart displays the 12 month rolling HSMR trends from April 2015 to October 2021:



2.4 The Trust currently has the 25<sup>th</sup> lowest HSMR value from the 124 Trusts nationally, and lowest value of the eight North East Trusts.

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.

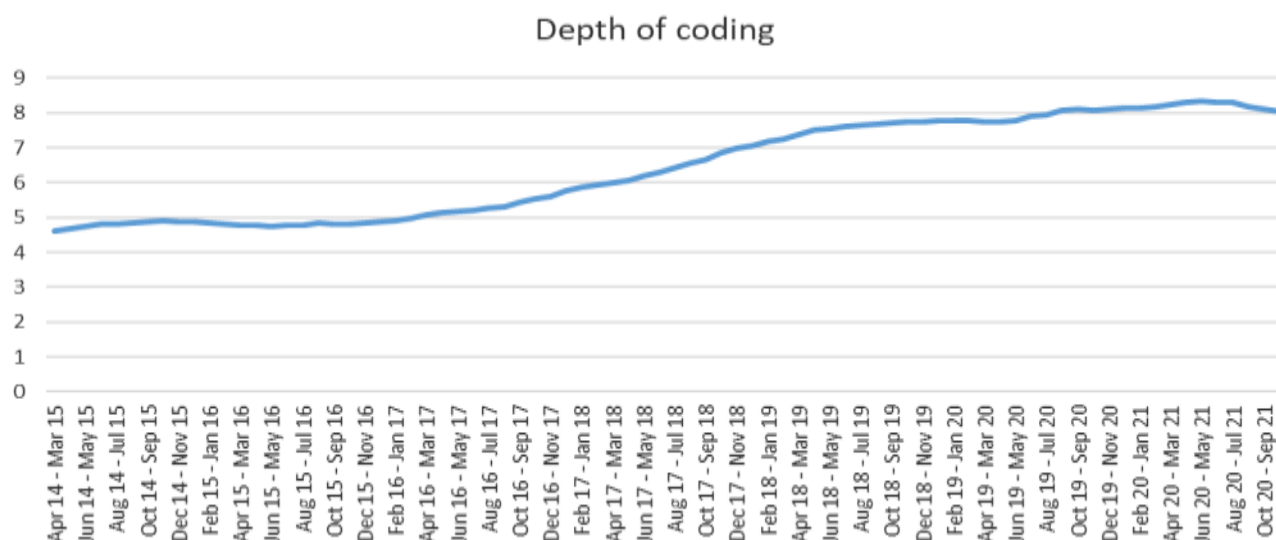
2.6 The latest SHMI value is now this has increased slightly to **99.16** (August 2020 to July 2021) from the previously reported value of **99.9** (May 2020 to April 2021). The value of 99.16 continues to remain inside the ‘as expected’ range. The graph below shows the 12 month rolling SHMI from April 2014 to April 2021:



2.7 The Trust currently has the 50<sup>th</sup> lowest SHMI value from the 123 Trusts nationally, and 2<sup>nd</sup> lowest value of the eight North East Trusts.

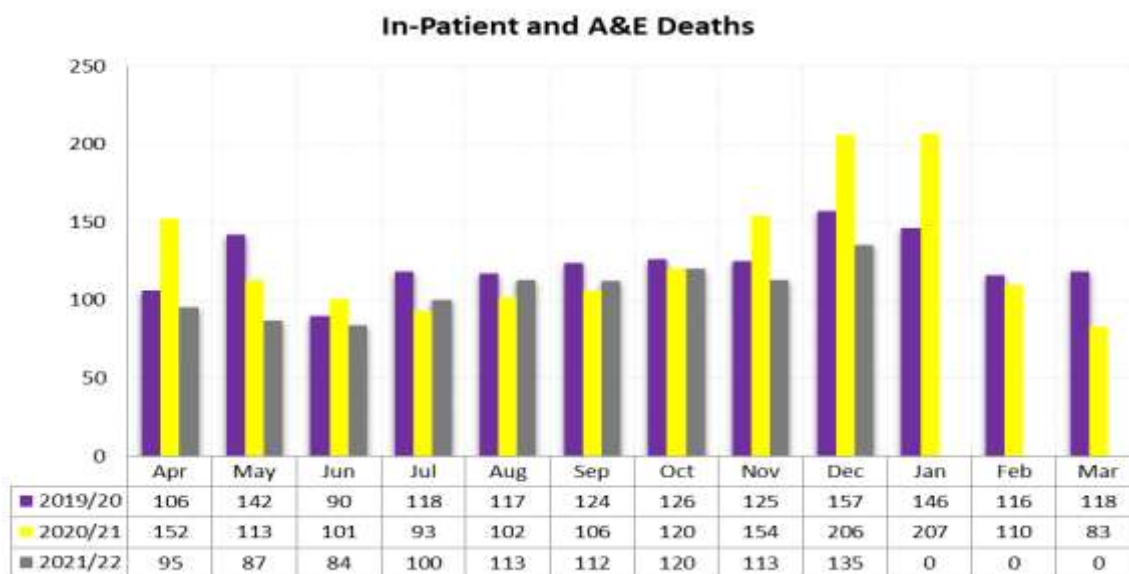
- 2.8 There continues to be an ongoing focus on ensuring there is accurate documentation of the diagnosis and co-morbidities; this information is required to ensure there is clear clinical communication between healthcare professionals who are caring for the patients.

The Trust is currently maintaining a high level of clinical coding, with a current average of eight co-morbidities recorded for each of our patients, which is thought to accurately reflect 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.



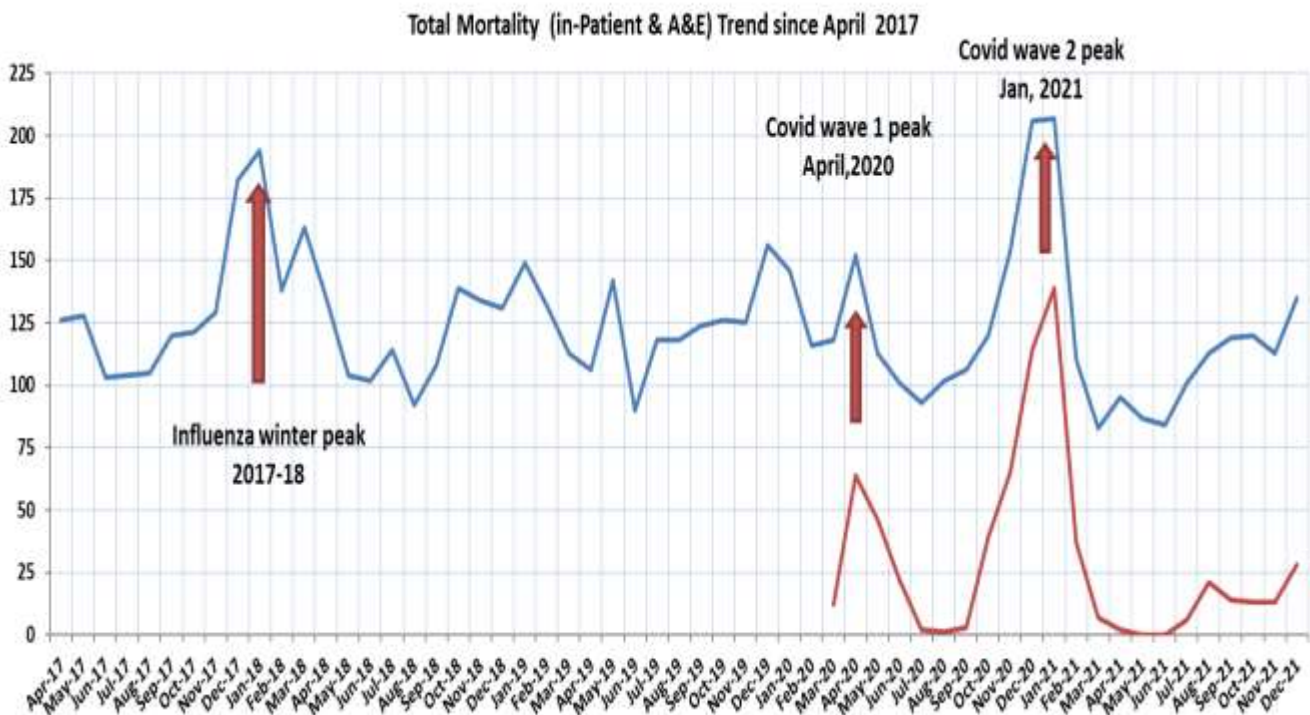
### 3. Mortality reviews

- 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 since April 2019 to December 2021.





3.2 The following chart shows the monthly trend and fluctuations in mortalities since April 2017 to June 2021; the markers represent key areas of peak deaths linked with influenza over the winter of 2017-18 and Covid-19 during 2020-21:



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.
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool.

- 3.5 The following table provides a summary of the data, by financial quarters, for 2021-22. 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.

<b>2021-22</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>Total</b>
Total deaths in scope	269	331	371		<b>971</b>
Deaths in compulsory criteria	40	50	28		<b>118</b>
Compulsory case reviews completed (no.)	19	29	21		<b>69</b>
Compulsory case reviews completed (%)	49%	58%	71%		<b>58%</b>
Compulsory reviews pending	21	21	7		<b>49</b>
Additional reviews & ME scrutiny completed	133	273	345		<b>751</b>
Total completed (no.)	152	303	366		<b>821</b>
Total completed (%)	56%	91%	99%		<b>85%</b>
Reviewed Deaths considered avoidable (no.)	0	0	0		<b>0</b>
Reviewed Deaths considered avoidable (%)	0%	0%	0%		<b>0%</b>
Reviewed Deaths considered not preventable (no.)	152	303	366		<b>821</b>
Reviewed Deaths considered not preventable (%)	100%	100%	100%		<b>100%</b>

- 3.6 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.
- 3.7 During 2021-22, to the end of quarter 3, there have been three mortality cases reported and investigated as serious incidents. Two of these cases are subject to Coronial investigation, the overall outcome of these will be reported in future reports. The third case has been assessed as not being preventable following investigation and review.
- 3.8 Over quarter 3, 99% 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. There has been a low number of other SJRs completed for those cases identified as requiring further review. The capacity of clinical staff to undertake required mortality reviews, during the Covid pandemic, has been significantly restricted. 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 required 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 ME team have been providing summary information to the Trusts Safety Panel on a weekly basis, this provides details of the number of cases reviewed as well as informing the clinical services of any cases that have been referred into any of the Trusts governance structures. This feedback also allows the team to start to recognise trends in any issues that are being identified during the scrutiny of the records and discussion with families. These are currently in the early stages of development and will be built into feedback in future reports.

- 3.10 From March 2020 to the end of December 2021, the Trust has notified 622 deaths where patients were recorded as testing positive for Covid-19. A significant amount of this information continues to be provided for national data collection. The Trust continues work with other organisations, through the North East Quality Observatory (NEQOS) as part of the Regional Mortality Group, to collate data to assist in examining risks related to mortality across the region and how this has developed over the pandemic.

A key area of this is to understand the transmission of Covid in the local population; but also to examine cases where patients may have developed Covid whilst being cared for as an in-patient, this is known as “nosocomial” infection. The Trust is continuing to apply national guidance and taking stringent measures to protect patients, visitors and staff in the hospital. These are being updated via central government and NHS England as the pandemic is progressing, the Trust is examining and implementing to ensure safety.

#### **4. Learning from Deaths**

##### **4.1 Deteriorating patient**

Recognition and management of the deteriorating patient has been identified as one of the most important areas of learning from all types of case reviews, not only for patients who have died but also those who have survived. The Trust recognises it is important to look at both to ensure all learning opportunities are taken to identify what is being done well, as well as where improvements can be made. The Deteriorating Patient Group has been established to provide oversight in relation to this area of learning. The group is led by senior clinical staff and is multidisciplinary, with all speciality groups are represented, acute and community, this is to ensure good communication and sharing of information. This Trust group is also working in collaboration with the Regional Deteriorating Patient Group, with information being shared at both groups for wider learning.

The Trusts Sepsis pathway is monitored to assess compliance against key performance indicators (KPIs); the recent cycle of the audit has identified that the results are good in Accident & Emergency, Paediatrics and Maternity. The results show that on occasions sepsis screening is not being well documented for in-patients; the Trusts sepsis screening tool/bundle has recently been updated and is in the process of being added to Trakcare (the Trusts electronic patient record). Future audits should demonstrate improvement as a result of having these on the same system and linked with, the other patient records.

Following recognition of sepsis, or a deterioration in a patients National Early Warning Score (NEWS), the key focus is escalation to ensure that senior staff are involved in the management and decision making for these patients. To support monitoring of appropriate escalation, the Deteriorating Patient Group have designed a tool within the electronic record providing key information that can be reviewed prospectively to help identify, escalate and manage deteriorating patients, but also retrospectively to allow cases to be reviewed in order to gain assurance.

The Community Services have developed a sepsis pathway that is to be used by the Rapid Response Community Matrons; this has been shared with Simon Stockley, who is the lead GP Nationally for sepsis, to ensure he is in agreement with the suggested process for escalating concerns about patients to GPs. Once agreed the pathway will be implemented and added into SystmOne (the community electronic record system). The patients on District Nurse caseloads currently, have baseline observations recorded and where there are concerns these are escalated to the Rapid Response team.

The Trust also supports ongoing work with Care Homes as part of an Education Alliance; this provides support to staff in the homes to access a training package to help them manage patients who may become unwell. The Care Homes use a digital monitoring system for NEWS and this aids them using the “is my resident unwell” tool to identify deterioration. This tool helps by using clinical observations, but also includes the use of potential “soft” sign observations that can aid staff to identify the need to request support from relevant professionals, via Integrated Single Point of Access (ISPA).

Handover of information has been identified as an area where improvements can be made in order to ensure there is effective, consistent communication between staff providing clinical care in the hospital. The handover process is currently being reviewed in order to implement a supportive digital solution; the proposed clinical handover system is being trialled in three key areas of the Trust, once the trial has been evaluated, plans will be implemented to expand this across all areas.

The Trust has thankfully, very few deaths in children; all are reviewed in depth to provide learning internally but to also ensure this learning is shared with the Teeswide Child Death Overview Panel (CDOP). To support wider opportunities the Paediatric service have a system in place to review all of their patients who have required transfer to another unit. The team look at all cases for learning, regardless of why they were transferred. However, a key focus is on children whose condition has deteriorated and who require transfer as an escalation in their clinical care. This work has resulted in closer working relationships with the specialist services, but has also supported the development of joint simulation training with the Paediatric, Anaesthetics and A&E teams. The Paediatric team have recently employed a Clinical Educator who will focus on Paediatric specific training opportunities and work with other local and regional services, to assist in standardising training where possible.

The Deteriorating Patient Group has also commissioned the development of a “dashboard” to display data to reflect compliance with the key areas of work linked to the group. The dashboard, once finalised, will display all KPIs in relation to the deteriorating patient including compliance with mandatory training such as NEWS, sepsis and acute kidney injury (AKI) prevention etc.. In preparation for this the group have reviewed all of the mandatory training requirements linked to identification and management of the deteriorating patient, this has led to some changes in training requirements for a variety of staff. Examples of this are the change of Sepsis and AKI training from once only, to being required every 2 years for clinical staff; these have been introduced into the updated training schedules.

## **4.2 Surgical update**

The Surgical department has continued to undertake reviews of all in-hospital mortalities at their monthly Mortality and Morbidity (M&M) meetings. These reviews focus on cases where complications have occurred, and where patients may have died under their care, which are thankfully uncommon. The monthly M&M meetings encourage Multidisciplinary Team (MDT) involvement in the case reviews to promote shared analysis and learning. The reviews also give the wider range of professionals an opportunity to have frank discussions and identify any actions that may need to be taken for future learning.

The team have identified the following areas where improvements and changes in practice have been initiated as a result of the M&M case reviews:

- The team recognised that there needed to be clearer information relating to the provision of senior input into clinical decision-making. As a result, they have focused on enhancing the daily Consultant led meetings where the team discuss all in-patients who have been admitted under the surgical team. This MDT approach ensures that all relevant patients receive consultant input into their management, either by reviewing test results or attending the patient directly, and ensuring decisions made are entered in the healthcare records.
- The Surgical team recognise the importance of using Computerised Tomography (CT) scans to help support their clinical decision making, especially, about undertaking emergency surgical procedures. Discussions take place with radiologists so that CT scans are requested, undertaken promptly and that the National Emergency Laparotomy Audit (NELA) standards on reporting are followed.
- The surgical team collate data for NELA as part of an ongoing process, during 2021, they arranged for the national lead, from Freeman Hospital, to attend their Clinical Governance meeting to discuss the national, regional and local results and any learning from the audit. Although the Trust is not an outlier in relation to this data, emergency laparotomies represent a significant part of the Trusts emergency surgical activity and the team felt the wider picture was pertinent to maintain good outcomes.
- A number of the surgical mortality cases reviewed continue to identify the need for broader discussions across other specialist services to support shared learning and collaborative improvements. In 2021, the Vascular Lead from South Tees virtually attended the surgical Clinical Governance meeting to discuss the management of mesenteric ischaemia. Although this diagnosis was only linked to a small number of mortalities, the current pathway was reiterated to promote awareness.
- Following on from some case reviews, the surgical team have undertaken an audit in relation to their use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. Following this, the team have introduced the review of DNACPR forms during the M&M presentations for any surgical cases reviewed. This has led to enhanced support to members of the surgical team when they are considering management and escalation plans for critically ill patients; and where necessary escalation to, and the involvement of, the specialist palliative care team.

### **4.3 Community Services**

Although the Trusts Community Services are not directly linked to in-patient deaths, the service take an active role in using the information from various reviews to identify pertinent areas of learning and to generate actions. The actions identified have supported improvements in care for patients who need further support in their home, those who may need hospital admission, but also for those reaching the end of their life, providing appropriate palliative care and support around decision making about place of death, and to help provide any relevant care requirements or equipment to support this.

The Community Matrons facilitate a weekly MDT discussion as part of “Enhanced Health in Care Homes”, this links with the primary care directors over the seven Primary Care Networks. These meetings include as a minimum, the Community Matron, GP, Care Home and ISPA

representation. Other relevant professionals, such as the Specialist Palliative Care Team (SPCT), can also be included to discuss the ongoing management of residents when required, or identified by individual professionals, to support the completion of an appropriate plan of care. The aim of these meetings is that all permanent care home residents have their care reviewed with them and their family, by the whole MDT, at least once a year. This promotes a shared understanding between patients, families and healthcare professionals of the overall care plan, to ensure all involved are following the same plan to provide the care the patient wants and needs.

The Community representatives attend the Trusts Safety Panel each week, as some mortalities are discussed at this meeting and there is often learning that can be shared with the relevant MDT. It has been agreed with the primary care directors that any cases discussed at Safety Panel where patients are from care homes will also be discussed as part of the Enhanced Health in Care Homes MDT to share any learning.

The Community Team have also recently introduced training for some staff to be able to verify expected death in the community for patients with a confirmed diagnosis of industrial terminal illness. Having timely verification of death will improve the quality of care for newly bereaved families by avoiding potential delays. The patients identified are agreed in collaboration with their GP and other involved healthcare professionals.

The SPCT have identified that there is on occasion, a lack of sharing of the content of the End of life documentation with families/ carers. The team are promoting discussion of this documentation, as well as their involvement, whenever a patient is identified as being at the end of their life; both in and out of hospital. As part of this, staff are asked, at an appropriate time, to discuss and hand out the “Family Voice” booklet. This booklet provides information for families in relation to end of life care but also provides them with an opportunity to make some notes and provide feedback in relation to the care given during this difficult time. These booklets provide a significant of positive feedback for the staff involved in the care, however any learning points are reviewed by the SPCT, feedback given to the relevant team and also shared at the Trusts End of Life Steering Group.

#### **4.4 Medical Examiners (ME) update**

The ME team have maintained full scrutiny of all of the deaths within the Trust, currently all ME staff are in post but there are vacancies in the ME officers and Bereavement team that have been impacting on overall workload. Due to the planned roll out into community during 2022-23, the team are supporting a new cohort of potential MEs through the Royal College of Pathology training package. It is also anticipated that the Trust will be a pilot site for the national ME database, in collaboration with South Tees, during quarter four.

The Trust has a 3 day target for completion of death certificates, as a result of staffing challenges across all clinical teams, as well as the MEs, achieving this target has been challenging towards the end of the quarter, which has led to some delays for families. To try and prevent this the MEs have “super-certified” to assist with patient flow; this means the MEs have certified deaths themselves following review of the case records and discussion with clinical staff involved. However, there have been no delays in release for funerals and the Trust has managed to support several requests for rapid releases.

The ME team have summarised some positive learning points:

- The majority of bereaved families are giving positive feedback about their experience and witnessed care for their relative from “everyone in the team”. The ME team are reporting this using the Trusts Greatix system to allow sharing of the positives.
- The MEOs are completing preliminary clinical assessments of records to assist the MEs; it is recognised that appointing staff with clinical backgrounds to these appointments has proven to be a significant asset.
- MEs and MEOs are answering questions regarding care, processes and diagnoses when talking to bereaved families, which is helpful to them directly and is also thought to be reducing formal complaints. This will be examined further during 2022-23 when there is more longitudinal data available within the complaints system.
- Doctors in training have recognised interaction with the MEs is a supported learning experience and is also thought to be limiting the need for them to undertake mortuary visits. This has led to reducing the time they spend in the Woodlands Suite (MEs offices), releasing more time for their clinical roles on the wards.
- The majority of cases raise no concerns, but interactions with the Coroner Officers and Coroner have become more systematic with the introduction of standard reporting forms, this has helped streamline communications between the Coroner and the Trust, as well as with families.
- Verification delays are reducing and the documentation of verification by junior doctors and nursing staff has improved significantly.
- Wards are predominantly using the ICE referral system for handover of care to the Bereavement and Mortuary staff, as a result this has improved the accuracy of Cremation form completion with fewer queries being raised.

The MEs team have also identified some themes for learning; most of these have also been discussed earlier in this report:

- Documentation of presumed cause of death and the information shared with families can be variable, and can lead to distress for the bereaved. Some examples of the causes are unknown diagnoses, the use of different descriptions or “language” creating confusion, and misunderstanding of the prioritisation of the main cause of death on the certificates. All of these issues are being covered within the education provided by the MEs to the doctors in training, which should help provide consistency and reduce the impact of these issues over time.
- The management of fluid balance and recording of this remains an issue; this can lead to problems with electrolyte disturbances and increase the risk of fluid overload. The management of fluid balance, prevention and management of AKI is part of the work of the Deteriorating Patient Group, which is covered in section 4.1 of this report. The inclusion of fluid management into the calculation of NEWS and also the move to electronic recording of fluid monitoring being implemented by the group should support the reduction of future problems.
- There continue to be inappropriate admissions from 24-hour care settings, including patients who have an agreed Emergency Health Care Plan (EHCP), there are also

delays in arranging Fast-Track discharges for patients at the end of their life. Both of these issues lead to poor experiences for the patients and their families, but can also contribute to capacity issues in the hospital. The Community Services work described in section 4.3 of this report outlines some of the actions that have been implemented to try to resolve some of these issues and to support patients being supported and cared for in their preferred place of death.

- There is also potential for delays in recognising the impending death of a patient, this can lead to non-productive investigations, late referral to the SPCT and delayed use of Care of the Dying documentation. All of these can lead to a potential missed opportunity to discharge the patient to their preferred place of care, which can also then impact on patient and bereaved experience/choice. The SPCT have given some details of actions being taken in section 4.3; there is further action planned in relation to promotion of the services offered by the team in relation to supporting patients, families and the clinical teams involved.

## **5. Conclusion/Summary**

- 5.1 The Trust HSMR value is now **91.19** (November 2020 – October 2021), this has decreased slightly from the previously reported **91.97** (July 2020 to June 2021). The latest SHMI value is now this has decreased slightly to **99.16** (August 2020 to July 2021) from the previously reported value of **99.9** (May 2020 to April 2021). 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 ongoing data collection in relation to Covid-19 deaths, not only for research studies but to also understand how Covid is being transmitted in the community and what can be learned, this will be examined further in future reports.
- 5.4 There is summary information in the report relating to actions initiated as a result of learning from deaths in patients in relation to the Deteriorating Patient, surgical reviews, Community services and the Medical Examiners team.
- 5.5 During 2021-22, to the end of quarter 3, there have been three mortality cases reported and investigated as serious incidents.
- 5.6 During the Covid-19 pandemic clinical teams have not been able to provide all of the information that would generally be included in this report; updates are being obtained flexibly as the teams are able to supply the information.

## **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**

Title of report:	Guardian of Safe Working Hours Report									
Date:	27 January 2022									
Prepared by:	Jamie Waters, Head of Business Support - NPSQ									
Executive Sponsor:	Deepak Dwarakanath, Medical Director and Deputy Chief Executive									
Purpose of the report	The New Junior Doctor Contract (2016) requests that the Guardian of Safe Working Hours (GOSW) prepares a quarterly report to the Board of Directors. These reports contain information relating to the safe working of doctors within the Trust. This report covers the period October 2021 to December 2021.									
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:										
<p>As with the wider NHS Workforce, COVID-19 continues to have a significant impact on the working lives of Doctors in Training (DiTs). Our workforce continues to work together as a team and flexibly to meet both service and training needs.</p> <p>The Guardian of Safe Working Hours has increased the frequency of the doctors' forum to bi-monthly, in order to increase our level of support to our doctors, obtain feedback, and address or escalate concerns. Unfortunately, the planned forum in November 2021 had to be stood down and therefore no forum took place in Q3.</p> <p>Exception reporting continues to be the mechanism used to highlight non-compliance with safe working hours, lack of support, and missed educational opportunities. Following an initial reduction in exceptions, which is thought to be related to the first pandemic surge, the rate of exception reporting appears to be returning to pre-pandemic levels. Flexible and remote working has increased, allowing teams to meet virtually and continue training/teaching sessions.</p>										
How this report impacts on current risks or highlights new risks:										
<ul style="list-style-type: none"> <li>Possible disruption to educational and training opportunities due to subsequent pandemic surges.</li> <li>Possible breaches to safe working hours and rest requirements resulting in fines</li> </ul>										
Committees/groups where this item has been discussed										
Recommendation	The Board of Directors are asked to note the content of and accept this report.									

## **Guardian of Safe Working Report October 2021 – December 2021**

### **Executive Summary**

This report highlights the latest data from Exception Reporting system and forms part of the reporting requirements of the 2016 contract for doctors and dentists in training. Ordinarily, the report would outline the highlights and key topics reported through the Doctors in Training (DiT) Forums that occurred in the quarter. Unfortunately, the DiT Forum scheduled for November 2021 had to be stood down, and therefore there is nothing to report back from this forum.

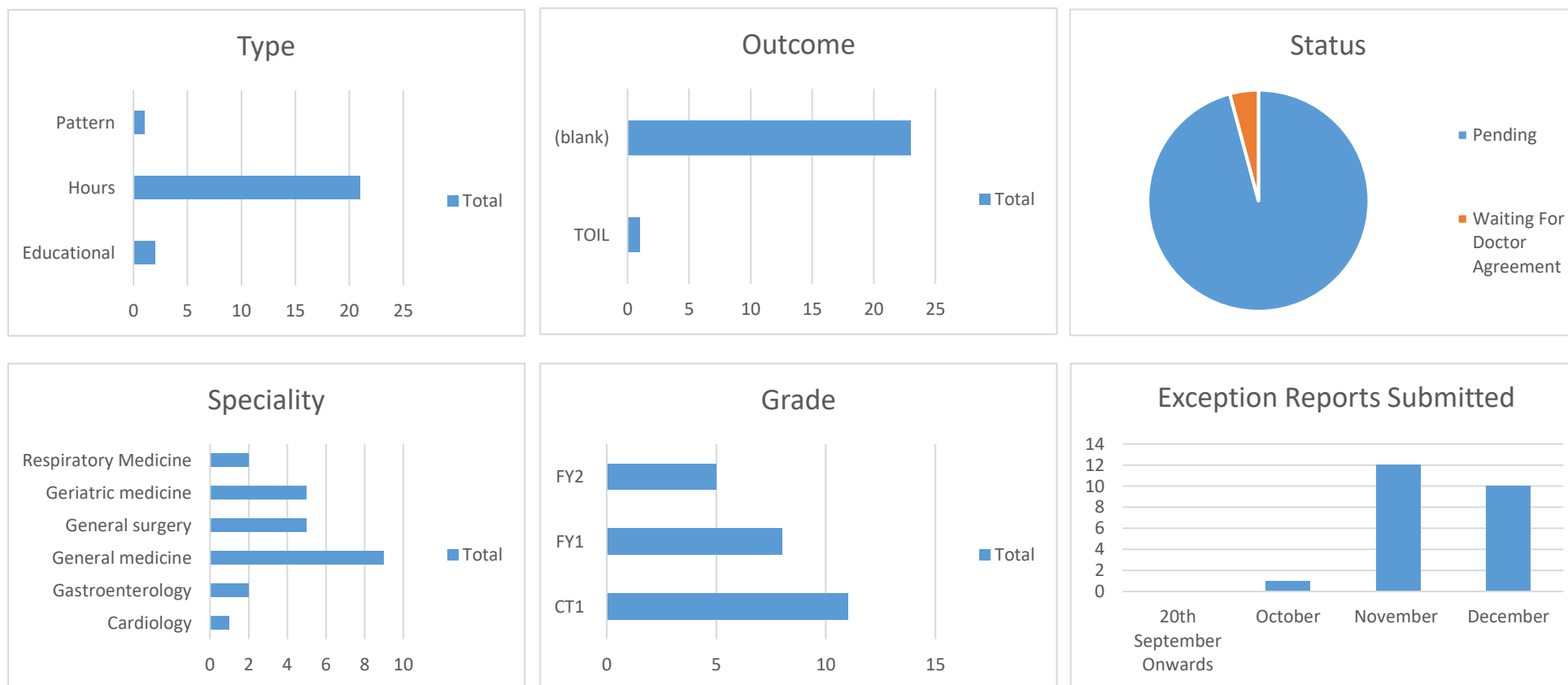
The Guardian of Safe Working continues to be available for urgent queries relating to exception reporting and work is on-going to schedule DiT Forums for 2022.

The board is asked to note this report for information and assurance

**Jamie Waters**

**Head of Business Support – Nursing, Patient Safety and Quality**

## Appendix One: Exception Reporting Dashboard Screenshot – October 2021 – December 2021



**31 Exception Reports Submitted By 16 Doctors**