



Board of Directors Meeting

**Thursday, 28 January 2021
at 1pm**

**Boardroom
University Hospital of North Tees**

PG/SH

21 January 2021

Telephone: 01642 617617
www.nth.nhs.uk

Dear Colleague

A meeting of the **Board of Directors** will be held on **Thursday, 28 January 2021 at 1.00pm** in the **Boardroom, University Hospital of North Tees**.

Yours sincerely



Paul Garvin
Chairman

Agenda

		Led by
1.	(1.00pm) Apologies for Absence	Chairman
2.	(1.00pm) Declaration of Interest	Chairman
3.	(1.00pm) Minutes of the meeting held on, 26 November 2020 (enclosed)	Chairman
4.	(1.05pm) Matters Arising / Action Log (enclosed)	Chairman

Items for Information

5.	(1.10pm) Report of the Chairman (verbal)	Chairman
6.	(1.20pm) Report of the Chief Executive (enclosed)	J Gillon
7.	(1.30pm) Teesside Provider Collaboration Update (enclosed)	J Gillon
8.	(1.40pm) Board of Directors Declaration of Interests and Fit & Proper Persons Declaration (enclosed)	B Bright

Quality

9.	(1.45pm) Professional Workforce Bi-annual Report (enclosed)	L Robertson
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Strategic Management

10.	(1.55pm) Capital Programme Performance Q3:2020/21 (enclosed)	N Atkinson
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Paul Garvin
Chairman

Julie Gillon
Chief Executive

Performance Management

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|-----|----------|---|--|
| 11. | (2.05pm) | Integrated Corporate Report (enclosed) | L Taylor, L Robertson
G Wright & N Atkinson |
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Governance

- | | | | |
|-----|---|---|---------------|
| 12. | (2.20pm) | Ockenden Report, Maternity Services Review Findings and Recommendations (enclosed) | L Robertson |
| 13. | (2.30pm) | Learning from Deaths Q3: 2020/21 Report (enclosed) | D Dwarakanath |
| 14. | (2.40pm) | Guardian of Safe Working Hours Report (enclosed) | D Dwarakanath |
| 15. | (2.50pm) | Any Other Notified Business | Chairman |
| 16. | Date of Next Meeting
(Thursday, 25 March 2021 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

Video-conference meeting of the Board of Directors

Thursday, 28 January 2021 at 1 pm

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 video-conferencing meeting.

The electronic pack of papers was circulated to the full Board

Paul Garvin, Chairman*	Chairman
Steve Hall, Vice-Chair/Non-Executive Director*	SH
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* <i>[via video link]</i>	JE
Kevin Robinson, Non-Executive Director* <i>[via video link]</i>	KR
Neil Schneider, Non-Executive Director* <i>[via video link]</i>	NS
Rita Taylor, Associate Non-Executive Director <i>[via video link]</i>	RT
Julie Gillon, Chief Executive*	CE
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Barbara Bright, Director of Corporate Affairs and Chief of Staff	DoCA&CoS
Neil Atkinson, Director of Finance*	DoF
Levi Buckley, Chief Operating Officer* <i>[via video link]</i>	COO
Graham Evans, Chief Information and Technology Officer <i>[via video link]</i>	CITO
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality* <i>[via video link]</i>	CN/DoPS&Q
Gary Wright, Deputy Chief People Officer <i>[via video link]</i>	DCPO
Lynne Taylor, Director of Performance and Planning	DoP&P

In attendance: -

Neil Mundy, Interim Joint Chair (designate)	IJC(d)
Ruth Dalton, Head of Communications and Marketing <i>[via video link]</i>	
Stuart Arnold, Local Democracy Reporter, Reach PLC <i>[via Audio link]</i>	
Samantha Sharp, Personal Assistant (note taker)	

Governors in attendance via video conferencing: -

Tony Horrocks, Lead Governor / Elected Governor for Stockton
Mary King, Elected Governor for Easington
Alan Smith, Elected Governor for Hartlepool

BoD/4416 Apologies for Absence / Welcome

Apologies for absence received from Alan Sheppard, CPO.

BoD/4417 Declaration of Interests

Declarations of interest were noted from the DoP&P in respect to her role with North Tees and Hartlepool Solutions LLP and SH (Non-Executive Director), NS (Non-Executive Director) and the DoCA&CoS 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.

* voting member

BoD/4418 Minutes of the meeting held on, Thursday, 26 November 2020

Resolved: that, the minutes of the meeting held on Thursday, 26 November 2020 be confirmed as an accurate record.

BoD/4419 Matters Arising / Action Log

There were no matters arising.

BoD/4420 Report of the Chairman

The Chairman provided an outline in respect to the Teesside Provider Collaborative which would be discussed later in the meeting highlighting that proposals had been approved by the Nominations Committee and the wider Council of Governors.

Resolved: that, the verbal update be noted.

BoD/4421 Report of the Chief Executive

The CE provided an update on the Trust's response to COVID-19 highlighting that there were currently 161 confirmed cases within the Trust occupying 32% of available beds from a peak of 43% of the bed stock. This was causing a major impact on respiratory and critical care and the operating and staffing model had been revised to provide appropriate support to both patients and staff. Occupancy had remained above 85% and had reported above 90% at its peak. The Trust continued to work with the local authorities, neighbouring Trusts and the independent sector to address the current position.

The rate of infection in both Hartlepool and Stockton remained high although the rate in Hartlepool had seen a rapid reduction in recent weeks and concern was raised as to the reason for this and whether less people were coming forward for testing.

The CE reported that the Trust's vaccination hub had administered over 9500 vaccinations which included staff, social care colleagues and patients over 80 years old.

532 participants had been recruited into the Trust's COVID-19 vaccine trial of Novavax, the highest recruiter out of 35 UK research sites. In addition, the COVID-19 treatment trial, RECOVERY had recruited 563 patients to date, the second highest recruiter in the country out of 176 active sites.

Support for staff health and wellbeing continued with a range of initiatives being implemented to complement the Trusts usual health and wellbeing offer. The Trust had recently partnered with the Tees, Esk and Wear Valley NHS FT to provide enhanced psychological support for staff. The Rainbow Rooms were now available on both sites for staff to take a break away from their work area.

On 11 December, the Trust had opened its combined Accident and Emergency and Urgent Care entrance at the University Hospital of North Tees. This had been completed within budget and agreed timescales and phase 2 had commenced.

In response to a query from JE, the CE reported that she had spoken with the Director of Public Health at Hartlepool Borough Council in respect to a rapid reduction in cases of COVID-19 in Hartlepool highlighting that further discussion was necessary to assess the position. It was noted that there was now a mass testing site in operation at Hartlepool.

In response for clarification from the Chairman, the CE reported that there had been no notification of limited supply of the Pfizer vaccine which had been confirmed by NHSE/I and the North East vaccination hub.

SH commended the work to provide an integrated service for A&E and Urgent Care and suggested that the Secretary of State could be invited to officially open the facility.

The Chairman placed on record his thanks to all staff for their continued hard work in response to the COVID-19 pandemic as well as ensuring the continued recovery of services in the wake of COVID-19. In addition, he praised the leadership of the Executive Team who led from the front to ensure services were safe for patients and that focus on the health and wellbeing of staff continued during this unprecedented, challenging period.

Resolved: that, the contents of the report and the pursuance of strategic objectives amongst the COVID-19 recovery and restoration programme be noted.

BoD/4422 Teesside Provider Collaboration Update

The CE provided an overview of the process and progress of the ongoing discussions between NHSEI, South Tees Hospitals NHS Foundation Trust and the Trust in the development of a Teesside Provider Collaborative, including a summary of work to date. This work would assist to consolidate the outcomes of the clinical services strategy and to progress the population health and prevention agenda to the benefit of the population of Teesside.

The CE reported that a full work programme to take forward the partnership would be developed setting out governance arrangements, workstreams and timelines to ensure progress was in line with strategic intent and swift and maintained. In addition, a communication and engagement plan would be developed.

The Chairman commented that by working in collaboration, this would help to support integrated services for the benefit of patients and that the Trusts must look towards forming a Strategic Board to take the work on Teesside forward.

Resolved:

- (i) that, the fit of a provider partnership to the aspiration of this Trust towards population health be acknowledged; and
- (ii) that, the move to a provider collaborative and the opportunity to capitalise on the next steps in the context of regional position and national policy direction be noted and endorsed; and
- (iii) that, the work underway to develop the appropriate governance arrangements and structure to support the establishment of a Strategic Board be acknowledged; and
- (iv) that, the outline work programme be noted.

BoD/4423 Board of Directors Declaration of Interests and Fit and Proper Persons Declaration

An updated register of interest was presented, where Board of Directors were required annually to declare any interests that may conflict with their position as a Director, Non-Executive Director or Associate Non-Executive Director of the Trust. The interests were required to be made at an open meeting of the Board and to be recorded in a register, which was referred to in the Trust's Annual Report and should be available for inspection by the public. Following the introduction of the 'fit and proper persons' standard in November 2014, an annual declaration was required for an Executive Director/Non-Executive Director or equivalent, to demonstrate continued fitness to undertake the role and such declarations would be recorded as part of the register.

- Resolved:** (i) that, the content of the updated register be noted; and
(ii) that, the register would be referred to in the Annual Report 2020/21 and be made available for public inspection.

BoD/4424 Professional Workforce Bi-annual Report

The Professional Workforce Report was presented which combined the nursing, midwifery, allied health professionals, medical and dental workforce bi-annual review for 2020/21.

The CN/DoPS&Q provided an overview of the current professional workforce position and ways the Trust were recruiting and retaining staff. In addition, the CN/DoPS&Q provided an update of service changes in response to COVID-19 and outlined key achievements gained despite the pandemic.

The CN/DoPS&Q reported on the significant workforce pressures highlighting a high level of sickness absence amongst nursing and midwifery staff which averaged 9.1% between April and November 2020, peaking at 12.6%. There were 61 WTE (4.5%) RN vacancies, 4.3 WTE (3.4%) RM vacancies and 23.7 WTE (3.6%) unregistered nursing and midwifery vacancies in December 2020. The vacancy factor across allied health professional services showed a total of 18.82 WTEs (18.82%). Sickness absence between April and November 2020 averaged 4.79%.

Following a recruitment drive, the Trust had successfully appointed 50 Team Support Workers as part of a six-month pilot to support clinical and administrative teams across the organisation to reduce the pressure by undertaking tasks such as answering telephones, communicating with patients and relatives, supporting with completion of paperwork and general admin or patient care duties. The value of this role would be continually assessed with the aim of determining its effectiveness in improving patient experience and communication.

A review of the Medical and Dental workforce had been undertaken and it was reported that there was a shortfall of 25.13 WTE between the budgeted and contracted medical and dental workforce, however this did not necessarily reflect the actual number of vacancies and rota gaps which may differ due to changes in services, temporary rota redesign, skill mix or working restrictions. The average sickness absence rate between April and November 2020 was 2.03%, lower than the Trust target of 3.5% but higher than the same period the previous year which was 1.38%, potentially attributable to the pandemic. The average turnover rate for medical and dental staff between December 2019 and November 2020 was 9.22%.

NS requested an update in respect to staffing in anaesthetics. The MD/DCE reported that anaesthetics was the area of most pressure in respect to COVID-19 with critical care expanding into theatre recovery over the past 3 to 4 weeks. Senior staff continued to provide 24/7 cover in critical care.

It was noted that it was important to be able to identify the early signs of staff suffering post-traumatic stress disorder and that a long-term package of support be available for those who had worked under a great deal of pressure for a prolonged period of time.

- Resolved:** (i) that, the work undertaken to date in relation to nursing, midwifery, allied health professionals and medical staffing be noted; and
(ii) that, the focus on valuing staffing through recruitment and retention processes be noted and that ongoing development of the workforce be supported; and
(iii) that, the impact of the COVID-19 pandemic on both patient acuity and infection control management against a backdrop of increased staff

- sickness be noted; and
- (iv) that, the huge effort in response to unprecedented pressures created by COVID-19 to ensure the safest staffing across the Trust be noted.

BoD/4425 Capital Programme Performance Q3: 2020/21

The DoF provided an update in respect of the Capital Programme Performance for Quarter 3 2020/21 highlighting that the Trust were £3.7m behind plan incurring capital spend of £8m against a year to date plan of £11.7m. It was noted that progress against the capital plan had been impacted by COVID-19 and suppliers/contractors putting their staff into furlough. There was a circa £600k risk associated with capital spend in respect to COVID-19 with the Trust anticipating payment from the centre in February/March 2021.

The DoF reported on a number of externally funded capital schemes which would now be delayed until the next financial year. This totalled £2.1m and the Capital and Revenue Management Group had agreed that items would be brought forward from the internal capital programme for the next financial year to be able to re-provide for the external funds in 2021/22.

The DoF provided an update on capital schemes in respect to the estate highlighting work ongoing around oxygen supply, roofing, concrete repair works, fire alarm replacement, car park resurfacing and lift replacements. In addition, the Trust had submitted a bid to support the climate change agenda to create additional electric vehicle charging points. An update on the medical equipment replacement programme was also provided and the CITO provided an update on both internal and external digital technologies.

The DoF reported that there would be significant pressure on capital monies available in 2021/22 with competing priorities across the ICP and ICS. All Trusts had submitted indicative plans for the next five years.

In response to a query from the Chairman, the DoF reported that the Trusts in the Tees Valley ICP were taking initial steps to address investment across the ICP but that this had a long way to go.

In response to a query from KS, the CITO highlighted that it was the Trust's ambition to share digital information for the benefit of patients and to help in clinical decision making with a desire for common systems to be developed around integrated care partnerships.

Resolved: that, the position on the capital programme at 31 December 2020 be noted.

BoD/4426 Integrated Corporate Performance Report

The DoP&P provided an overview highlighting performance against key access targets included in the Single Oversight Framework and the Foundation Trust Terms of Licence for the month of December 2020. This was presented in a newly agreed format using Yellowfin and was reported in respect of operational performance, efficiency and productivity, quality and safety, workforce and finance.

The DoP&P highlighted the significant pressures which continued across the Trust with the management of COVID-19 alongside the requirement to deliver business as usual and recovery. Delayed transfers of care, stranded patients and staff sickness absence continued to have a significant impact upon the Trust.

The pandemic had inevitably impacted upon the delivery against a number of standards, however, RTT, cancer and diagnostics standards remained positive compared with national and regional positions. To help identify risk and manage patient flow throughout the Trust,

lateral flow testing had commenced for patients presenting at A&E and maternity. Patients waiting longer than 52 weeks had increased to 87 in December due to the unavoidable cancellation of procedures due to COVID-19 pressures. To put into context, the region had reported circa 10,000 over 52 week waiters with individual organisations reporting up to 3,000 long waiters.

A rise in stage 3 complaints was noted with complainants choosing written responses rather than face to face meetings. The majority of complaints were around restrictions in visiting and the effect on communication with ways to mitigate this being developed.

There had been no falls resulting in fracture although the number of falls had increased. In addition, category 1 and 2 pressure ulcers had increased whilst category 3 and 4 ulcers had remained static. The Trust had reported an improved position against the majority of infections, all reporting within control limits.

The staff sickness absence rate for November reported at 6.83%, 1.99% attributable to COVID-19 related sickness. The majority of those identified as in the 'clinically extremely vulnerable' group had received the first dose of their COVID-19 vaccine, with second doses being prioritised three weeks after the first dose.

Appraisal compliance reported at 83%, a decrease of 1% on the previous month and mandatory training remained the same at 89%. Staff turnover had decreased.

Volunteer activity had resumed, however the recent 'lockdown' meant volunteer services had to be withdrawn due to personal and health circumstances. Recruitment continued with interest especially high following a recent regional COVID-19 'call to arms' campaign.

A modest surplus of £500k was reported at Month 9 2020/21, with a surplus year to date position of £1.95m. The Group cash balance was £65.5m, driven by cash received in advance for December 2020 block payment and delays in the capital programme. Based on current assumptions, the Trust anticipated delivering a small in-year surplus of circa £3m. Capital spend was slightly behind plan but anticipated to be delivered by year end.

The contribution of the volunteers and the work of the Volunteer Coordinator were noted and commended for their support during COVID-19.

RT commented that despite COVID-19, the Trust continued to perform well and that this had been recognised by the Audit Committee. In response to a query, the CN/DoPS&Q reported that the Trust continued to support families to visit patients virtually using iPads with the Patient Experience Team leading a central process to provide updates to families and to arrange virtual visits.

- Resolved:**
- (i) that, the on-going and significant 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; and
 - (ii) performance against the key operational, quality, finance and workforce standards during December together with the additional pressures of winter alongside the impact of staffing resource be noted; and
 - (iii) that, the on-going financial pressures be recognised; and
 - (iv) that, the successful roll out of the COVID-19 vaccine and lateral flow testing be noted; and
 - (v) that, the contribution of the volunteers and the work of the Volunteer Coordinator be noted and commended for their support during

COVID-19.

BoD/4427 Ockenden Report, Maternity Services Review Findings and Recommendations

The CN/DoPS&Q provided the Trust Board with the emerging findings; the immediate and essential actions and the Trust's gap analysis in respect to the Ockenden Report explaining that this followed an independent maternity review focused on all reported cases of maternal and neonatal harm between 2000 and 2019 at the Shrewsbury and Telford Hospital.

The CN/DoPS&Q provided the Trust's position against the 7 immediate and essential Actions in the Ockenden Report and provided assurance of steps being taken to address gaps.

AB highlighted her assurance that the Trust had been robust in its self-assessment and the steps it was taking to address any immediate and essential actions.

RT highlighted that in light of COVID-19, an increase in births may be seen and requested that the Trust consider undertaking an audit into its response in respect to the Ockenden Report. The CN/DoPS&Q reported that the LMS were undertaking an audit on behalf of Trusts but that the Trust could also programme this into its audit forward review programme.

The CE provided an update on maternity services highlighting that the Rowan midwifery led unit had opened in Hartlepool and that this would raise the profile of the service in the area. In addition, a piece of work was being undertaken by the Provider Collaborative to look at collaboration and the need to develop and invest in maternity services in the North East and North Cumbria.

- Resolved:**
- (i) that, the report and findings be noted; and
 - (ii) that, the gap analysis and assessment in Appendix 1 be noted; and
 - (iii) that, the high priority of maternity services at national level and the requirement for Board oversight be noted.

BoD/4428 Learning from Deaths Q3: 2020/21

The MD/DCE provided an update in respect of performance against Learning from Deaths guidance.

The Trust's HSMR value had increased slightly to 95.91 (October 2019 to September 2020), reporting lowest in the North East and the 31st lowest nationally. The SHMI had increased to 98.69 (August 2019 to July 2020), reporting 2nd lowest in the North East and 48th lowest nationally; both were within the 'as expected' range.

The MD/DCE outlined the trend in in-patient and A&E deaths and the monthly mortality trend and fluctuations since April 2016 highlighting the influenza winter peak of 2017/18 and the COVID-19 wave 1 peak of April 2020. The Trust had reported a total of 460 (4.6%) deaths attributed to COVID-19.

The MD/DCE provided an update on the work of the Medical Examiners and highlighted improvements in depth of coding, particularly around palliative care.

- Resolved:**
- (i) that, the content of the report be noted 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; and
 - (ii) that, the ongoing work programme to maintain the mortality rates

within the expected range for the organisation be noted and that the Board be aware of the impact of the changes to COVID-19 coding as future statistics were published.

BoD/4429 Guardian of Safe Working Hours Report

The MD/DCE presented the Guardian of Safe Working Report for the period August to November 2020 reporting a total of 43 exceptions submitted by 15 doctors, the majority highlighting trainees working above their contract hours. No new fines had been levied by the Guardian

The MD/DCE reported that the Trust sought to provide the best experience for trainees, despite the pandemic, ensuring that their physical and mental welfare continued to be met.

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

BoD/4430 Any Other Notified Business

a. Governor Representation

The Chairman invited those Governors present via videoconference whether they would like to comment on any business discussed at this meeting.

A Governor requested clarity around testing for COVID-19 in Hartlepool commenting that he had witnessed a greater number of people wearing masks in the town and abiding by the restrictions as laid out by the Government. The CE reported that there were fewer people coming forward for tests in Hartlepool together with a reduction in the number of positive tests, raising concern.

It was explained that the gap analysis undertaken in respect to the Ockenden Report would be presented to the Patient Safety and Quality Standards Committee for review prior to a report being presented to a future Council of Governors' meeting. A Governor highlighted that they were satisfied with the report as set out today and gained assurance that steps were being taken to address any areas of concern.

b. Paul Garvin

The Chairman placed on record his thanks to the Board and Council of Governors for their support during his tenure as Chairman of the Trust. He highlighted the benefits of collaboration and that this would benefit patients by providing integrated, joined up services across Teesside. He wished all colleagues the very best of luck and highlighted that he would watch developments with interest as Neil Mundy took on the role of Interim Joint Chair and Steve Hall as Vice Chair for North Tees and Hartlepool NHS FT.

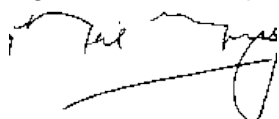
Resolved: that, the verbal updates be noted.

BoD/4431 Date and Time of Next Meeting

Resolved: that, the next meeting be held on Thursday, 25 March 2021 in the Boardroom at the University Hospital of North Tees

The meeting closed at 3:30 pm

Signed:



Date: 25 March 2021

Board of Directors

Title of report:	Chief Executive Report										
Date:	28 January 2021										
Prepared by:	Julie Gillon, Chief Executive Barbara Bright, Director of Corporate Affairs and Chief of Staff										
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.</p> <p>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"> • COVID-19 update and Phase 3 recovery including vaccination roll out • Brexit/EU Exit • Shining Stars walkabout – 17 December 2020 • Listening into Action – engaging with our staff • Integrated Care System and Integrated Care Partnership Update • Clinical Services Strategy • Combined Accident and Emergency and Urgent Care Centre • Prevention Board focus and delivery • NHSP Chairs and Chief Executive Network 											
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 receive and note the content of this report and the pursuance of strategic objectives.										

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

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 update and Phase 3 recovery

Context

As previously reported to the Board of Directors, NHS England and NHS Improvement reinstated level 4 incident management across the NHS on 5 November 2020. A further announcement on 4 January 2021 recommended a move up to level 5. This 'red' level means there is a 'material risk of healthcare services being overwhelmed', whilst social distancing measures should increase to 'extremely strict'.

The incident management system is different to the four tiers in place in England and was established in May 2020 during the first wave. The UK's four Chief Medical Officers supported the UK alert level increasing to level five citing that 'Cases are rising almost everywhere, in much of the country driven by the new more transmissible variant. We are not confident that the NHS can handle a further sustained rise in cases and without further action there is a material risk of the NHS in several areas being overwhelmed over the next 21 days.'

2.1.2 Operational Priorities

NHSE/I published a letter regarding 'Operational priorities for winter and 2021/22' on 23 December 2020 outlining the key priorities for the remainder of 2020/21, including the winter pressures.

Key requirements include:

- A. Responding to COVID-19 demand; maximising available surge capacity; timely discharges and robust infection control procedures (implementing ten key actions).
- B. Pulling out all the stops to implement the COVID-19 vaccination programme; in line with Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out.
- C. Maximising capacity in all settings to treat non-COVID-19 patients; utilising IS capacity and implementing the twelve clinical priorities from the Ockenden Review.
- D. Responding to other emergency demand and managing winter pressures; Ensure 'reason to reside' criteria patients are discharged promptly, including stretch targets to reduce LLOS patients; complete the flu vaccination programme and maximise community pathways of care for ambulance service referrals.
- E. Supporting the health and wellbeing of our workforce; systems could continue to deliver the actions in their local People Plans and communicate to all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

2.1.3 Planning for 2021/22

The Trust has maintained strong performance against the recovery trajectories however, this will become increasingly challenging due to the continued and increasing impact of COVID-19. Operational delivery is likely to be impacted, whilst the Trust retains focus on keeping patients safe and supporting staff wellbeing.

2.1.4 COVID-19 current position

The rolling seven-day positive incidence of COVID-19 per 100,000 population, continues to demonstrate high infection rates in Hartlepool and Stockton.

The infection rate increase in communities is leading to a consequential rise in admissions into the Trust. Regular bed modelling data is reviewed by the executive team to inform operational decision making and the wider strategic delivery and development of services.

Total COVID-19 Admissions	2,413
Total Admissions Base Wards	2,003
Total Admissions ITU	140
Number of Discharges	1,521
% Discharged	70.98%
Number of Deaths Positive COVID-19	420
% Deceased	19.6%
% still in Hospital	9.5%

Data as at 18 January 2021

Decisions regarding bed configuration and the operating model include a continued focus on infection control measures to limit nosocomial outbreaks and consequential impact.

2.1.5 COVID-19 Vaccination Programme

The Trust was allocated the first doses of the Pfizer COVID-19 vaccination on 22 December 2020 with deployment through the Rapid Assessment Unit (RAU) at the UHNT site, and vaccination commenced immediately. As the vaccine arrives frozen and has strict requirements for reconstitution and transportation the focus has been for patients over 80 years old, staff working for the Trust, social care colleagues and staff from NEAS and TEWV. The Trust vaccine hub has deployed 6,276 vaccinations as of 18 January 2021.

Primary Care Networks (PCNs) are deploying the more stable Astra-Zeneca vaccine to care home residents and further cohorts of the population on a staged basis.

2.1.6 Escalation and Mutual Aid

An approach of mutual aid across the ICS to manage and mitigate individual provider's capacity and demand has allowed some levelling of demand and ensures a focus on managing clinical pathways that could affect service delivery.

An example of integrated, collaborative working in the Tees Valley is the Cancer Cell, which reviews clinical prioritisation to ensure that patients are treated in a timely basis and to maximise the utilisation of capacity across providers. This approach is consistent with the focus on provider collaboration and

ensures that resources are effectively used for the benefit of equitable patient access and safe management.

2.1.7 Staff Health and Wellbeing

As a Trust, we are committed to supporting the physical and emotional wellbeing of our staff; this has become even more important during the pandemic. A range of initiatives have been implemented to complement our usual health and wellbeing offer. These include development

of recharge hub facilities on both the Hartlepool and North Tees Hospital sites, called the Ramplin Rainbow Room and Rainbow Room respectively. There is evidence to suggest that there are significant psychological benefits of having separate break-out areas available for employees to recharge. The basic principle being that it allows employees to temporarily disengage from the steady stream of daily tasks. The Trust was fortunate to receive funding for these facilities from the Sir Captain Tom Moore charity and were completed in readiness for the Christmas period.

Enhanced psychological support has also been put in place with the development of a Staff Psychological Support Hub (SPSH). The aim of the hub is to provide staff with psychological support at this challenging time during Covid-19. SPSH are working alongside many differing internal and external providers of psychological support which has recently been further bolstered with support of TEWV.

2.1.8 COVID-19 Research

The Trust is currently running 16 COVID-19 studies looking at treatments and vaccines as well as observational studies in both patients and staff. Over 3,000 participants have been recruited into COVID-19 studies in this financial year to date. There are more Urgent Public Health COVID-19 studies currently in set-up.

The Novavax vaccine study had a target of 350 participants but we were able to extend this and recruited 532 participants. The first results from Novavax are expected by the end of January 2021.

The main COVID-19 treatment trial, RECOVERY, has recruited 563 patients to date. This trial has already shown Dexamethasone to be of benefit for patients who required therapy with supplemental oxygen or mechanical ventilation. North Tees is the second highest recruiter in the country out of 176 active sites. This is due to a number of factors including an engaged Principal Investigator, Dr Ben Prudon, a focussed research team, excellent engagement from clinical teams and support services and support from senior management.

2.1.9 Brexit/EU Exit

The UK exited the EU on 31 January 2020 and began a period of transition which ended on 31 December 2020. The UK government has now reached an agreement with the EU as to the relationship beyond the end of the transition period. The trade and cooperation agreement was concluded between the UK and EU on Christmas Eve 2020.

Despite the agreement of a deal, there remains a risk of disruption at the border associated with the UK leaving the Single Market and Customs Union at the end of the year. For this reason, the request from NHS England and NHS Improvement is that organisations keep in place the plans and mitigations stood up for the end of the transition period until further notice.

Key guidance from NHSE/I included the following:

Medicines – To be prescribed and dispensed as normal and shortages to be reported through the usual routes.

Workforce – The EU Settlement Scheme is open to all EU citizens, including NHS staff, and can allow EU nationals to gain ‘settled’ or ‘pre-settled status’ as well as recognition of professional qualifications will apply for at least two years after the end of the transition period.

Data – NHS organisations and staff should continue to handle data as they currently do (which is covered by GDPR).

The NHS is using a single operational response model for COVID-19 and the end of the EU transition period to avoid conflict and reduce burden on the system. The designated SRO for the Trust is Neil Atkinson, Director of Finance, and designated clinical lead is Deepak Dwarakanath, Medical Director / Deputy Chief Executive.

2.2 Strategic Objective: Valuing our People

2.2.1 Shining Stars Event – 17 November 2020

The awards ceremony is an annual event to celebrate the outstanding work in place across the organisation, recognising the efforts employed by staff in their commitment and dedication to quality and patient experience – with excellence as our standard. Unfortunately, the impact of COVID-19 meant a change to plans in 2020, however, I was privileged to visit and present the final recipients personally with their awards on 17 December 2020. The importance of this event cannot be underestimated and the recognition it affords to staff, especially in light of the challenges that have been faced by all. The event, facilitated virtually via MS Teams, demonstrates the ethos and values of the organisation. I would like to congratulate all winners and all those nominated for their outstanding contribution to performance, safety, quality, patient experience and overall service delivery.

2.2.2 Listening into Action – engaging with our staff

Following the investment into the Listening into Action (LiA) programme/App discussed at the Board of Directors meeting in November, a further commitment has been made to re-launch the App with a focus on Staff Health and Wellbeing. Actions from staff feedback will be assigned to members of the Trust LiA Navigation Team with progress monitored and discussed at the Executive Team meeting on a weekly basis.

2.3 Strategic Objective: Transforming our Services

2.3.1 Integrated Care System/Integrated Care Partnership (ICS/ICP) Update

The NENC Provider Collaborative met on 15 December with a key focus on Breast Diagnostic Services, with unanimous agreement that the future model for this service is to move to a Managed Clinical Network approach that will be established for diagnostic services aligned to the four screening centres in North, Central, South and North Cumbria ICPs.

A virtual workshop was held on 12 January 2021 facilitated by the provider collaboration development team. The purpose of the event was to provide input into the emerging national policy development and direction, as well as to outline areas of learning and focus for the collaborative from the national ‘Northern region’ work in the ongoing development of the Provider Collaborative.

Work is ongoing with our partners in Tees to develop a collaborative based on an ambitious strategy for Teesside.

2.3.2 Clinical Services Strategy

The Clinical teams across Tees Valley continue to focus on the development of the Clinical Services Strategy moving from proposals to implementation. The Programme Management support is working

to co-ordinate implementation plans to understand the key milestones through to March 2021 and beyond.

Governance and decision making is now supplemented by a Clinical Review Group to add clinical challenge and oversight to the evolving plans.

2.3.3 Combined Accident and Emergency and Urgent Care Entrance

Following a successful four-month design phase and project build the new combined Accident and Emergency and Urgent Care Centre opened at the University Hospital of North Tees on 11 December 2020. The project came in on budget and has enhanced the efficiency and available space of the Urgent Care and Emergency Department, and allows all self-presenting patients to the Trust to use a single entrance for both services. The next phase involves integrated paediatric assessment services and is due for completion this month.

2.4 Strategic Objective: Health and Wellbeing

2.4.1 ICS Prevention Board Workshop

The Prevention Board continues with positive developments implemented across the breadth of support in its mission to improve health and wellbeing, and reduce health inequalities amongst the population. Some of the key considerations for continued focus include: areas of greatest need during COVID; resilience apparent in some deprived wards; developing the role of public health expertise within hospital settings; access to data from agencies outside of health, working closely with the Fire Service and supporting the voluntary sector.

Work continues on the regional alcohol prevention programme - co funded. Balance's now alcohol campaign and establishing an Alcohol Clinical Network to engage clinicians to reduce alcohol harm.

The Smokefree NHS/Treating Tobacco work continues to support campaigns and to work in partnership with the Local Maternity System to provide a digital offer for pregnant women and partners, including 9 months free access to stop smoking advisors, and a smoke free App to compliment the existing stop smoking promise.

2.4.2 NHS Providers – Virtual Chairs and Chief Executive Network

A virtual NHS Providers Chairs and Chief Executives network meeting took place on 3 December 2020. The focus of the event was to provide policy updates from Health Education England, NHS Providers and Brexit presented by Professor Keith Willett.

3. Recommendation

The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives amongst the COVID-19 recovery and restoration programme.

Meeting of Board of Directors

Title of the Report	Teesside Provider Collaborative Update												
Date:	28 January 2021												
Prepared by:	Hilton Heslop, Head of Strategy & Corporate Affairs Barbara Bright, Director of Corporate Affairs and Chief of Staff												
Executive Sponsor:	Paul Garvin, Chairman Julie Gillon, Chief Executive												
Purpose of the report	This paper provides the Board of Directors with an overview of the process and progress of the ongoing discussions between NHSE/I, South Tees Hospitals NHS Foundation Trust and the Trust in the development of a Teesside Provider Collaborative, including a summary of the work to date.												
Action required:	Approve			Assurance		X	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>On 26 November, NHSE/I published its policy document 'Integrating Care – Next steps to building strong and effective integrated care systems across England' as part of consultations with stakeholders ahead of a planned NHS Bill to feature in the Queen's speech with proposed legislation for Integrated Care Systems (ICSs) from the Spring of 2021. In this document, NHSE/I set out their plans and proposals for all providers and partners within the health and care system to work together as Integrated Care Systems.</p> <p>A range of meetings have taken place and both Trusts have considered the proposals and have jointly agreed that the development of provider collaborative arrangements is the most appropriate approach to take as the organisations consider their ambitions and aspirations for the future. The creation of a Provider Collaborative involving North and South Tees Foundation Trusts with absolute clarity of responsibility and accountability, will require work in relation to governance processes, communication and engagement particularly in relation to the establishment of a vehicle for strategic business.</p> <p>Building on much of the work that has been achieved during the last 12 months, a full Work Programme will be developed which will set out governance, work streams, and timelines to ensure progress is swift and maintained.</p> <p>This is an opportunity to drive strategic change in the context of regional positioning and national policy direction. The early period pf evolvment will see the agreement of the shared vision and common purpose, including a Communication and Engagement plan, with milestones subject to review and refinement as the workstreams model requirements into a more detailed project and implementation plan.</p>													
How this report impacts on current risks or highlights new risks:													

Risks associated with provider collaboration is included within the Board Assurance Framework	
Committees/groups where this item has been discussed	Board of Director meetings.
Recommendation	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> • Acknowledge the fit of a provider partnership to the aspiration of this Trust towards population health; • Note and endorse the move to a provider collaborative and the opportunity to capitalise on the next steps in the context of regional positioning and national policy direction; • Acknowledge the work underway to develop the appropriate governance arrangements and structure to support the establishment of a Strategic Board; • Note the outline work programme.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

Report of the Chief Executive

Teesside Provider Collaborative Update

1. Introduction

This paper provides the Board of Directors with an overview of the context and progress in the development of a Teesside Provider Collaborative, including a summary of the work to date.

2. Background

On 26 November, NHSE/I published its policy document 'Integrating Care – Next steps to building strong and effective integrated care systems across England' as part of consultations with stakeholders ahead of a planned NHS Bill to feature in the Queen's speech with proposed legislation for Integrated Care Systems (ICSs) from the Spring of 2021.

In this document, NHSE/I set out their plans and proposals for all providers and partners within the health and care system to work together as Integrated Care Systems to develop:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care.
- **Formal collaborative arrangements with provider organisations being asked to step forward to allow them to operate at scale.**
- Strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

The policy focus for provider collaborations is based on acute providers and/or mental health collaboratives with ambulance, specialised services and/or some mental health services based on a wider geography with an acknowledgement from NHSE/I that collaboratives will vary in scale and scope, and not necessarily be aligned to ICS boundaries.

A provider collaborative for Teesside between acute providers, in the first instance, will build on the processes and structures already underway between both North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts.

3. Strategic Rationale for a Provider Collaborative

The proposals contained in the policy document acknowledge that COVID-19 has necessitated an acceleration of learning from the pandemic and a step up in scope and ambition towards the roll out of system working focused on greater devolution and a 'localism'. However, whilst the policy guidance included a broad steer on the critical elements of commissioning, finance, digital, and the legislative requirements for ICSs, the focus on greater partnership working in 'place' and strong collaborations between providers across wider geographies and footprints has emerged as one of the key drivers towards integration.

The 'Integrating Care – Next steps...' guidance sets out an expectation that all NHS provider trusts will become part of 'provider collaboratives' whilst continuing to be the main unit of delivery for secondary care. The proposals place a renewed emphasis on providers playing an 'active and strong leadership role' in Integrated Care Systems (ICSs) by joining-up services via place-based partnerships' and this endorses the commitment and ambition of both South Tees Hospitals NHS Foundation Trust and the Trust in progressing a new health care model/entity for Teesside.

A significant amount of collaborative effort has been achieved in the last 24 months, and whilst the process may not have progressed at the pace originally anticipated, the Provider Collaborative approach now provides both Trusts with the best opportunity to cement the good work achieved to date

by continuing with the initial proposals, building on strengths and combining to improve weaknesses and risks to the challenges faced within our populations. The opportunity to work together through a structured work programme with a shared common purpose has never been greater.

The provider collaborative is therefore seen as an important step for secondary care across Teesside to address the population health agenda and this reflects the Trust's ambition, not only in terms of the vision which is *'providing the best healthcare for everyone in our population'*, but also helps strengthen collaborative efforts with partners and stakeholders as a next step in the evolving process.

4. Teesside Provider Collaborative

The Board of Directors will be aware that the concept of a 'provider collaborative' mirrors the strategic aim and ambition that the Trust has set over the last 24 months and that there has been much work during this time, initially, involving all three Foundation Trusts in Tees Valley with a current emphasis on developing a clinical services strategy through managed clinical networks. The service strategy will remain the nucleus for change with the more pressing requirement for pathway changes to occur in the partnership between North and South Tees.

A range of meetings have taken place and both Trusts have considered the proposals and have jointly agreed that the development of provider collaborative arrangements is the most appropriate approach to take as the organisations consider their ambitions and aspirations for the future. The creation of a Provider Collaborative involving both Foundation Trusts with absolute clarity of responsibility and accountability, will require work in relation to governance processes, communication and engagement particularly in relation to the establishment of a vehicle for strategic business.

Operating a Strategic Board will accelerate the agreement and execution of changes to services, capital investment and system finances and will be endorsed by each Board of Directors. The objective of this will be to deliver an agreed clinical and corporate plan, with an emphasis on regular communication, joint strategic decision making and a strong ability to execute and implement collaborative working across the organisations to maximise the capacity and capability of the broader partnership, and to also help deliver a truly integrated healthcare system for the population.

The requirement to articulate the vision and shared common purpose for future healthcare provision across Teesside will be key to achieving the strategic ambitions and will be crucial in liaising and working with stakeholders to formulate strategic plans and wider planned development to ultimately ensure the Teesside Provider Collaborative is aspirant in achievement of its outcomes for the population it serves and reflective of the relative needs of local populations

It is anticipated that the Teesside Provider Collaborative will take overall responsibility for delivery of the strategic priorities and investment plans, and will make recommendations to be taken to each individual Board for approval, where required, and make joint decisions on a range of matters on which authority has been delegated and which do not adversely impact on the statutory responsibilities of the individual organisations.

5. Work Programme for 2021/22

Building on much of the work that has been achieved during the last 12 months, a full Work Programme will be developed which will set out governance, work streams, and timelines to ensure progress is swift and maintained.

The early period of evolution will see the agreement of the shared vision and common purpose, including a Communication and Engagement plan, with milestones subject to review and refinement as the workstreams model requirements into a more detailed project and implementation plan.

6. Regional and Local Positioning

The Integrated Care System continues to develop and mature, with regards to governance, partnership and focus, with the next stage in the process; the appointment of an independent chair, Sir Liam Donaldson, who has public health and a population health focus at the core of his approach, a major move toward consolidating action.

The establishment of the North East and North Cumbria Provider Collaborative provides the backdrop of a pan regional approach to support and sustain specialist and core services in this region for the future. The Teesside collaborative will be a key influencing partner in the drive for equity and priority of services in the Teesside area. The NENC Provider Collaborative continues to meet both formally on a six weekly basis to address ongoing business and informally on a weekly basis to ensure an appropriate and timely system response to the COVID challenge.

Whilst the collaborative has continued with the ongoing management of COVID as a priority and more especially the ability to collaborate effectively across the ICS foot print, a number of joint pieces of work will be progressed through a forward plan. This includes a focus on capital prioritisation, system-wide clinical strategy and linkage to the ICS Optimising Health Services work stream, opportunities for efficiency initiatives, joint working and integration between providers and immediate service priorities across the ICS.

The Integrated Care Partnership will remain pivotal in ensuring a stakeholder approach to whole system delivery within the framework of the population health outcomes' delivery for Tees Valley and as guidance and policy emerges there will be an opportunity to develop a health care model or entity for the future, which capitalises on the benefits of strategic collaboration with a focus on locality provision and influence in outcomes for the communities we serve.

7. Conclusion

The approach set out in this report will help to deliver an evolving partnership between the two Tees Trusts based on greater provider collaboration and the development of a new healthcare model.

There is a considerable amount of co-operation and collaboration at an operational and clinical level within the acute providers across Teesside and there is great potential to use this as a route towards creating and maintaining a much stronger relationship with colleagues, partners and neighbours across the healthcare landscape for the benefit of the population served.

Operating as a Strategic Board will support the overall objectives of provider collaboration. The collaboration will capitalise on the aspiration for population health and therefore will shape and develop the strategic direction, vision and values in order to deliver on the intent and key objectives, whilst streamlining processes, governance and decision making.

8. Recommendations

The Board of Directors is asked to:

- Acknowledge the fit of a provider partnership to the aspiration of this Trust towards population health;
- Note and endorse the move to a provider collaborative and the opportunity to capitalise on the next steps in the context of regional positioning and national policy direction;
- Acknowledge the work underway to develop the appropriate governance arrangements and structure to support the establishment of a Strategic Board;
- Note the outline work programme.

Paul Garvin
Chairman

Julie Gillon
Chief Executive

Board of Directors

Title of report:	Declaration of Interests and Fit and Proper Persons Declaration									
Date:	28 January 2021									
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"> note the contents of the appended updated register; and note that the register will be referred to in the Annual Report 2020/21 and will be available for public inspection. 									

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

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Mr Paul Garvin Chairman	None	None	None	None	Daughter Insolvency Partner at Wardhadaway (Trust's Legal Advisors)	✓
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	✓
Prof Jonathan Erskine Non-Executive Director	Executive Director of European Health Property Network	JECR (Jonathan Erskine Consultancy and Research)	None	None	Honorary Professor of the Bartlett School of Construction and Project Management, University College London Wife is a member of the governing body of Teesside University	✓
Mr Kevin Robinson Non-Executive Director	None	None	None	None	Consultant with Auriola Consulting (Justice Services)	✓
Ann Baxter Non-Executive Director	None	Ann Baxter Ltd – Independent Consultancy	None	Independent Scrutiny – Darlington Safeguarding Partnership	None	✓
Mr Philip Craig Senior Independent Non-Executive Director	None	None	None	None	None	✓

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

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Mr Neil Schneider Non-Executive Director	Director of The Flying Geese Leadership and Development Company Director, Trading Company for North Tees and Hartlepool NHS Foundation Trust (Optimus Health Ltd)	None	None	None	None	✓
Mrs Rita Taylor Associate Non-Executive Director	None	None	None	None	None	✓
Mrs Julie Gillon Chief Executive	None	None	None	None	None	✓
Dr Deepak Dwarakanath Executive Director / Deputy Chief Executive	None	None	None	None	None	✓
Mr Neil Atkinson Executive Director	None	None	None	None	None	✓
Mrs Barbara Bright Executive Director	None	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	None	None	None	None	None	✓

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

Name	Directorship including non-executive directorships held in private companies or PLCs (with the exception of dormant companies)	Ownership, or part ownership, of private companies businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in a field of social care	Any connection with a voluntary or other body contracting for NHS services	Signed Fit and Proper Person Dec
Prof Graham Evans Executive Director	None	None	None	Trust Representative to HealthCall Board Chief Digital Officer for NENC ICS Honorary Professor at Teesside University	Son employed by NTH Solutions	✓
Mrs Lindsey Robertson Executive Director	None	None	None	None	None	✓
Mr Alan Sheppard Executive Director	None	None	None	Vice President of the NE&NC Branch of the Healthcare People Management Association	Wife employed by Trust	✓
Mrs Lynne Taylor Executive Director	Director of NTH Solutions, a Trading Company for North Tees and Hartlepool NHS Foundation Trust	None	None	None	None	✓

Board of Directors

Title of report:	Professional Workforce Bi-Annual Report											
Date:	28 January 2021											
Prepared by:	Karen Sheard, Deputy Chief Nurse											
Executive Sponsor:	Lindsey Robertson, Chief Nurse											
Purpose of the report	This report provides the Board of Directors with an overview of the professional workforce which includes Nursing, Midwifery, Allied Health Professionals, Medical and Dental. The National Quality Board (2016) articulates the requirement to undertake workforce reviews annually with an update on actions highlighted to the Board on a six monthly basis. This report provides the bi-annual review 2020/21 including updates from the last annual review produced July 2020.											
Action required:	Approve			Assurance			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		
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>A review of current nursing and midwifery staffing has been undertaken with those wards and departments where changes to patient acuity and staffing requirements had occurred in response to Covid-19.</p> <p>There are a number of initiatives being taken to address issues, ensure continuity, and deliver safe patient services. Alternative staffing models have been implemented, registered nurse, midwifery and un-registered nurse recruitment centres have continued to assist in reducing vacancy rates throughout the year.</p> <p>A review of the Allied Health Professional workforce has been undertaken and vacancies are being actively managed.</p> <p>A review of the Medical and Dental workforce has been undertaken.</p> <p>The Trust faces a number of professional workforce challenges and continues to monitor the situation closely.</p> <p>Technology is being utilised and implemented to support workforce planning and ensure the workforce is being deployed effectively. It is also a key enabler in ensuring compliance with working hour's limits and rest requirements.</p> <p>The Covid-19 pandemic has continued to impact on the professional workforce since the annual review which was completed in July 2020. All of the efforts being undertaken contribute to ensuring there are workforce safeguards in place, the right staff, with the right skills are in the right place at the right time, whilst being financially sustainable.</p>												

How this report impacts on current risks or highlights new risks:	
<p>This report provides assurances that the Nursing, Midwifery, Allied Health Professionals, Medical and Dental workforce in place enables the delivery of safe, high quality care to patients with continued monitoring.</p> <p>Highlights areas of risk in terms of workforce challenges in some speciality areas.</p>	
Committees/groups where this item has been discussed	N/A
Recommendation	<p>The Board of Directors are requested to note the work undertaken to date in relation to Nursing, Midwifery, AHP and Medical staffing.</p> <p>The Board of Directors are requested to note the focus on valuing staffing through recruitment and retention processes and in supporting ongoing development of the workforce.</p> <p>The Board of Directors are requested to note the impact of the Covid-19 pandemic on both patient acuity and infection control management against a backdrop of increased staff sickness (due to the impact of Covid-19).</p> <p>The Board of Directors are requested to note the huge effort in response to unprecedented pressures created by Covid-19 to ensure the safest staffing across the Trust.</p>

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

Professional Workforce Bi-Annual Report

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



1. Introduction

- 1.1 This report provides the Board of Directors with an overview of the professional workforce which includes Nursing, Midwifery, Allied Health Professionals, Medical and Dental. The National Quality Board (2016) articulates the requirement to undertake workforce reviews annually with an update on actions highlighted to the Board on a six monthly basis. This report provides the bi-annual review 2020/21 including updates from the last annual review produced July 2020.
- 1.2 In October 2018 NHS Improvement (NHSI) published Developing Workforce Safeguards which supports providers to deliver high quality care through safe and effective staffing. The key principles of safe staffing 'triangulated approach' as identified by NHSI can be seen in figure 1 below.

Figure 1.



- 1.3 NHSI recognise the need for a more consistent approach to safe staffing levels across all clinical workforce groups, a clear focus on developing evidence based tools for assessing the impact of variation in patient acuity and dependency. Guidance from

NHSI (Developing Workforce Safeguards, 2018) urges senior leaders to consider Trust Wide culture in leadership.

2. Purpose

2.1 The purpose of this bi-annual report is to provide the board of directors with an update of the current professional workforce position across the organisation which includes:

- Progress to date relating to actions identified within the annual report July 2020
- Recruitment and retention position
- The use of temporary bank and agency staff
- An update of the current workforce by Care Group; identify areas where staffing establishment may require further review in line with the business planning process taking place throughout 2021/22
- An update of service changes in response to Covid-19 pandemic that impact the professional workforce
- Assurance that workforce decisions are evidenced based and comply with the Care Quality Commission (CQC) fundamental standards

3. National and Local Position

3.1 Nationally workforce supply remains high on the agenda, the 2018/19 workforce statistics confirm that nursing remains the key area of shortage and pressure across the NHS. The nursing vacancies nationally increased to almost 44,000 in the first quarter of 2019/20, which is equivalent to 12% of the nursing workforce (Health Foundation, 2019). To prevent nursing shortages growing further, urgent action is needed to increase the numbers of nurses in training, reduce attrition and improve retention.

3.2 Changes in skill mix can reflect a range of factors: changing patient needs, technological developments and legislative changes to allow some staff groups to expand the scope of their practice. It is important however that quality and safety are at the forefront of any skill mix change, changes are not introduced in an unplanned way in response to cost pressures or recruitment difficulties.

3.3 NHSI has established a national Safe Staffing Faculty programme, directly supported by the Chief Nursing Officer for England. The aim of the programme is to strengthen Nursing and Midwifery scrutiny and oversight of staffing nationally and use the faculty to inform and support local and national work in relation to safer staffing. The Head of Nursing for Responsive Care has already completed this programme and a further place on the programme has been supported with the Deputy Chief Nurse commencing this in March 2021.

3.4 The bi-annual workforce review focuses on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It is vital to understand the nature of workforce pressures and what can be done to address them both in the long and short term. Within this review the recent and ongoing impact of Covid-19 has been considered when planning the workforce models.

4. Covid-19 Pandemic

4.1 Although this report is designed to provide a bi-annual update, the extraordinary events and response to Covid-19 pandemic have been included for information and assurance. The pandemic has had a significant impact on the Nursing, Midwifery,

Allied Health Professionals and Medical workforce with rapid redeployment and training of staff was necessary to meet expected demand. Outlined below is some workforce context during the most recent phase of the pandemic:

- A review of the whole bed base to ensure that patients received the right care in the right place delivered by staff who had the right skills and support to assure safest staffing across the Organisation.
- The reduction in the elective activity created additional bed capacity and released staff to be redeployed across the trust
- Additional staff were required to expand the front of house model and prepare for the extension of critical care to meet expected surge. The number of staff required for critical care was based on adjusted templates to ensure staffing was in line with national governance and assurance processes.
- Staff moves were led by Heads of Nursing and overseen by the Deputy Chief Nurse to ensure patient and staff safety
- Changes in specialist nurse provision to include 7 day working, front of house support, palliative care support and maintaining closer links with community services and Local Authority to support patient discharge and admission avoidance
- Critical care surge was led and managed by the MDT with close partnership working between the senior medical, nursing and AHP leaders.
- A number of wards and departments were converted to Covid-19 positive (red) and non-Covid-19 (amber) areas, a continued high patient acuity with higher occupancy levels across the Trust
- Wards were closed when required to support safer staffing levels
- A high level of support continues to be provided into care homes from community matrons and IPC team
- Higher rate of staff sickness due to Covid-19 symptoms, isolation and usual sickness absence.
- Virtual visiting was implemented to try and maintain contact between patients and relatives
- Virtual clinics have continued in some areas with good response from patients
- Change in staff resilience, responsiveness and continued reliance on good will of staff to flex according to the changing demand
- The extent of changes across the organisation during this surge cannot be underestimated and it is recognised the importance of leadership across all professional staff groups.
- There is a recognition that psychological support will need to continue for both patients and staff post Covid-19.

5. Nursing and Midwifery Workforce

Nursing and Midwifery workforce accounts for 27% of the total workforce in the Trust.

5.1 Methodology

- 5.1.1 A comprehensive and thorough review of Nurse and Midwifery staffing was undertaken in June 2020 (as described within the Annual Professional Workforce Report presented July 2020)
- 5.1.2 Face to face meetings were carried out with each team (ward/department matron, senior clinical matron, Head of Nursing/Midwifery, Finance and Workforce Business partners) to discuss workforce for the annual review. The

face to face meetings supported a move towards a more 'bottom up' approach to annual workforce reviews and is scheduled to take place again during summer 2021.

5.1.3 For areas where significant changes were taking place either in patient mix, acuity, or environment due to Covid-19 were invited for a second review during November 2020. The outcomes of these review meetings are included within the specific service sections of this report.

5.1.4 Specialist Nurse reviews have been included for this report using similar methodology with plans in place to extend this further during 2021.

5.2 Healthy Lives Care Group

5.2.1 The Holdforth Hub

The transition from an in-patient ward to a community hub took place in September 2019 with further changes to a full community hub at the start of first wave of the Covid-19 pandemic, to enable a service for patients outside the hospital setting and providing a flexible patient pathway working across the two hospital sites. The model now incorporates both an in hospital unit working 8am – 8pm seven days per week and the community aspect of the hub which allows flexibility for care home residents where pathways are taken to the patient rather than having to make an unnecessary hospital journey for assessment. Alongside this, a new outreach model has been developed to support patients with their hospital discharge or as a step up with 'Home First pathways' (described further in the report). This service provides support for up to a 72-hour period for patients ensuring that care is delivered at home (own or care home) for the most vulnerable patients; this takes place over 24 hours.

5.2.2 Out of Hospital Care

The **District Nursing** teams manage and maintain the care of individuals in their own homes or residential care homes. The teams provide complex patient care including wound care, administration of injections, indwelling pleural catheters, Hickman line management, continence care and palliative care providing support to patients, families and carers. When a vacancy arises within the Out of Hours service, the district nursing service has an effective workforce model that meets the demands of the Out of Hours service through rotation of staff from the Primary Care Network (PCN) teams. The current RN vacancies are mostly due to staff development opportunities within other areas of the care group such as clinical triage, the discharge team and specialist palliative care.

Rapid Response is a crisis intervention team to prevent hospital admission or facilitate early discharge providing health and social care including administration of intravenous antibiotics and the utilisation of specific pathways. The team also provide the nursing support to patients in a residential rehabilitation or transitional bed within West View Lodge. This service currently has a number RN vacancies following a number of non-recurrent funded development posts becoming permanently funded. These include Frailty - front of house frailty coordinator and clinical triage nurses.

Spa Clinical Triage/iSPA The clinical triage nurses work as part of the iSPA team triage all urgent referrals for a number of community nursing teams including Rapid Response and Community Matrons. They also provide support and advice and assist in the decision making process for health and social care and are instrumental in the delivery of the Primary Care Network MDT process for Enhanced Health in Care Homes. **There are currently no vacancies in the team.**

Specialist Palliative Care Team (SPCT) delivers specialist palliative care advice and support to patients and professionals in their own homes and hospital settings.

As part of the last annual workforce review there were plans to review the SPCT staffing model to strengthen resilience across the service. There was 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 and welcome extension to the service providing support to patients and their relatives. The Team are currently supporting band 3 and band 5 short rotations to upskill and support the wider workforce. **This service currently has no RN vacancies.**

The **Home First** service is still in its infancy with further plans in development; to realise the potential 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 include increased frailty coordinator capacity and the potential for community teams to in reach to acute areas (physically / virtually) to support timely transfers of care. The service will continue to build upon the temporary funding in place, until March 2021, to help support the development of a Discharge to Assess component of the Home First service. A measure success of this service, will be a positive impact for patients with a shift in some activity from an acute inpatient base to a community setting. Careful workforce modelling will be required to deliver this on a sustainable basis.

Improved coordination of patient flow in hospital is planned; achieved through greater integration of the Clinical Site Managers, Bed Management team and the Integrated Discharge Team which will include a new leadership structure and shared governance through the combined Care Group Senior Management Team. An additional key development during 2021 includes the progression of the Enhanced Care project and associated deliverables in line with the Home First Model.

Following the last nursing workforce review within **Outpatients Departments**; an effective workforce model met the demands of the service and an implementation manager was recruited to drive forward the initiatives associated with the productivity plan which included the nursing workforce. Whilst there has been a number of service improvements and changes to service delivery for patients in response to Covid-19 pandemic; there is a recognised need to develop the service or 're-brand' to attract the right nursing workforce to be employed there. The service was running with 74% of the nursing workforce approaching the end of their career with high rates of sickness absence and many staff who have been redeployed there due to health restrictions. This was considered as part of the review with an agreement

to employ newly registered nurses into this speciality. This approach has been successful with a change in staff skill mix, focused leaders within the service with a noticeable reduction in sickness absence.

5.2.3 Women and Children's Services

Women and Children's Services consists of Maternity, Obstetrics, Gynaecology Outpatient, Paediatrics and Special Care Baby Unit.

Maternity utilise Birth-rate plus (BR+) which is a nationally recognised tool for maternity services based on the number of deliveries and ante-natal and post-natal care requirements. Birth-rate plus analysis was last undertaken in 2019 (expected to repeat every 3 years) with the recommendation to increase the midwifery establishment and skill mix areas within the postnatal ward area. This skill mix included the introduction of 2.0wte RN posts (which have since been recruited to) and band 3 posts to support breastfeeding, post-partum post-surgery care to mother and transitional care within the postnatal ward for mother and baby. To support the development of the Maternity Hub at Hartlepool Hospital, the community midwives will rotate one week per month to delivery suite to support focused learning and upskilling within both planned and unplanned maternity situations. During Covid-19 escalation there was a positive move to support new mothers via virtual technology which the service has maintained as an alternative option for women and families.

The trust provides a **Special Care Baby Unit** level 1 service. Staffing continues to be based on the British Association of Perinatal Standards (BAPM) at an 80% occupancy level which is 1 nurse to 4 babies within the unit. BAPM is not routinely met as there is no supernumerary team lead incorporated into the current establishment. The introduction of this role was incorporated into the Care Group business plan and whilst the daily mitigation includes an Advanced Neonatal Nurse Practitioner (ANNP) being on the unit 24hrs per day, this continues to be a role that needs to be factored into the current establishment to maintain consistent cover in line with BAPM standards.

The **Paediatric ward** consists of 20 beds throughout April to October with an increase to 26 beds as required from November to March. The usual route of admission is from ED or patients assessed and requiring admission from the Paediatric day unit. The role of professional judgement and local intelligence is applied daily for assurance of safe staffing levels. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but which is not reflected in the national Safer Nursing Care Tool (SNCT). There is a general perception that children have carers present at all times however this is not an accurate reflection of reality. There are often vulnerable children on the ward who are unable to be left unsupervised either due to their age or development. Highly complex, social and safeguarding issues are managed daily and often account for children being unaccompanied on the wards. This also generates a need for staff to attend meetings and coordinate complex pathways as there is not a hospital social worker or discharge coordinator for paediatric patients.

A number of children have significant complex conditions requiring higher ratios of nursing care regardless of age due to acuity e.g. tracheostomy, respiratory support, neurological disability. There is a focus on family centred care and teaching and supporting parents and carers to look after children affected by

illness to enable safe discharge home also impacts on nurse time that is not reflected in the SNCT.

The **Paediatric Community Service** is currently under a service review and an integral part being the Children's Services Administration Hub which went live in December 2020. This model standardises processes by simplifying one access route for new patient referrals and enquiries for Children's Services. The model is supported with a dedicated telephone system and associated software that will manage all telephone calls into and out of the system. Registration of patients is utilised within the existing System One unit with emphasis on communication to all teams and healthcare professionals being enveloped within these systems. The service includes appropriately trained staff to manage all referrals/enquiries in accordance with standard protocol and guidance including timely access to clinical professionals for support and advice.

The **Paediatric Day Unit NT** continues to provide a 7 day per week service from 09:30 to 22:00. Mobilisation work is underway to relocate this service to co-locate with the paediatric emergency department developing an integrated purpose built paediatric unit from February 2021. As part of this review a paediatric elective day case unit will also open from February based within the current paediatric day unit area. This unit will run Monday to Friday providing pre and post-operative services for children undergoing elective surgery alongside a range of procedures including phlebotomy, infusions and allergy challenges.

5.3 Responsive Care Group

Responsive Care continue to have the highest number of registered nurse vacancies with 33.8wte vacancies as of December 2020. A new cohort of newly registered nurses are planned to take up their positions in January 2021 to support a reduction in vacancies. The Care Group continues to strive for full recruitment of the nursing workforce; following some targeted work with performance and finance are actively preparing to recruit to their turnover rates in order to provide further resilience to safe staffing.

5.3.1 Emergency Care

Emergency Care comprises of the Emergency Department (ED), Integrated Urgent Care Services (IUCS) on both the North Tees and Hartlepool sites and the Emergency Assessment Unit (EAU), which includes Ambulatory Care and the Initial Assessment Unit.

ED currently has minimal RN vacancies against funded establishment. The nursing workforce model is currently under review within the Care Group following recent building work to create a one door approach to managing both Urgent and Emergency Care. When this building work was initially planned it was agreed that, despite a new footprint, the patient demand would not change therefore the existing nursing workforce model in place should remain. Since the new footprint has been established it has been agreed that the workforce model, to support the new build and subsequent new patient pathways, does require a review. This collaborative review is planned to take place in January 2021 with Nursing, Operational and Clinical leads. The Trust awaits the appropriate SNCT tool specifically for an ED from NHSI and the Shelford Group

to accurately record the acuity and dependency levels of patients coming through the department. This tool will greatly support future workforce planning.

The workforce model within the **IUCS** at North Tees and Hartlepool continues to meet the demands of the service. The IUCS 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.

EAU is ordinarily a 42 bedded level 1 admitting area with an additional 10 ambulatory care beds, an EAU waiting area, Initial Assessment and a Discharge Lounge. Patient case mix includes those from paramedic, GP and ED acute medical admissions. EAU and the ambulatory care unit have seen significant changes throughout the Covid-19 pandemic. Currently the main EAU area has 42 beds and the ambulatory care (plus the previous ACU area) are functioning as a 29 bedded EAU providing safe separating and the appropriate cohorting of Covid positive patients. Following these recent changes, the Care Group have uplifted the registered nurse establishment to provide two additional nurses per shift to support the increase in bed base within the ambulatory area and to consistently staff the waiting area which can remain open till the early hours of the morning to safely assess, transfer or discharge patients. Due to this uplift of RNs there is a current vacancy of 11wte, 9.4wte have already been recruited to but will not commence in post until late January/February time. With this level of vacancy there is a consistent demand and spend on temporary staffing to support the unit. During peaks in demand with Covid related admissions, the critical care outreach team and respiratory physiotherapists continue to support the unit. More recently Ward 40 has been closed to redeploy the workforce to EAU to support the critical gaps and the continued increase in the acuity of patients.

5.3.2 In-Patient Wards/Departments

Respiratory wards 24 and ward 25 have seen changes in service provision over the last 12 months with an increasing demand for level 1 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). The care group identified that the workforce model needed to better reflect a bed base to support Acute Respiratory Care to ensure that the area is compliant with the national anaesthetic guidance for level 1 care which states that level 1 patients should be nursed with a ratio of 1:4 (registered nurse to patient). This has remained a challenge during the ongoing Covid-19 pandemic and the usual winter demands on respiratory areas. To support this, an alternative workforce model was approved and the physiotherapists are now well established on ward 25 (acute respiratory including x7 level 1 beds). The physiotherapists were temporarily redeployed from other areas due to Covid-19 as are equipped with the skills needed to care for respiratory patients in this area. From February 2021 newly appointed therapists will take up their posts on the ward and will become permanent members of the ward team to continue to support this workforce model. Early feedback from Therapy, Nursing and Clinical staff has all been extremely positive and it is agreed that this alternative workforce model has a great deal of potential for the future. There are plans to replicate this model onto ward 24 during 2021 and to agree a competency framework which

will support the learning and developmental needs of the new therapists. This framework will be developed in collaboration with Nursing, Therapy and clinical teams.

Gastroenterology - Ward 26 changed function and speciality during Covid-19 pandemic to support the increasing demand for acute respiratory care and subsequently the workforce was relocated to other areas to support with the associated speciality moves. There are no current proposals to change the workforce model associated with ward 26. Plans to recruit to the current funded establishment remain in place to meet the demands of the service.

Ward 27 - specialises in gastroenterology including liver disorders, alcohol dependency and eating disorders. At present the ward does not have a nursing workforce model that meets the demand of the service due to the complexity of nursing a specific patient group (patients with eating disorders). An occupational therapy role is currently being explored in collaboration with therapy and TEWV. The role is expected to be at Band 6 level and will require applicants to have a level of experience in working with patients with complex mental health issues including drug and alcohol withdrawal and eating disorders. The vision is for this role to be part of the substantive workforce model on ward 27 to provide expertise in managing the emotional, psychological and acute care needs of patients. There is also the aim of supporting an improved patient journey between primary and secondary care settings thus potentially reducing the need for some patients having repeated unplanned admissions. A business case is being devised to support the financial element of introducing this role.

Acute General medicine - Ward 29 specialised in diabetes and cardiology. During covid-19 pandemic the ward was closed to deploy the nursing workforce into other areas to support gaps in workforce. There are no immediate plans to reopen this ward without a review of the workforce and clinical purpose of the ward.

Ward 36 specialises in acute medicine and has repurposed to include diabetes.. The workforce model is to undertake a further review in light of the changing and complex patient case-mix. Many patients require increased levels of observation and therapeutic intervention resulting in them scoring higher using the SNCT to identify care needs. Proposals for an alternative workforce model in January 2021 will likely include an uplift of the registered and unregistered nurses to support the management of patients and the increased level of observation needed from this patient group.

Ward 38 specialises in haematology, oncology and acute general medicine. The management of the Medical Day Unit (MDU) also falls under the same workforce model and is open from 9-5, Monday to Friday. Due to success of the Medical Day Unit, the overall demand had increased with more patients being required to attend for support with a wide range of procedures including venepuncture and cannulation, administration of various IV infusions, Hickman and other line flushes and ascetic drainage etc. The Care Group commenced rotation of the nurse practitioner into the unit to provide further resilience for some specialist nurse services. The workforce model will be reviewed summer 2021 to take into consideration any ongoing increases in activity demand.

Elderly Medicine - Ward 40 specialised in frail and elderly patients with medical needs. Due to continued gaps in nursing workforce due to Covid-19, the ward was closed to deploy the nursing workforce into EAU to support their critical gaps in workforce. There are no immediate plans to reopen this ward without a review of the workforce and clinical purpose.

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 continues to meet the needs of the service.

Acute Stroke Unit/Ward 41 is a 26 bedded admitting acute stroke unit (although there is the physical ability to flex the bed base up to 31, there is no budgeted establishment to do this). The unit 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. Whilst the unit was established as a level 0 unit, the patient acuity generally meets level 1 therefore the care group are looking to uplift the registered nurse workforce to reflect an acute level 1 admitting area which will 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 which is in line with national guidance.

Acute Cardiology Unit (ACU)/Ward 37 is a 19 bedded unit now located on ward 37 following changes to the EAU/ambulatory care footprint in a response to Covid-19. The unit continues to specialise 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. There are 10 additional surge beds which open to manage the capacity pressures associated with both winter and Covid-19 when safe staffing allows. The workforce model will be reviewed during summer 2021.

5.4 Collaborative Care Group

Collaborative Care consists of a bespoke Surgical decisions unit in support of the acute admissions for Surgery/Orthopaedic trauma and Gynaecology. Collaborative care provides the Anaesthetic and Theatre provision for pre and post-op services to elective, trauma, emergency, and obstetric patients across the trust. There is also Pre-assessment/Day Case supporting the elective pathways with an Elective Hub (Ward 9) at University Hospital of Hartlepool which is working towards our Centre of excellence, but also there is a transition phase in relation to a nurse-led unit. As part of transformation the bed profiling has been agreed in line with the vision across the Care groups. This will continue to be agile due to the unprecedented pressures within the Trust due Covid-19. Due to these pressures, nursing workforce remains a challenge with the change of acuity and demand within the surgical areas. The elements of the elective programme have been paused and are under daily review.

5.4.1 Acute/Elective Pathways

Ward 32 specialises in patients with fragility fractures and due to the patient mix there is a continuing reliance on enhanced care support resulting in an increase in unregistered temporary staff usage. There has been an agreement to increase the funded unregistered nurse establishment to support enhanced care at ward level in support of the continued increased demand. There is also a plan to consider an alternative workforce model in this area in relation to therapy teams after proving successful in other ward areas. The workforce model will be reviewed during summer 2021 to understand nursing/therapy workforce requirements.

Ward 33 was previously an identified unit specialising in trauma patients, however during Covid-19 trauma patients have been diverted to the Surgical

Decisions Unit (SDU) on ward 30. Ward 33 currently cares for a combination of Surgery/Orthopaedics and Medicinal patients is challenging at times. Following the pandemic, the plan is for this ward to revert back to a 22 bedded trauma unit.

Ward 30 is now identified as a 20 bedded Surgical Decisions Unit following the previous review in response to the covid-19 pandemic and supporting patient pathways with regard to Covid swabbing prior to elective admission.

Ward 31 was funded as 15 x level 1 beds and 5 x level 0 beds. The care group have proposed a change to the level 1 provision by increasing to 20 x level 1 beds to support a step-up and step-down model for critical care. This will result in the need for increased RN funded establishment to support 1 RN to 4 patients which is currently under review.

Ward 28 is now a 31 bedded general surgical ward for both acute and elective admissions. This area was previously a mixture of medicine, urology and general surgery and lacked consistent identity. In the last review SDU was on ward 28 and this has now been relocated onto ward 30. The ward has supported elective and non-elective admissions and the changes in patient pathways during covid-19. The substantive workforce model will be reviewed in Summer 2021 to ensure the nursing workforce safely meets the future demand.

Ward 9 (Hartlepool Hospital) was closed in response to covid-19 pandemic and the need to significantly reduce elective provision and workforce deployment to meet critical demand in other areas. This remains under daily review.

5.4.2 Anaesthetics and Theatres

The anaesthetic and theatre services provide pre and post-operative services to elective, trauma, emergency, and obstetric patients across the Trust. 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. Despite the differences between the sub- speciality provision across 52 weeks and the challenges this can pose to staff rostering, there has been a phased progression to health roster which supports the visibility and monitoring of staffing capacity. The skill set required of theatre staff is significant due to the increasingly changing sub specialisation. The level of complexity within some specialities requires training over a period of 18+ months. Band 6 staff currently carry out theatre education and training for theatre staff but this is becoming more challenging and the need for a designated educator in this area is now recognised. The care group are exploring options to introduce this role within the establishment.

5.4.3 Critical Care and Outreach

Critical Care had a high number of new RNs being recruited to the unit in the latter part of 2020. Whilst supporting the vacancy position, it is recognised the

high level of training and support required to new nurses on the unit is a challenge. A seasonal demand template was implemented within Critical Care in order to manage staffing levels across the year. This enabled an increase in the nursing workforce when faced with the increase in patient activity and acuity in the winter period. The seasonal template is now under review due to the unprecedented pressures over the last 10 months.

Due to the nature of this speciality, 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 usually meets the demands of the service; despite challenges, have continued to do so during Covid-19 pandemic. Critical care ensures senior cover is provided by staff members that possess the appropriate level of knowledge and skills to co-ordinate the department. A daily review of occupancy and acuity takes place to ensure that the nurse in charge remains supernumerary and co-ordinates this highly specialised area and provides senior clinical support. The requirement for cover to maintain patient safety and mitigate risk associated with this is planned.

As with theatres, the skill set required of critical care staff is significant. Band 6 staff currently carry out education and training for critical care staff but this is a continuing challenge due to capacity and the need to work clinically on the unit themselves. National standards (GPICS) recommend that for every unit with 75 or more staff members should have a designated clinical educator. The current number of nursing staff members is above 90 (84.77wte). The care group are progressing a business case to introduce this role within the establishment.

The Critical Care Unit has also embraced the introduction of new roles into their current workforce models including the Advanced Critical Care Practitioner (ACCP) however this remains in its infancy and will be reviewed as part of the workforce review in Summer 2021.

5.5 Specialist nurses/midwives

During September and October 2020 a review was undertaken with the specialist nurse teams using the same methodology of that used for the general nursing workforce establishment reviews. 33 different nurse/midwife specialities were included in this review, those reviewed within each care group can be seen in table 1 below with general themes arising from those reviews.

Table 1. Specialist Nurse Reviews

Healthy Lives Care Group	Responsive Care	Collaborative Care
Macmillan Carers	Urgent care practitioners	Lower limb
Palliative Care	In-hospital nurse	Colorectal
Diabetes	practitioners	Breast care
Stop Smoking	Parkinson's Disease	Spinal
Continence	Specialist Lung	Bariatric
Rheumatology	Macmillan	Pain
Community Dementia	Oncology/haematology	Emergency surgery
Paediatric community	Eating disorders	Urology
Early Pregnancy Assessment	COPD	Trauma
Assisted reproduction	Anticoagulation	Surgical care practitioner
New-born screening		

Gynaecology		Advanced nurse practitioner Duty clinical practitioner
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Themes arising from reviews being addressed in Care Groups

Locality cover
 Development/rotational posts – succession planning
 Team leader roles review
 Minimal educational requirements
 Training needs analysis (e.g. Prescribing, clinical skills)
 Competency packs
 Resilience/single point of failure
 Job planning/capacity and demand modelling
 Clinics/admission avoidance/ward support
 Recording all activity (e.g. telephone advice)
 Autonomous working/clinical decision making
 Differences between specialist nurses and practitioners
 Admin support varies

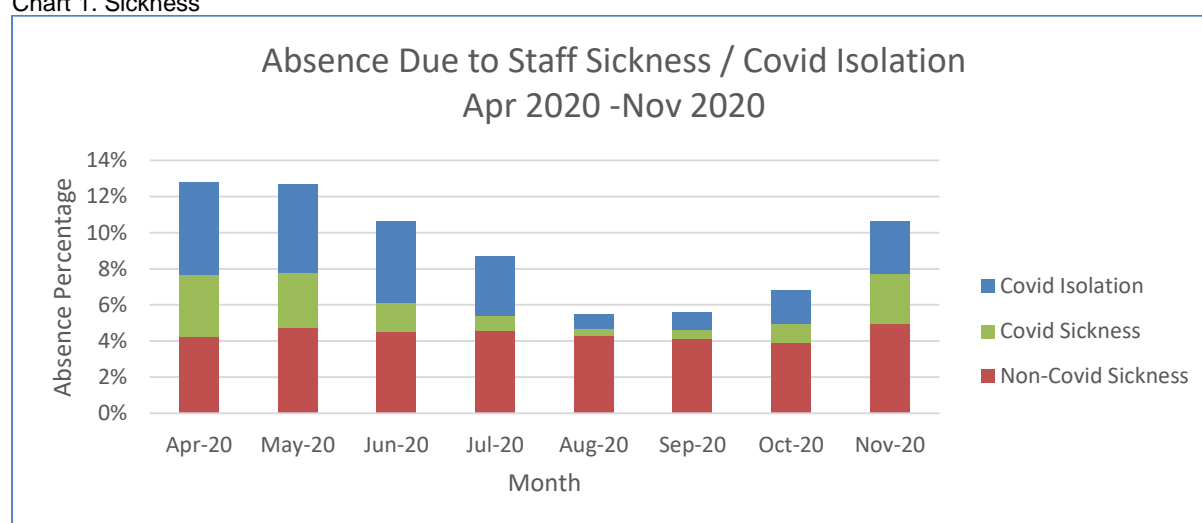
A review into the endoscopy specialist nurses took place within the care group outside this bi-annual review, all specialist nurse teams will undertake further review during summer 2021 alongside the other professional workforce reviews.

5.6 Workforce Metrics

5.6.1 Nurse and Midwifery Sickness

Chart 1 below shows the overall nurse and midwifery sickness absence April to November 2020. The average across those months was 9.1% which remains a significant challenge. April, May and November are showing the highest levels of sickness absence with a peak of 12.6%. It is important to note that whilst this includes sickness due to Covid symptoms and staff absences due to Covid related isolation. The breakdown can be seen below.

Chart 1. Sickness



Within the funded headroom, 4% is allocated for both registered and unregistered nurses for predicted sick leave. The current rates continue to be over and above this. 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.

5.6.2 Vacancies and Turnover

Chart 2 below shows the Nurse and Midwifery vacancies during 2020 identifying a continued high monthly RN vacancy. The RN vacancies peaked at 84.7wte (6.2%) in June 2020 with the lowest vacancy rate in August at 51.6wte (3.8%). Unregistered nurse and midwifery vacancies peaked to 33.3wte (5.1%) in October with the lowest rate of 25.7wte (3.9%) in April. Registered midwife vacancy level peaked to 9.5wte (7.5%) in May with lowest rate of 2wte (1.5%) in July 2020.

Chart 2. Vacancies 2020

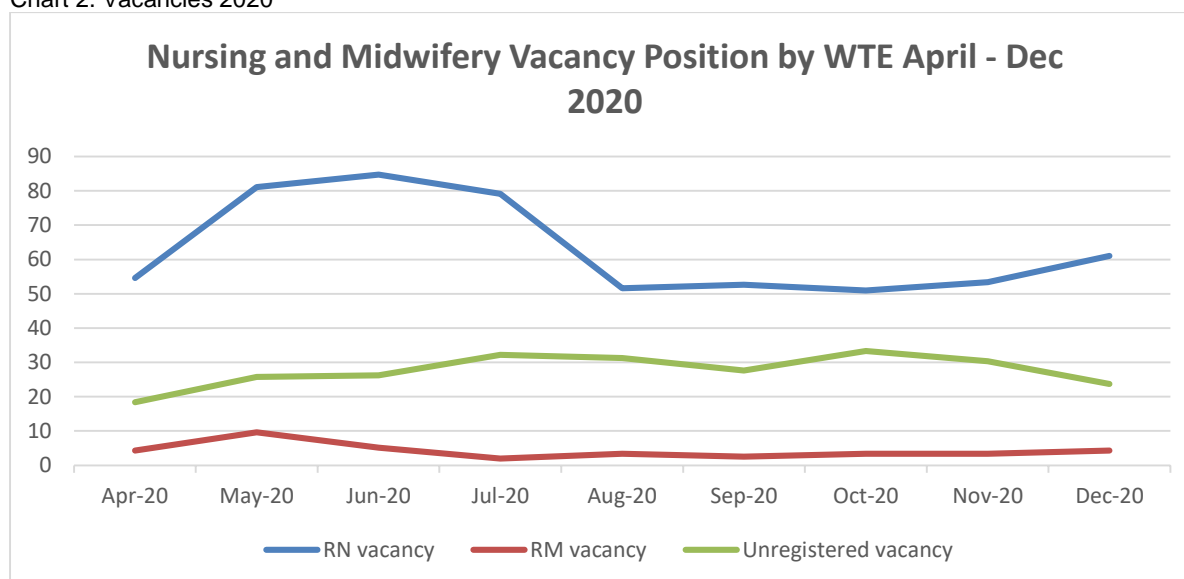


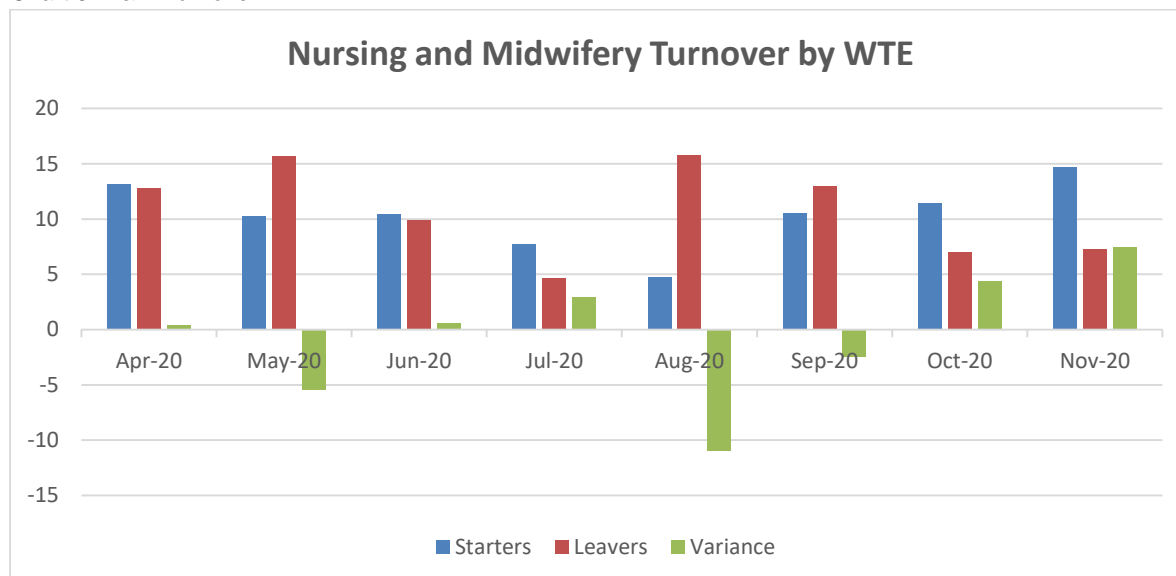
Table 1 below shows the breakdown of vacancies for December 2020. This is expected to improve over throughout January and February 2021 due to an increase in recruited nurses, both registered and unregistered.

Table 1. Vacancies December 2020

Registered Nurse	Registered Midwife	Unregistered N&M
61wte (4.5%)	4.3wte (3.4%)	23.7wte (3.6%)

The nursing and midwifery turnover, as seen below in chart 3, shows the breakdown of starters and leavers each month. Between April and November 2020 there has been a total of 83wte starting and 86.12wte leaving.

Chart 3. N&M Turnover



5.6.3 Planned and Actual Staffing

In line with the National Quality Board (NQB) publication; Nursing, Midwifery and Care Staffing Capacity and Capability; the Trust continues to report the planned and actual staffing data on a monthly basis to NHSI.

Safe Care Live (SCL) allows the Trust to generate both a required and an actual CHPPD for all inpatient areas twice per day. This gives a more accurate reflection of staff allocation and staff to patient ratios across a 24-hour period.

The Trust bases staffing establishments on the case mix and acuity of the patients within the wards or departments and utilises the nationally approved nursing and workforce tool, the Safer Nursing Care Tool (SNCT). This tool is overlaid with professional judgement and quality outcome metrics. The Trust's nursing workforce tool focuses on patient safety, quality, cost effectiveness and effectively managing staffing resources and is based on a Care Hours per Patient Day CHPPD which reflects patient needs.

In response to the need to remain flexible in the way nursing and midwifery staffing is planned the Trust also utilise the Safe Care Live module (SCL) on a day to day basis to safely and efficiently assess accurate staffing levels and to redeploy nursing staff throughout the organisation.

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 staff, 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. The data within Safe Care Live currently has a high compliance of completion at >80%, validated of the data will take place by the Senior Clinical Matrons on a monthly basis.

A small number of areas within the Trust utilise bespoke nationally recognised tools combined with overarching professional judgement to identify their staffing

needs including Birth Rate Plus (BR+) in maternity and the British Association of Perinatal Medicine (BAPM) Standards in the Special Care Baby Unit (SCBU).

5.6.4 Care Hours per Patient Day (CHPPD)



The overall average CHPPD figures in Safe Care Live module for Q2 and 3 2020/21 can be seen below in table 2. The data submission was paused nationally during the initial Covid-19 surge between March and June 2020. It can be seen that the variance between required and actual significantly reduced in Q3 2020/21 as occupancy and staff unavailability increased.

Table 2. Average CHPPD July – December 2020

	Required CHPPD	Actual CHPPD	Variance
2020-21 Q2	8.25	10.25	2.00
2020-21 Q3	8.31	8.58	0.27

The average fill rates; as seen below in table 3, show a reduction in RN during the day and a high rate of Health Care Assistants on nightshift; this often reflects RN gaps and the increased provision needed for enhanced care. The fill rates in Q1 reflect the reduction in occupancy across the organisation throughout the initial Covid-19 response.

Table 3. Trust Average Fill Rates January – December 2020

	RN Day	HCA day	RN Nights	HCA Nights
2019-20 Q4	83.26%	95.58%	93.83%	143.55%
2020-21 Q1	68.51%	70.67%	73.17%	89.25%
2020-21 Q2	76.62%	82.83%	83.23%	111.98%
2020-21 Q3	80.21%	82.03%	87.64%	116.17%

5.6.5 Monitoring of Clinical Outcomes

NICE guidance (2014) identifies organisational approaches to safe nurse staffing of in-patient wards in acute hospitals. It aims to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. Within this guidance 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 within the organisation on a weekly basis where all potential harms are discussed from the previous week with

attention to any themes or staffing concerns. The continued work reviewing patient acuity and dependency will help to address whether the harms have occurred as a result of reduced staffing.

Falls

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

Table 4 below shows the number of falls sustained across the trust during 2020 (January to December). It can be seen that a high proportion (79%) of falls resulted in no injury.

Table 4 Falls

2020	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020 Total	%
Fall No Injury	57	64	52	59	55	61	74	74	74	91	85	100	846	79.36%
Fall Injury, No Fracture	15	20	13	15	8	13	14	16	22	14	20	37	207	19.42%
Fall with Fracture	0	9	0	0	0	0	1	0	2	1	0	0	13	1.22%
2020	72	93	65	74	63	74	89	90	98	106	105	137	1,066	100.00%

Pressure Ulcers

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. The patient's pressure ulcer could be categorised as 1, 2, 3 or 4. Although pressure ulcers may be sensitive to the number of available nursing staff, pressure ulcers prevention requires a multidisciplinary approach, and pressure ulcers rates will also be 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

Table 5 below shows the number of Hospital and Community acquired pressure ulcers during 2020 (January to November) which shows the highest level of pressure ulcers are category 1 and 2, 94.17% in hospital and 75.61% in the Community.

Table 5 Pressure Ulcers

2020	Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2020 Total	%
Hospital	Category 4	1	0	0	0	0	0	0	0	0	1	1	3	0.92%
	Category 3	2	4	0	0	1	0	0	4	3	1	1	16	4.91%
	Category 2	29	33	20	28	24	21	13	8	11	18	36	241	73.93%
	Category 1	8	7	3	4	6	6	3	1	7	6	15	66	20.25%
2020		39	44	23	32	31	27	16	13	21	25	52	326	100.00%

2020	Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2020 Total	%
Community	Category 4	1	3	0	0	1	1	0	0	1	1	2	10	4.07%
	Category 3	6	3	6	1	3	7	3	6	7	5	3	50	20.33%
	Category 2	15	12	16	10	16	8	14	10	10	16	15	142	57.72%
	Category 1	1	3	0	5	8	2	3	5	4	6	7	44	17.89%
2020		22	18	22	16	27	17	20	21	21	27	25	246	100.00%

5.6.6 Occupancy level

In addition to patient acuity, the occupancy rates within hospital are also important to monitor when reviewing staffing establishments. The occupancy from April to December 2020 (inclusive of surge beds) can be seen in chart 4.

Chart 4 . Occupancy

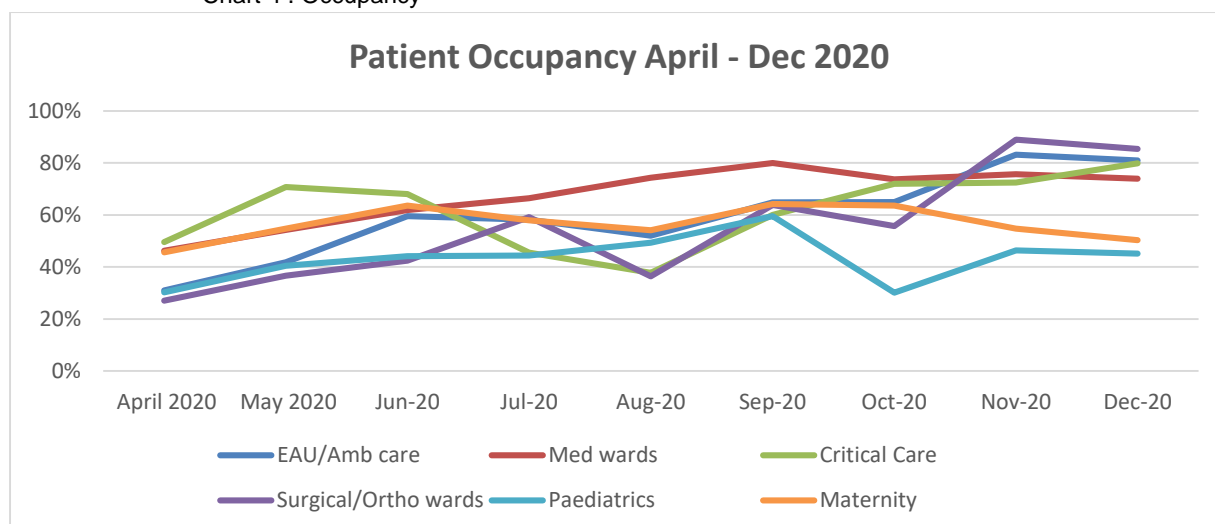


Table 6 below shows the overall average monthly average % occupancy across all adult In-patient areas (excluding Paediatrics and Maternity)

Table 6. Average Occupancy

April 20	May 20	June 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
38.47	50.87	57.97	57.33	50.08	67.20	66.60	80.07	80.02

5.6.7 Nurse and Midwifery Recruitment Registered Nurse and Midwifery Recruitment

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.

Frequent use of social media platforms provides information to the public around vacancies and opportunities within the Trust with a particular focus on promoting the Trust as the employer of choice.

All band 5 Registered Nurse recruitment continues to be carried out via value based monthly recruitment centres and this method has proven to be a positive way of attracting pre-registered and registered nurses to the Trust.

A successful candidate reserve provides a pool of staff awaiting posts in specific areas/specialities. This has proved successful as many have taken up interim posts in other wards/departments until their preferred area of work declares a vacancy. They are then supported to transfer into that vacancy. Bespoke recruitment continues to be successful in some specialist areas where recruitment had to be targeted to attract the right workforce with the right skills and experience (e.g. Critical care, theatres).

There continues to be 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. The Nursing Associates are regulated by the Nursing and Midwifery Council (NMC).

Nursing Associate Apprentices are in practice in some areas with plans for future cohorts, based on workforce plans. These posts; where appropriate; enhance and support the care provided by Registered Nurses.

The Trusts vision is to build the nursing workforce of the future and as such has continuous links with local schools, colleges and Higher Educational Institutes to raise the profile of nursing.

The organisation has supported a recent implementation of a new 'Team support worker' role (6-month pilot) 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 aims to reduce the pressure on nursing teams by undertaking tasks such as answering phones, communicating with patients and relatives, supporting with completion of paperwork and general admin or patient care duties. The recruitment of these

workers were fast-tracked with support from the recruitment team having been involved from the inception of this programme of work. Initial cohort interviewed in December resulted in 21 being appointed and some commenced in post early January 2021.

Further interviews have taken place in January with high level of interest in these posts from a variety of backgrounds. It has been agreed that each worker will become integrated within the team/ward to provide a sense of belonging and identity for the wider team. The role also offers the opportunity to improve communication pathways between clinical services, support patient discharge and virtual visiting during a time when relatives are limited in their ability to attend the hospital to visit patients. The value of the role will be continually assessed with the aim of determining its effectiveness in improving patient experience and communication, both internally and externally with the additional hope of observing a positive impact on staff experience.

5.6.8 Nurse Retention

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 our 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.

The Faculty for Inter-Professional Education and Staff Training (FINEST) commenced in 2017; The FINEST programme continues to offer six month posts for the duration of the nurses first year of employment within the Trust.

Monthly registered nurse development days are being revised by the Heads of Nursing and are planned to continue throughout 2021. There will be a continued focus on personal and professional development and the health and wellbeing of staff.

Clinical skills days for the registered nursing workforce promote continuous learning and the consolidation of essential core clinical skills. Core skills development days are planned to continue monthly with band 5 registered nurses across all Care Groups attending the sessions that are planned and delivered by the Education Department.

The organisation continues to provide new staff with a block week of mandatory training immediately following the block week of preceptorship training. This ensures that all staff new to the organisation are fully compliant with their mandatory training prior to commencing work in clinical practice.

Substantive nursing staff are supported to move across specialities within the Care Groups and are also 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.

In 2021 there are plans to streamline this by introducing a 'transfer window' process whereby all staff will be given a number of opportunities across the year to apply for an internal transfer. The transfer windows will support offering

fair and equitable opportunities for staff and will provide a more organised and structured process for the Care Groups to manage this process.

Developing our current and future leaders is a key priority of the Trust. In October 2018 NHSI published a 'Ward leaders' handbook' which is a guide for those who aspire to be a ward leader, those already in post and for Trusts that want to support and develop this important role. Developing leaders and managers within the Care Groups is essential in ensuring a stable workforce for the future. Career pathways and leadership modules are currently being explored to help support Registered Nurses moving into Matron and Deputy Matron posts.

There is a significant focus on the personal and professional development of staff. During 2020, registered nurses were offered individualised skills passport relating to the area they work. In addition, all new nurses taking up post are placed onto a developmental pathway which will consist of a three-year programme to support their learning needs.

Within the workforce reviews, attention was given for teams to have awareness of the potential retirement plans for nurses who are aged 55yrs+ to ensure that succession planning is in place as many of these nurses have advanced skill sets with many years of experience that is not easy to replace.

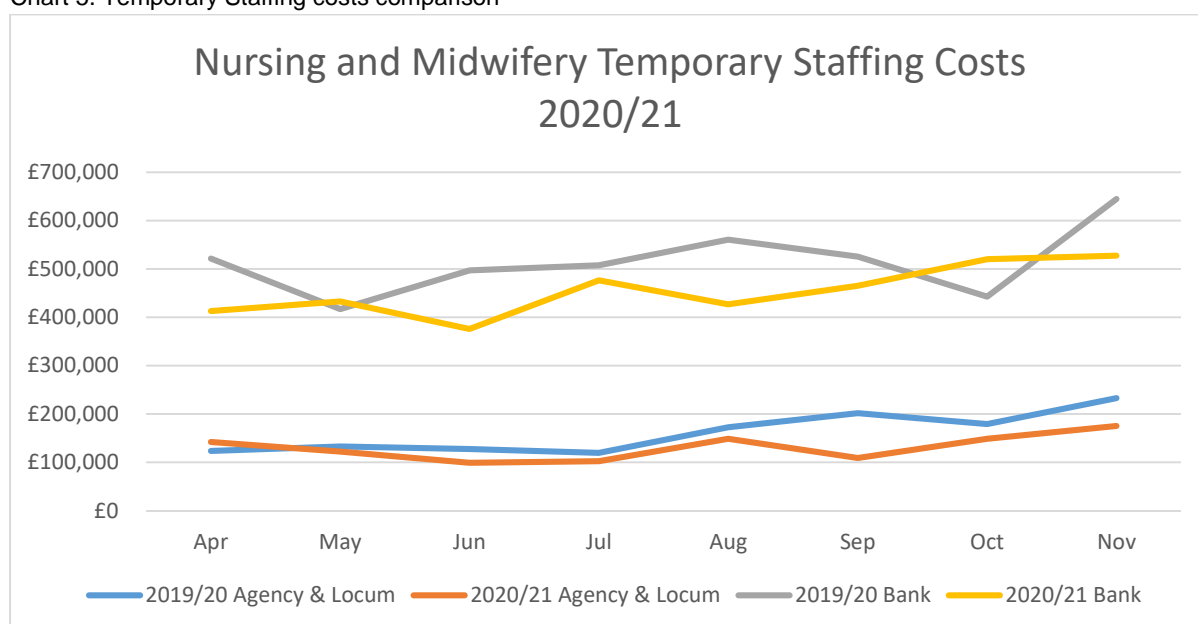
Work streams are in place to focus more consistently on RN recruitment and retention strategies throughout 2021 which include the following;

- Rotation through different areas and specialities
- Clinical training days
- Simulation training
- Aspiring Ward Matron meetings
- Continuation of Education panels
- Quality Improvement projects
- Quarterly Care Group band 6 and 7 development sessions.
- Quarterly Care Group Specialist Nurse/Practitioner development sessions

5.6.9 Temporary Staffing Usage

Temporary staffing expenditure for Nursing and Midwifery staffing has reduced by £669k year to date (YTD) in M8 compared with the same period in 2019. YTD Temporary Staffing expenditure in M8 totals £6,024,178, which includes Bank, Agency and Locum, and Overtime costs. A year on year comparison for Bank, Agency and Locum is displayed in Chart 5.

Chart 5. Temporary Staffing costs comparison



The improved position is notable, and the following mitigation can be applied to the year to date spend:

- Increase in bank rates from April 2020 in line with agenda for change pay award
- Increased agency rates in line with the increase in NHS Improvement price cap and framework compliance
- Costs associated with COVID-19 included in the expenditure summary and highlighted separately for context
- Consistent temporary staffing demand within the Enhanced Care service

Agency expenditure trend is consistent with previous years and the reduction of agency usage across the organisation remains a key priority moving into 2021. Bank expenditure has reduced year on year and has not followed the same trend as in previous years, resulting in significantly reduced fill rates going into the winter period. This can be attributed to the pressures staff are under whilst working throughout the COVID-19 pandemic. Staff unavailability is unprecedented resulting in less availability of staff to fill bank shifts as well as working their contractual hours.

Table 7 below shows the fill rates between bank and agency for registered and unregistered nursing staff. It can be seen that there continues to be a higher fill rate for the unregistered nurses than the registered.

Table 7 Temporary Staffing fill rates

	Qualified					Unqualified		
	Hours Requested	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Hours Requested	NHSP Filled Hours	% NHSP Filled Hours
April 2020	14,622	6,390	43.7 %	1,472	10.1 %	15,974	13,278	83.1 %

May 2020	13,761	5,576	40.5 %	1,429	10.4 %	16,055	12,932	80.6 %
June 2020	11,750	4,851	41.3 %	1,362	11.6 %	14,231	11,767	82.7 %
July 2020	11,740	5,177	44.1 %	1,258	10.7 %	16,093	13,169	81.8 %
August 2020	12,163	5,820	47.9 %	1,606	13.2 %	16,482	14,687	89.1 %
September 2020	11,949	5,737	48.0 %	1,630	13.6 %	17,699	15,226	86.0 %
October 2020	13,765	5,850	42.5 %	2,583	18.8 %	20,635	16,045	77.8 %
November 2020	18,841	7,616	40.4 %	2,515	13.4 %	28,101	18,648	66.4 %
Total	108,591	47,017	43.55 %	13,855	12.7%	145,270	115,752	80.9 %

5.6.10 Electronic Rostering

The progress of the Health Roster Implementation Project was significantly impacted by the COVID-19 pandemic, however the project was completed in December 2020, with the understanding that continued work is required in some areas. The project resulted in the successful implementation of around 4000 clinical and non-clinical staff across all staff groups in the organisation, and ensures electronic payroll processes are in place removing the requirement for paper SVLs transferring between departments.

Flexible rostering is in use across Urgent Care Services and Emergency Assessment Unit with significant time-saving implications for managers. Staff in these areas can now request 100% off-duty in line with agreed rules and restrictions for that area or team. Further roll out is being scoped on other clinical areas and was discussed as part of the face to face meetings for the annual workforce review.

Regular budget and demand template reviews with Ward Matrons, Senior Clinical Professionals (SCPs) and Finance Business Partners (FBPs) are undertaken to ensure available shifts in the system do not exceed planned budgeted establishment and that the available budget is used efficiently and effectively in areas where the template cannot be simply aligned to the budget.

In June 2020, a Nursing, Midwifery and AHP workforce assurance group was developed to meet monthly to oversee the compliance against E-Rostering key performance indicators alongside other workforce metrics, including Temporary Staffing and acuity data. These meetings have been on hold over recent months due to pressures within the organisation but there is a plan to recommence as soon as able to do so.

5.6.11 Enhanced Care

Due to continued high demand in patients requiring 1:1 enhanced care, work was progressed to review the service, demand and capacity. An options paper was presented to the Executive Team in December 2020 where it was approved to progress to an alternative model for providing enhanced care within the current annual control total. There are 5 wards with continued high patient demand for enhanced care that will now receive a substantive uplift in

the unregistered nurse establishment to help support this need, resulting in an additional 32wte in total across those wards.

The enhanced care assessment function will integrate with the current discharge team to support the 'Home First' model and also takeover centrally co-ordinating the temporary staffing resource to support urgent enhanced care requests. This integration is being progressed in line with the agreed project plan whilst recognising the longer term vision is to reduce the demand on enhanced care by fully implementing a 'home first' model of care. It was agreed to evaluate the success of this before 31 June 2021.

6. Allied Healthcare Professionals (AHPs)

Allied Health Professionals account for 8% of the total workforce within the trust.

- 6.1 The 14 Allied Health Professions form the third largest clinical workforce in health and care. Healthy Lives Care Group employ Occupational Therapists, Physiotherapists, Podiatrists, Dietitians and Speech and Language Therapists with Diagnostic Radiographers working in the Responsive Care Group. Each profession works with children and adults. There is also contracted work with a private orthotic Service. The breadth of AHPs' skills and their reach across people's lives and organisations makes them ideally placed to support change and improvement.
- 6.2 'AHPs into Action' was produced back in 2017 by NHS England. The framework represented the start of a journey to highlight the transformative potential of AHPs within the health, social and wider care system. Three years on, local examples can be provided as identified in figure 1 below.

Figure 1



- 6.3 AHPs are key to implementing the vision of the NHS Long term plan. All AHPs across Healthy Lives are aligned to Senior Clinical Professionals and they report directly to the Head of Specialist Services, integration and Partnerships. Progress has been

made implementing key Lord Carter principles and work is ongoing with regards to job planning and clinical supervision. E-rostering is in place for the majority of AHP groups and a plan is in place to roll out further. Flexible working hours are supported to meet clinical needs 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.

- 6.4 In terms of operational productivity, AHPs have embedded Lord Carter dashboards and continue to benchmark services against Model Hospital data, NHS Benchmarking and GIRFT.
- 6.5 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 3 years and on-going continuing professional development supporting the increased use of Advanced Practice roles. Locally Physiotherapy (PT) and Occupational Therapy (OT) institutions are currently working through the PT and OT apprenticeship programme, this is exciting for the AHP profession and this approach is supported within recruitment.
- 6.6 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.
- 6.7 There are new and emerging roles including AHP Consultant and 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. Locally there is a Physiotherapist who is currently working with the Intermediate Care Service and being supported by the Emergency Department to become an advanced practitioner Physiotherapist. This role has the potential to feature across patient groups within the different Care Groups.
- 6.8 AHPs will continue to work with partners to further develop the role of the non-medical prescriber in order to afford patients a greater opportunity of quickly accessing the right medicines they require at the right time, from the right person. This will better utilise workforce across the health system with financial savings. Areas for development include MSK, Respiratory Physiotherapy, Podiatry and Nutrition and Dietetics.
- 6.9 The health and care system requires integrated leadership. Coaching and mentoring has an important role within workforce. It is important that leaders and managers are able to effectively demonstrate these skills. North East Learning Academy (NELA) have commissioned Level 5 and Level 3 certificate programmes. AHPs that would benefit from this development are supported. Also Coaching / motivational interviewing would support leadership / culture changes as highlighted in the interim NHS people plan and will be explored further within the Care Group.
- 6.10 In partnership with our 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 provide a platform to develop relationships with partners in primary care as well as delivering more support to our care homes utilizing the *Enhanced Health in Care Homes* framework.
- 6.11 Two Physiotherapy Leaders have recently presented a local First Contact Practitioner (FCP) Service model to local Primary Care Network Clinical Directors. This innovative

approach to managing musculoskeletal injuries in primary care has resulted in investment into our local Physiotherapy workforce, new preceptorship opportunities and further development with advanced practice to develop the FCP offer as a part of the integrated MSK service. The FCP role is not ring-fenced to Physiotherapists. The role could be taken by other AHP groups including Occupational Therapists. Collaboration within this forum at this time is key to influencing and potentially securing further investment to improve local health and care systems. AHPs have played a pivotal role in the evolution of the integrated musculoskeletal service, with the opportunity of extended scope practice across rheumatology, orthopedic and pain pathways.

- 6.12 Locally the Physiotherapy and Occupational therapy teams are part of an integrated intermediate care service, delivering reablement and rehabilitation to our local population. Integration across acute and community teams has become custom and practice for local therapy teams, demonstrating true 'better together' and performance improvements in reducing delayed discharges and the number of stranded patients in Hospitals. The acute Physiotherapy and Occupational therapy teams 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) and they form 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. Learning from nursing colleagues to implement a model that works best for our patients and our staff will be acknowledged.
- 6.13 The AHP workforce is ideally placed to explore further opportunities with regards to alternative workforce models. Examples include system leadership posts and Ward Manager positions traditionally associated with Nursing Professions. This role would be particularly relevant to ward areas that care for our older patients who benefit from a multi-disciplinary approach. AHPs including Physiotherapists and Occupational Therapists are integral to efficient ward management and good patient flow and this is emphasised in recent AHP workforce literature.
- 6.14 Recent changes to the Operating model and the introduction of 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 we can deliver the best care in the right place at the right time. AHPs are key to this conversation and are often best placed to innovate and facilitate change. This approach to transformation could support the growth of AHP roles whilst developing services in line with the strategic aims of the Organisation.
- 6.15 The AHP workforce has taken a lead on multiple strands of digital work, showing innovation and collaboration to achieve real success. The Trust has an AHP digital lead who supports this work and is linked with national programmes. Locally the work includes:
- Leading on the implementation of video consultations within the Trust
 - Development of a patient facing digital resource to support our patients and population to 'live well' which proactively supports patient health and well-being within the community
 - Virtual visiting
 - Virtual home assessments as part of discharge pathways

- Supporting digitally enabling care homes - leading on the development of a digitally enabled integrated health and social care team
- Remote monitoring of patients

There is an understanding that the move towards a more digitally enabled workforce and population could potentially widen the inequality gap. Work is being progressed by the AHP team to ensure a system approach to mitigate this impact to ensure integration with the population, recognising that patient choice will still be important.

6.16 AHPs are leading a movement to increase physical activity levels within the local population. This is a key strand of the population health strategy. Having successfully secured being awarded an Active Hospital Status, a Physiotherapist has been appointed to the Active Hospital project lead role to ensure the importance of physical activity becomes a cornerstone of the organisational culture to improve the well-being of our workforce and service users.

6.17 Workforce Data

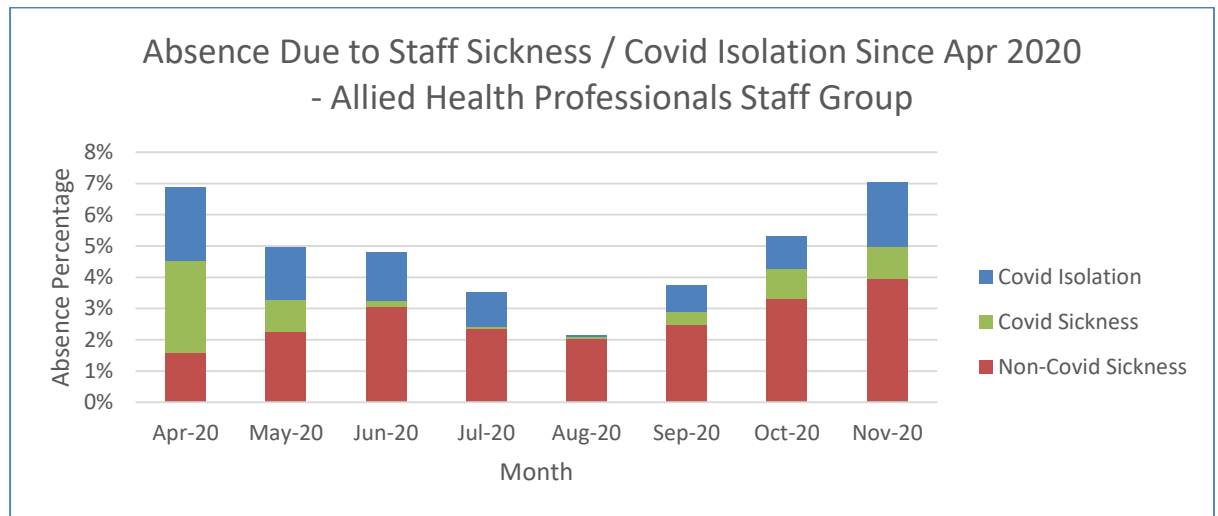
Table 8 below shows the current vacancy factor across AHP Services (within Healthy Lives). This shows a total of 18.82wte vacancy which equates at 6%, however it can be seen that SALT (children) provides the biggest impact with current vacancy position.

Table 8 Vacancies

Row Labels	Sum of WTE Budget	Sum of WTE Contracted	Vacancy	%
Nutrition & Dietetics	19.78	20.8	-1.02	0.00%
Occupational Therapy	45.6	43.81	1.79	3.93%
Physiotherapy	118.59	121.47	-2.88	0.00%
Podiatry	26.48	24.15	2.33	8.80%
SALT (Adults)	7.62	7.02	0.6	7.87%
SALT (Children)	92.45	74.45	18	19.47%
Grand Total	310.52	291.7	18.82	6.06%

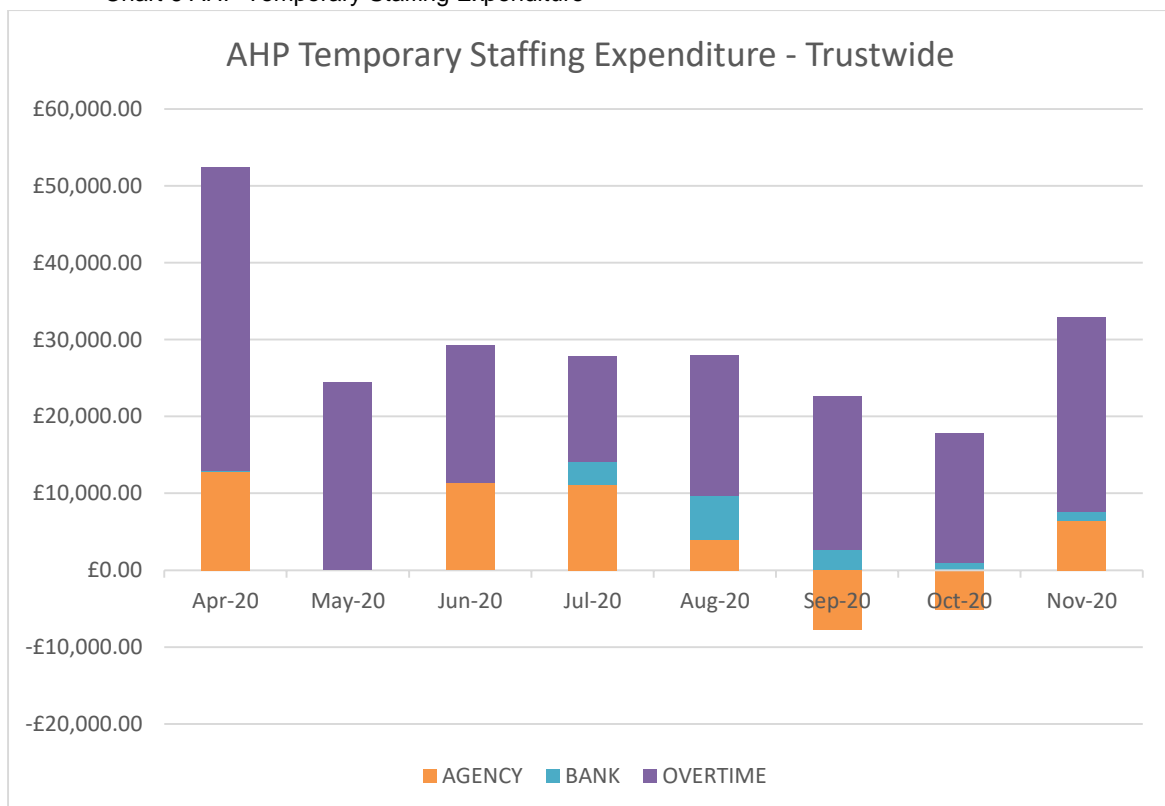
Sickness absence for AHPs from April – November can be seen below in chart 5. Sickness absence rates have averaged at 4.79% with noticeable peaks in April, October and November 2020. It is important to note that this information includes sickness due to Covid symptoms plus staff absence due to covid isolation. The breakdown can be seen below.

Chart 5 Sickness absence



Temporary staffing continues to be used to backfill gaps within the AHP workforce. Chart 6 below shows the expenditure April to November 2020. It can be seen that the total expenditure is £222,680.42 with the highest cost being due to overtime at £176,157.24 and the lowest being bank at £13,695.58. The plan to progress further with AHP workforce transitioning across to NHSP aims to further reduce overtime spend and increase the use of a lower bank cost.

Chart 6 AHP Temporary Staffing Expenditure



6.18 Nutrition and Dietetics

- Looking to extend the role of the dietician to further enhance MDT working, transformation of the coeliac service, requesting blood tests and DEXA's.
- As part of the service review, to consider ways to extend the role of the dietician in other areas of practice e.g. pancreatic insufficiency where the department is monitoring increase in referrals for this area and exploring skill mix to meet demand opportunity to expand service in future.
- Aim to improve patient flow and experience with joint clinic approach in MDTs. This may lead to additional training for dietetic staff and review of job roles.
- Aim to reduce prescribed treatments for Type 2 Diabetes in-patients referred to the Diabetes secondary care team. There is potential to expand current service and; if successful after exploration with CCG; could be open to GP referrals in the future. Pilot continuing with the Type 2 Diabetes 'very low calorie diet' clinic.
- Potential to explore dietetics role within Tissue Viability. Patients are currently picked up as part of a block contract in general clinics/ wards, team are looking at long term patient outcomes and costs in other Trusts.
- Potential development of dietetic prescribing roles (supplementary prescribing) to support extended roles in Pancreatic, Diabetes and Critical Care. Pathways must be clearly defined and supported by a medical prescriber with the use clinical management plans.
- Work will be undertaken to explore how enhanced advice and guidance for nutrition and hydration is provided in the acute hospital setting and community.
- Regularly reviewing skill mix to meet service needs. Recent skill mix of B6 and B3 hours to support a B4 education role in the team.

6.19 Podiatry

- Despite recruitment challenges nationally for podiatrists, locally recruitment and retention of staff is positive.
- The high risk podiatry service has held flagship status locally for the work they have conducted in partnership with the endocrinology Consultants and the specialist nursing team
- One Podiatric Surgeon is currently involved in the national effort to work towards a separate annotation on the HCPC Register for Consultant Podiatric Surgeons

6.20 Physiotherapy

- Physiotherapy demand is growing and with the development of FCP roles, supply will be a challenge
- Supporting the first round of apprenticeship PT students
- Providing a high quality rotational experience for new graduates with opportunities that span Care Groups and pathways
- Plan to offer leadership / coaching opportunities and build on the recent work associated with 'go mad thinking'
- Maintaining and where appropriate developing the private arms of services. Increasing the opportunity for staff to work within private practice and elite sport increases retention rate and is a draw for new graduates

- Continue to invest in development of clinical skills i.e. MSK u/s, NMP, injection therapy, etc.

6.21 Occupational Therapy

- Providing a high quality rotational experience for new graduates with opportunities that span Care Groups and pathways
- Supporting the first round of apprenticeship OT students
- Plan to further develop the local OT Forum, a platform for sharing good practice, staff development and to maintain professional contacts across areas
- Leading the way on developing the local spasticity management service across adults and paediatrics. Two local OTs are qualified to inject and treat spasticity, the team will continue to drive this forward as appropriate with the support from Clinicians
- Explore further investment in Specialist Posts to increase the number of staff and build on the work currently carried out by OTs in the Frailty Team, Hand therapy and Dementia
- Plan to formalise an OT rotational opportunity between health and social care, to support staff to work on the frontline of integrated services, share skills and influence generic development
- Leading the cross care group transformational project associated with *Discharge to assess* working across boundaries to support the transition of rehabilitation from the hospital and into the community

6.22 Speech and Language Therapy (SLT)

- In addition to core staffing, the Childrens SLT service deliver a high number of external service level agreements within different settings (largely schools). Funding typically supports recruitment of 13- 14 staff. However, this significantly increases the demand for generalist therapists within the service and this is a continual pressure as staff within these posts are typically new graduates. Recruitment following initial intake can be challenging. As an example, currently 2 therapists in post, 3 additional therapists recruited and further plans to recruit in interviews this month, anticipating 5-6 therapists. Work is ongoing in all 4 localities in relation to joint commissioning which is likely to impact on the continuation of SLAs in the future.
- Ongoing challenges around resilience in dysphagia. Increasing capacity in the team of dysphagia trained therapists to support resilience in the longer term.
- Retention issues as students generally have placements in the service from Newcastle University. They often reside in Newcastle, which means that they prefer to be closer to this location. For some, links have been developed with Stockton / Darlington teams but generally too far for a permanent post. General feedback also indicates that the geography of the Durham and Darlington service presents challenges for staff who are in posts that cover the whole service area as this can lead to increased commutes / travel expenses etc.
- Ongoing challenges to recruit to a specialist post in voice disorders. Despite caseload numbers being very small, resilience needs to be built into this service
- Exploring options for a mixed adult / children's post to provide a varied post that is different to those generally advertised regionally which may support recruitment / retention.

6.23 Radiology

- Radiology AHPs are integral to the delivery of a safe and effective diagnostic service across both the acute and community sites. The teams are led by a well-developed Advanced Practitioner structure which also supports patient flow and the timely reporting of diagnostics.
- There is a well-developed skill mix with progression to Advanced Practice and the Ultrasound service is primarily AHP led.
- Innovative roles, such as leading and reporting cardiac CT, continue to support the wider service and reduce reliance on the medical workforce
- Radiology continue to face a high level of Radiographer vacancies despite an increase in student numbers. Recruitment is targeted annually in advance of qualification in order to compete with other local Trusts
- Recruitment of skilled specialist Radiographers continues to be a pressure and therefore training is undertaken within current Radiographer workforce which results in a pressure at Band 5 level.
- No availability of Bank/NHSP Radiographers and therefore shortfalls in workforce are supported with overtime from existing workforce.
- Involvement in workforce discussions at a regional level has highlighted the need for a means of progression from Band 4 Assistant Practitioner to Radiographer in order to support and manage the shortfall. This has been escalated via HENE.

6.24 AHP Recommendations

- To support the Trust wide corporate priorities and develop AHP solutions to support these
- To introduce evidence based safe staffing models for AHPs working within acute Hospital settings
- To effectively plan workforce requirements linked to the Long Term Plan to move rehabilitation into the community setting. Define and enhance the capacity/capability within the community setting with a view to deliver a 'Home First' approach
- To work together to deliver the right care in the right place at the right time by the right person or professional
- To continue to represent AHPs at regional level to maintain connections across core and specialist service
- To influence the Trust Strategy and local health and care provision
- To work with the Chief Nursing team to ensure the workforce plans for all professions are connected and produced in partnership

7. **Medical and Dental Workforce**

Medical Workforce Update

- 7.1 The coronavirus pandemic has had a significant impact worldwide, in response to this extraordinary time our medical workforce continues to work flexibly and as a team to care for our patients. Their efforts and resilience is commended.
- 7.2. As the pressures of the pandemic continue, it is important that we look after ourselves and each other. This can be difficult when services are short staffed, to support its

workforce the Trust continues to offer many health and wellbeing initiatives. The Psychology Support Hub line is still available for those who need a bit of support, new recharge hubs have been opened, and a Wellbeing Guardian has been appointed.

- 7.3 Exception reporting is in place for our doctors in training and Trust doctors to raise awareness of hours worked, educational issues, and support issues. The Guardian of Safe Working has increased the frequency of the doctors' forum to support the junior medical workforce, obtain feedback, and address concerns.
- 7.4 Frontline staff are being offered COVID-19 self-testing (lateral flow testing), with the aim to reduce spread by identifying those who have the virus but are asymptomatic. The Trust also received its first supplies of the vaccine which is currently being rolled out.
- 7.5 Flexible and remote working has increased, allowing teams to meet virtually and continue with teaching sessions for doctors in training.
- 7.6 Long-standing senior vacancies with the added pressures of covering absent colleagues due to COVID-19 is a risk to the workforce. Temporary staffing usage has increased as a result. It is important that the Trust continues to implement initiatives to manage, attract, and retain its workforce. This should be done in line with national and local initiatives.
- 7.7 During the pandemic the Trust has continued to implement the requirements of the national doctors in training contract

8. Medical and Dental Workforce Metrics

- 8.1 **Headcount:** The Trust currently employs 341 doctors/dentists and is currently hosting an additional 150 doctors in training (DiT's) who are provided by the Lead Employer Trust (LET). An additional 87 doctors are employed on a zero hours contract to help cover workforce shortages. A breakdown of the medical workforce, excluding zero hour workers, is shown in table 9.

Table 9: Medical and Dental Workforce (Headcount) December 2020

Grade	Care Group 1: Healthy Lives	Care Group 2: Responsive Care	Care Group 3: Collaborative Care	Central/Corporate Divisions	Total Headcount
Consultants	50	82	66	5	203
Specialty Doctors & Associate Specialists (SAS)	3	9	24	0	36
Trust Doctors (TD)	3	13	25	3	44
Doctors in Training (DiTs)	30	102	59	12	203
Senior Dental Officers (SDO)	5	0	0	0	5
Total	91	206	174	20	491

- 8.2 **Establishment:** The budgeted establishment for the medical workforce is 545.42 whole time equivalents (wte), according to the finance general ledger there are 520.39wte in post. Creating a shortfall of 25.13wte between budgeted and contracted. However, this does not necessarily reflect the actual number of vacancies and rota

gaps which may differ due to changes in services, temporary rota re-design, skill mix, or working restrictions. Therefore, actual vacancy data has been collected from the directorates themselves as detailed in section 6.

- 8.3 **Turnover:** The average turnover rate for medical staff between December 2019 and November 2020 is 9.22%. This is calculated as the number of leavers as a percentage of the average headcount of medical staff over the 12 month rolling period. If we were to include the attrition rate for non-voluntary leavers the rate would increase to 11.7% as shown in table 9. Figures exclude zero hour workers, flexi-retirees, and doctors in training who rotate between specialties or trusts every four to six months.

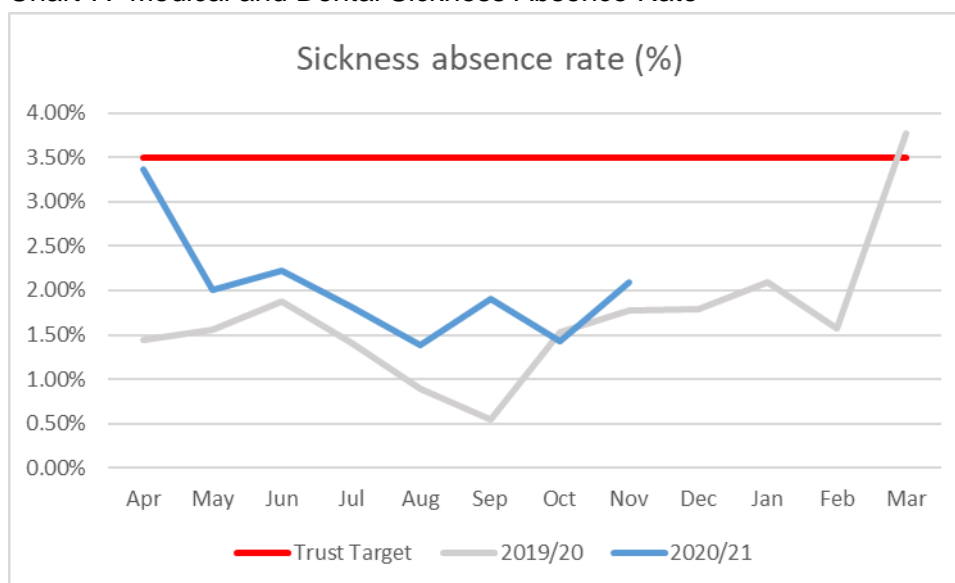
Table 10: Starters, Leavers and Turnover

Directorate	Starters	Leavers	Voluntary	Involuntary	Combined
345 Accident and Emergency Directorate	2		0.00%	0.00%	0.00%
345 Anaesthetics Directorate	5	2	13.64%	2.27%	15.91%
345 EAU/Ambulatory Directorate		1	26.09%	8.70%	34.78%
345 Endoscopy Directorate	1	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	2	2	4.65%	0.00%	4.65%
345 Medical Director Directorate	1		0.00%	0.00%	0.00%
345 Obstetrics and Gynaecology Directorate	1	1	5.71%	0.00%	5.71%
345 Orthopaedics Directorate	2	2	12.31%	3.08%	15.38%
345 Out of Hospital Care Directorate	1	1	9.09%	0.00%	9.09%
345 Paediatrics Directorate	1	1	3.45%	0.00%	3.45%
345 Pathology Directorate	2	2	20.00%	0.00%	20.00%
345 Radiology (Collaborative Care) Directorate			0.00%	0.00%	0.00%
345 Radiology (Responsive Care) Directorate		1	6.25%	0.00%	6.25%
345 Research and Development Directorate			0.00%	0.00%	0.00%
345 Resilience Directorate	1		0.00%	0.00%	0.00%
345 Surgery and Urology Directorate	8	4	12.50%	3.13%	15.63%
345 Workforce Directorate	1	3	22.22%	44.44%	66.67%
Grand Total	28	21	9.22%	2.48%	11.70%

9. Sickness Absence

The average sickness absence rate for Medical and Dental staff between April 2020 and November 2020 is 2.03%, which is lower than the Trust target of 3.5% but higher than the same period the previous year which was 1.38%. A higher than usual absence rate may be attributed to the pandemic. These figures, as seen chart 7 do not include reported sickness for hosted trainees employed by the LET as the Trust does not hold this information centrally.

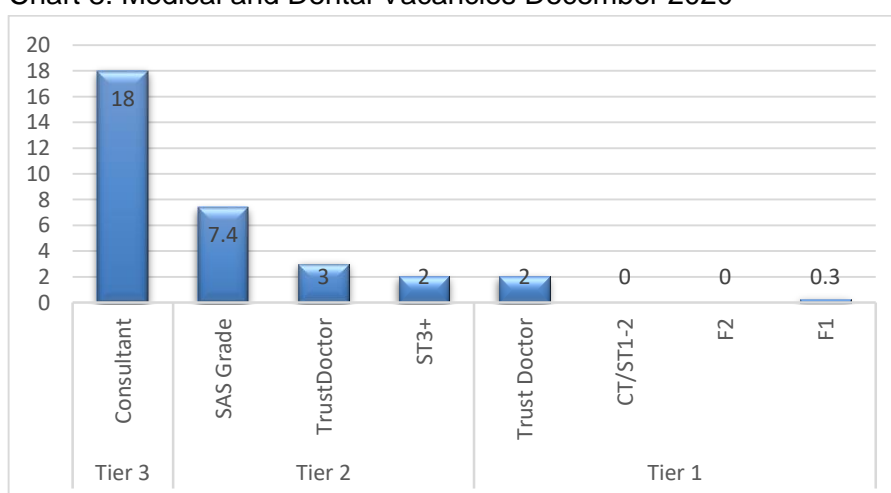
Chart 7: Medical and Dental Sickness Absence Rate



10. Vacancies and Recruitment

- 10.1 According to data collected from directorates, there are 32.7wte vacancies across the Trust, 18wte relate to consultant posts and 7.4wte to SAS grade posts. The graph in chart 8 shows the vacancy breakdown for all grades including locally employed doctors (LEDs) and doctors in training (DiT's). Training post vacancies have been excluded where Trust doctors are back-filling posts or where rotas have been amended to account for rota gaps. Gaps and vacancies due to shielding or isolation are not included but do create additional workforce pressures.

Chart 8: Medical and Dental Vacancies December 2020



- 10.2 The Trust continues to undertake a number of recruitment initiatives to address medical workforce shortages across all specialties. These include the use of recruitment agencies, and international recruitment schemes to attract workers from overseas, such as the Medical Training Initiative (MTI) scheme and international medical training fellowships.
- 10.3 In the last 12 months the Trust has appointed 12 consultants into Trust vacancies through a range of initiatives. Which include joint recruitment with other organisations,

recruitment agencies, and targeting trainees approaching completion of their specialist training and about to achieve their 'certification of completion of specialist training' (CCST).

- 10.4 Other initiatives include 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.

11. Workforce Planning and Deployment

11.1 Electronic Job Planning

11.1.1 Job planning is a contractual obligation between employers and senior medical grades (consultants and SAS doctors), which details the attendance and activity expectations for the year ahead. As such, the job plan should be reviewed regularly and at least annually. E-job planning software is in place to support the process alongside a Trust policy which outlines expectations, governance arrangements, and the appeals/mediation process. The job planning review group, which is overseen by the Medical Director, directs the process to ensure consistency and compliance with requirements. The group provide final sign-off to all job plans.

11.1.2 In response to COVID-19 surges, 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. This resulted in the annual job planning round being temporarily suspended. Over the last couple of months this work has recommenced and a total of 121 (51%) job plans have been reviewed and published in the electronic system ready for discussion and agreement. Out of those published, 17 (7%) have been fully agreed and signed off. However, in order to achieve level one outlined in the 'levels of attainment' by NHS Improvement and England, 90% of the medical workforce will need a job plan that has been reviewed and fully signed off within

11.2 Electronic Rostering

11.2.1 Electronic rostering continues to be rolled out to all doctors in training, providing visibility of the workforce and supporting effective deployment. Medicine, Emergency Medicine, Orthopaedics, Surgery, Obstetrics and Gynaecology, and Anaesthetics are all using electronic rostering systems providing mobile access to rosters and the ability to manage annual leave electronically. These systems are also being used to roster on-call and record unavailability for some consultants.

11.2.2 Paediatrics are currently using the electronic system and user accounts are due to be released to individual doctors in the next few weeks. Community Dental are also in the process of implementing the system for their Senior Dental Officers.

12. Safe Working

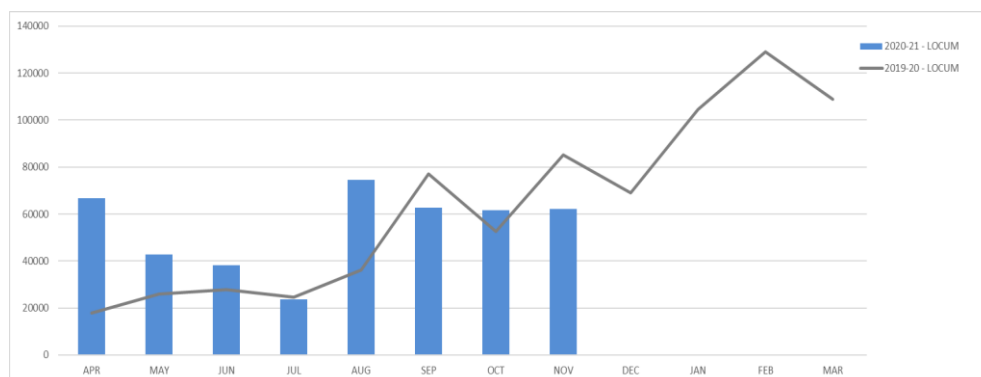
- 12.1 Our doctors and dentists have worked flexibly over the last few months to support the Trust in its response to the coronavirus pandemic. The Guardian of Safe Working Hours continues to champion safe working practices and is currently working with leads to ensure compliance with working rules is maintained during the pandemic.
- 12.2 Exception reporting continues to be the mechanism used by doctors in training to highlight additional hours worked, non-compliance with safe working hours, lack of support, and missed educational opportunities. A total of 56 exceptions were submitted by 21 doctors between April 2020 and November 2020, mainly by foundation year one trainees in medicine specialties for additional hours worked. Appendix 3 provides an exception report overview.
- 12.3 No fines have been levied for breaches in the safety limits of working hours. However, a fine is pending for Obstetrics and Gynaecology, due to a junior trainee being allocated to an unsupervised clinic. To maintain patient safety a specialist midwife in an adjacent clinic supported the trainee. Concerns outside of exception reporting have also been raised by other trainees in obstetrics and gynaecology, the Guardian of Safe Working Hours recommended the department appoints a clinical lead to oversee the rostering of their medical workforce.
- 12.4 The Trust has implemented the national revisions to the doctors in training contract. These changes resulted in the majority of rotas within the Trust being re-designed. Part of the amendments include a maximum of 1 in 3 weekends being rostered. Only one rota in the organisation falls shy of this requirement, which is the tier 2 (registrar) rota within Emergency Medicine.
- 12.5 The department applied the provisions within the contract to seek approval from those working the rota, the doctors' forum, and the Local Negotiation Committee to maintain the rota with a frequency of 1 in 2.67 weekends. Agreement was achieved with the stipulation that it is regularly reviewed. In order to reduce the weekend frequency, either cover would need to be reduced or the number of doctors contributing to the out of hours' work increased. The Clinical Lead for the rota is currently working with trainees to manage and review the rota, with the aim of reducing the weekend frequency.

NHS Employers and the BMA also published guidance on where working hours limits and rest requirements outlined in the terms and conditions of service were flexible during the initial phase of the pandemic. This has now been withdrawn and organisations are now expected to fully comply with the terms and conditions of service during pandemic surges.

13. Temporary Staffing

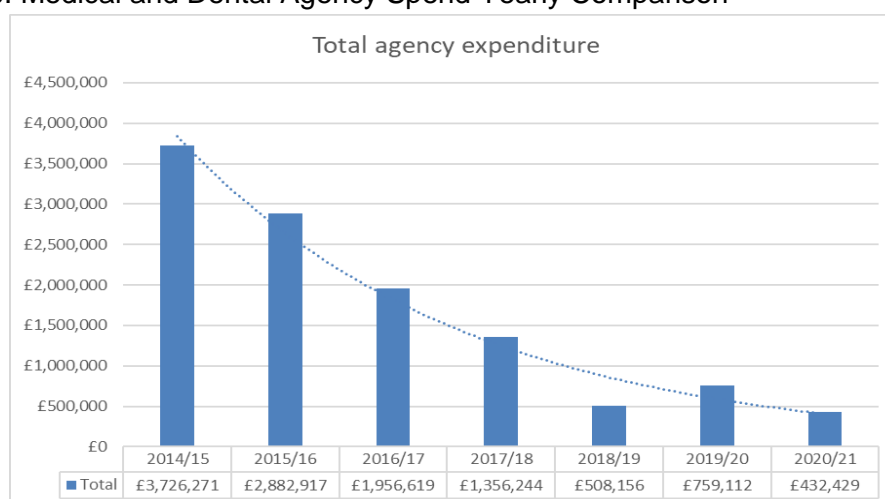
- 13.1 A total of 432k has been spent on agency locums between April 2020 and November 2020. This includes £70k for agency workers relating to COVID-19, and returning flexi-retirees who are supporting the Trust during the pandemic and have been costed against locum codes. Year to date figures show an overall increase in spend of £82k when compared with the same period the previous year as shown in chart 9.

Chart 9: Medical and Dental Agency Spend 2020/21



- 13.2 Whilst these figures show a rise in costs, spend remains lower than previous financial years as shown in chart 10 below. Agency usage is mainly due to long-standing trust vacancies and there are a number of locums booked over the next few months. Therefore, increases in agency spend is likely to continue. The figures in the chart for 2020/21 is for the period April to November 2020 only and is not a complete year. Efforts are being made to try and keep costs to a minimum.

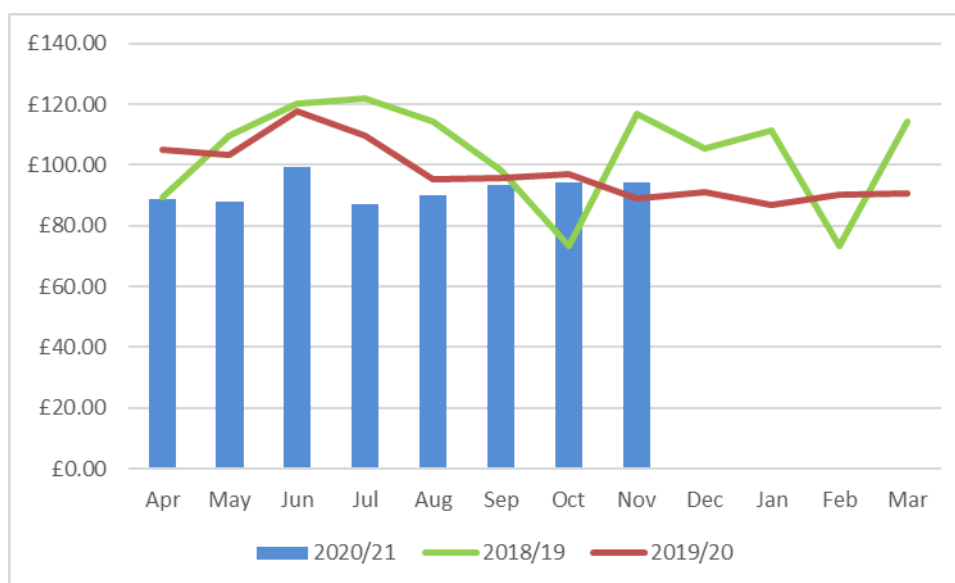
Chart 10: Medical and Dental Agency Spend Yearly Comparison



- 13.3 Long-standing vacancies in Collaborative Care accounts for 60% of agency spend, which mainly relates to multiple SAS vacancies in Anaesthetics, a consultant vacancy in urology, and past Trust grade vacancies in General Surgery. In order to minimise agency spend and fill substantive posts, the care group encourage agency workers to consider taking up substantive posts or flexible working contracts. They have also utilised recruitment agencies to help fill hard to recruit to posts. Unfortunately, start dates have been delayed due to the pandemic.
- 13.4 The Responsive Care Group have relied on agency workers at consultant level in Haematology and Microbiology spending £70K. An additional £70K has also been costed against the COVID central budget due to agency locums providing additional cover or covering workforce shortages due to the pandemic.

- 13.5 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 are fully explored before proceeding to agency. Any bookings with an hourly rate above NHSI price caps and £100 have to be approved by the Medical Director. The chart below shows the average total hourly charge for agency workers including agency commission fees. As agency usage mainly relates to senior posts the average hourly rate appears high, the regional bank is used to provide cover at training grade level rather than outsourcing to agency.

Chart 11: Medical and Dental average total hourly charges for agency workers



- 13.6 The LET collaborative bank (regional bank) went live in December 2017 and provides cover for training grades and trust equivalent grades. A total of 647 shifts were released to the bank between 1st April 2020 and 30th November 2020, 403 of these shifts were filled whilst 244 remained unfilled. Providing a Trust fill rate of 62.29%. There have been fluctuations in fill rates which are linked to hourly pay rates, as such the Trust has aligned rates with neighbouring Trusts in some specialties. Regional rates have been proposed and are currently awaiting agreement. The year to date bank spend is £240,637.
- 13.7 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. A total of £962,404 has been spent on ad hoc payments for these additional sessions. Overtime for locally employed doctors are absorbed into substantive costs and paid as locally agreed payments, the year to date cost is £864,389.
- 13.8 The year to date annual budget for medical and dental staff is £34.6m and the actual spend is £37.7m, an overspend of £3.1m. This includes £385k of pay spend associated with providing COVID-19 cover. Agency spend accounts for approximately 1% of actual spend.

14. Care Group Update: Healthy Lives

- 14.1 **Community Dental:** There is 1wte Consultant vacancy in Special Care Dentistry currently out to advert. The post will be split between Tees Community Dental Service (60%) and Newcastle Dental Hospital (40%).
- 14.2 **Obstetrics and Gynaecology:** The department currently has 1.6wte ST3+ trainee vacancies, 1.4wte are being backfilled by Trust Doctors and the remainder is being covered by locum shifts or the regional bank.
- 14.3 **Paediatrics:** The department has 2.7wte doctors in training vacancies due to unfilled posts and less than full time trainees. To cover this shortfall and avoid agency usage the rotas were amended. However, there are a number of doctors with working restrictions preventing them from undertaking certain duties or shifts. This is being covered internally. Further gaps are expected in February due to an increase in less than full time trainees and those with working restrictions. The consultant on-call rota currently has gaps due to doctors shielding or absent due to sickness and/or isolation.
- 14.4 **Palliative Medicine:** Palliative Medicine have a 0.8wte vacancy due to maternity leave, cover is coming from within the existing service but no additional hours are being picked up.

15. Care Group Update: Responsive Care

- 15.1 **Emergency Medicine:** The most significant threat to the workforce is currently sickness absence both long and short term. The rate in November 2020 was 9.89% excluding doctors in training employed by the Lead Employer Trust.
- 15.2 In addition to this they have a number of gaps due to 3.4wte consultant and 2.8wte SAS vacancies. An additional gap is expected in February due to an unfilled training post. The substantive workforce is covering gaps on the rotas and providing extra cover due to COVID. Putting the workforce under pressure. The middle grade rota requires additional doctors to reduce the weekend frequency to 1 in 3 weekends as per the national contract for doctors in training. These additional pressures present a risk to the wellbeing of the existing workforce and are being closely monitored.
- 15.3 The department utilised recruitment agencies to help attract candidates into the SAS grade vacancies. Interviews were held at the start of December and posts have been offered to candidates. The pre-employment checks process has now commenced for one candidate.
- 15.4 **Medicine Specialties:** There are 2wte consultant vacancies, which are in diabetes and stroke. In addition to this there are 1.2wte training post vacancies. As part of the winter plan the department have 'surge' beds which are opened flexibly in line with changes in demand. However, workforce has been an inhibiting factor in utilisation.
- 15.5 Towards the end of December, the department had 17 doctors absent relating to COVID-19 and an additional 3 for other reasons. Workforce shortfalls are covered by internal locums, the regional bank, and limited agency workers. An agency locum is currently covering consultant shortfalls in Haematology.
- 15.6 To support the department, two foundation year 2 trainees and a Trust doctor in out of hospital placements have been brought back into the Trust. The Director of Medical

Education sought approval from the Foundation School Dean to support this redeployment.

- 15.7 **Pathology:** The department currently has 1wte consultant vacancy and 1wte specialty doctor vacancy in Microbiology, plus 3wte consultant vacancies in cellular pathology. They also have additional workforce shortages due to COVID-19. A further gap is expected in biochemistry at the end of March due to anticipated retirements.
- 15.8 Pathology have explored opportunities with recruitment agencies to help fill long-standing vacancies, as continuous rolling adverts have failed to yield any suitable candidates via NHS jobs. Additional locum cover has been sought from agencies but has been extremely difficult to secure due to escalating rates and national workforce shortages. An agency locum Microbiologist is currently supporting the department which has been approved by the Medical Director.
- 15.9 Substantive consultants are undertaking additional workload and activities to absorb some of the demand with some routine work outsourced to an external company to avoid delayed turnaround times. This additional workload presents a risk to the wellbeing of the existing consultant workforce and is being closely monitored. The department remains engaged with initiatives such as collaboration, multidisciplinary working, digitisation, and new technology.
- 15.10 **Radiology:** As a shortage specialty there are very few radiologists around to appoint. Specific risks are breast radiology, gastrointestinal radiology, and musculoskeletal radiology. The department do not currently have any advertised vacancies, however, during their last review the service estimated a shortfall of five consultant radiologists but since then demand has also risen. In addition to this, there has been a recent retirement and flexi-retirement, with a further flexi-retirement expected.
- 15.11 If the department are able to fully staff the CT equipment they are expecting it will potentially generate work for an additional 2 to 3 consultants but some of this requirement would be for cardiology time rather than radiology. To help mitigate workforce shortages the service utilises advanced practitioners where possible. They currently have one in training and more planned. As part of national the national radiology expansion programme, the Trust now receives 2 additional non-funded specialty training posts.

16. Care Group Update: Collaborative Care

- 16.1 **Anaesthetics:** Anaesthetics has 3.6wte consultant vacancies, 3wte SAS grade vacancies, and 3wte MTI (Trust Doctor) vacancies. Recruitment has been a challenge and additional rota gaps due to flexi-retirements or working restrictions have exacerbated this issue. Despite these challenges the department have kept agency spend to a minimum due to internal locum cover, zero-hour (bank) workers, and rota re-design. The department has utilised recruitment agencies to assist in substantive recruitment which has led to the appointment of three specialty doctors. In addition to this, two doctors have been appointed through Trust recruitment processes. Pre-employment checks are currently underway for successful candidates and start dates are still to be confirmed but have been delayed due to COVID-19.
- 16.2 A second person has been added to the Tier 2 rota to support ICU, and the consultant on-call frequency has been increased to provide additional back-up cover. More recently the department has implemented their 'surge' rota providing 2 daytime

resident on-call consultants between 8am and 8pm, and a resident consultant overnight in ICU.

- 16.3 **General Surgery and Urology:** Urology currently has 1wte Consultant vacancy and 1 wte SAS grade vacancy. The service has relied on agency locum consultants for a while due to local and national recruitment challenges. The post had been filled but the worker subsequently withdrew after a number of delayed start dates. A consultant urologist was appointed by South Tees into a shared post with our Trust which will cover some of the shortfall.
- 16.4 As part of their workforce plans, the department are planning on appointing a 6th Colorectal consultant with interviews planned for April 2021 and an anticipated start date of October 2021. Further interviews are also planned in April for two breast surgeons due to retirees, this is still in the planning phase and the finer details are still being worked out.
- 16.5 **Trauma and Orthopaedics:** Trauma and Orthopaedics currently have 2 wte Trust doctor vacancies, which are covered by internal locums and the regional bank. From August 2021 the department will no longer receive 3 funded general practice (GP) specialty training posts. These posts are being disestablished by the training programme. The department are currently looking to fill this shortfall by securing additional foundation year 2 posts.

17. Workforce Challenges and Risks

- 17.1 The impact of COVID-19 poses 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 activities. This could have an impact on staff wellbeing and morale.
- 17.2 A number of training rotations were postponed by Health Education England (HEE) due to the pandemic, clinical activities also declined due to cancellation of some elective work. This has resulted in a loss of some training opportunities for trainees. Whilst this has not prevented most trainees in the region from progressing, subsequent surges could result in delayed progression of many trainees if the same approach is adopted. As such, HEE, released a statement on the 'principles for educational organisations during pandemic surges' to help guide Trusts and protect training.
- 17.3 Rotations recommenced from August 2020 onwards but the ongoing pandemic resulted in a number of delayed starters from overseas. These late starters joined the Trust in October and December 2020. Gaps were backfilled by Trust Doctors, supernumerary trainees, or locums.
- 17.4 Doctors in training have raised some concerns around the availability of scrubs and personal protective equipment (PPE), such as the size and type of face masks. In order to address these concerns, representatives from infection control and supplies attended the doctors' forum. They will also attend future meetings.
- 17.5 Meeting the new requirements of the 2016 doctors in training contract has been difficult and resulted in the majority of rotas being re-designed. Departments highlighted several issues such as added cost pressures and loss of rota hours. They also reported difficulties in filling short term gaps due to tighter working restrictions. Where possible, specialties have utilised physicians' associates and advanced nurse practitioners to compliment the medical rotas and minimise any potential risk.

- 17.6 NHS Employers and the BMA previously published guidance on where working hours limits and rest requirements outlined in the terms and conditions of service were flexible during the initial phase of the pandemic. This has now been withdrawn and organisations are now expected to fully comply with the terms and conditions of service during further surges. Non-compliance could result in financial penalties.
- 17.7 The intention behind exception reporting was to create a streamlined system through which trainees could indicate when they had worked additional hours; missed training or educational opportunities; experienced immediate safety concerns, or had concerns about the level of support available to them. However, there are several barriers to the process, such as; a fear that reporting will damage working relationships, reports will be used against them at ARCP (annual review of competence progression) meetings, or they will be seen as problematic trainees. Further work is required to improve the culture around the exception reporting process.
- 17.8 Areas continue to report difficulties in recruiting and retaining SAS doctors. The Trust offers support to SAS grades for gaining certificate of Eligibility for Specialist Registration and continues to roll out the SAS Charter. National initiatives to improve recruitment and retention of SAS grades include reform of the of national employment contracts. Any agreed proposals for the revised terms and conditions will come into effect from April 2021. Anticipated changes include the opening of a national senior grade that will replace the closed associate specialist grade, with pay and pay progression reform.
- 17.9 The need for additional cover due to increases in demand and staff absences as a result of COVID-19 has had a significant impact on areas already struggling with workforce shortages. This has resulted in an increase in agency usage and additional non-contracted hours by substantive staff. This could impact on the wellbeing of the workforce.
- 17.10 It could also lead to excessive hours being worked and increases the risk of non-compliance with working time regulations and contractual working hour limits increasing the amount of exception reports received, financial penalties being levied, and escalated internal locum rates. In areas where there are a high number of vacancies training could be impacted resulting in exception reports or poor morale.
- 17.11 There are a number of consultant appointments which the Trust has difficulty in recruiting to due to both local and national shortfalls. These include consultants in Anaesthetics, Radiology, Urology, Elderly Care, Emergency Care, Haematology, Microbiology and Histopathology. Anaesthetics has difficulties in recruiting Trust Doctors and SAS grade doctors. A number of recruitment initiatives and service reviews are being undertaken to help address challenges.
- 17.12 Senior medical vacancies can impact on the Trusts ability to deliver quality training and support available to trainees. This could result in training posts being withdrawn which would reduce staffing numbers even further. Exception reporting is in place to monitor the situation closely and address issues as they arise.

18. Initiatives and Next Steps

- 18.1 To ensure that doctors feel supported during this unprecedented time and able to feedback concerns, the Guardian of Safe Working Hours increased the frequency of

the doctors' forum utilising Microsoft Teams. This is resulted in increased attendance and engagement.

- 18.2 Other support offered to staff during the pandemic include free car parking, break out areas away from work areas, recharge hubs, support and wellbeing hotline, and a listening in action app. The Trust has recently appointed a Wellbeing Guardian.
- 18.3 On-going implementation of electronic rostering for doctors in training and Trust doctors to support effective deployment, including functionality to manage unavailability and vacant shifts. Review and updating of consultant and SAS Grade job plans.
- 18.4 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.
- 18.5 Training, development and implementation of new roles, where appropriate, such as physician associates, advanced critical care practitioners, anaesthesia associates, and surgical care practitioners.
- 18.6 Continued participation and use of the LET collaborative bank for doctors in training vacancies. Consideration and proposed regional rates of pay may help improve bank fill rates.
- 18.7 To support the workforce, the Trust continues to implement the recommendations from the fatigue and facilities charter. The doctors lounge is now fully refurbished and is well utilised, the additional rest room is now available but still requires some work. The Trust is also working towards implementation of recommendations outlined in the rostering best practice guidance, and the SAS charter. This will help improve the working environment, support training, support professional development, improve work life balance, and retain loyal Trust doctors.
- 18.8 The process for awarding Local Clinical Excellence Awards (LCEA) has been halted for 2020 as a result of national guidance issued in response to the coronavirus pandemic. The funding for 2020 is to be redistributed equally among all eligible consultants as a one-off, non-consolidated payment. The rate of investment has also been revised and this has increased to 0.424 per eligible consultant. Payments are expected to be made as part of February's payroll.
- 18.9 General Surgery has launched a new teaching programme for 4 months, designed to cover surgical topics as support to trainees new to surgery from medical school.
- 18.10 As a thank you for their support during a difficult year, all doctors in training received a £10 meal voucher to be used on either site.

As part of their recovery plans, some surgical areas are utilising facilities within the private sector for NHS work, these sessions are able to provide valuable training opportunities. Initially, HEE raised some concerns and advised that these facilities were not recognised for training. This led to both local and national discussions so provisions and assurances were put in place to support training at these locations. There are strict requirements which must be adhered to which are overseen by the Director of Medical Education.

19. Conclusion

The purpose of this bi-annual report is to provide the Board of Directors an overview of the professional workforce capacity and advise upon compliance with national guidance. The review provides assurance in relation to the ongoing work and actions identified within this report.

The Trust faces a number of workforce challenges and is monitoring the situation closely. There are a number of initiatives being taken to address issues, ensure continuity, and deliver safest patient services. Alternative staffing models are being explored, registered nurse, midwifery and un-registered nurse recruitment centres will continue to assist in reducing vacancy rates throughout the year.

The Trust continues to plan and take forward retention strategies for all staff groups.

Technology is being utilised and implemented to support workforce planning and ensure the workforce is being deployed effectively. It is also a key enabler in ensuring compliance with working hour's limits and rest requirements.

By introducing new roles, improving working conditions, and supporting flexibility the Trust hopes to attract, retain, and develop the workforce.

The revised terms and conditions of service for doctors in training and changes to training programmes poses both a financial risk and workforce risk to the Trust.

All of the efforts being undertaken contribute to ensuring there are workforce safeguards in place, the right staff, with the right skills are in the right place at the right time. Whilst being financially sustainable.

20. Recommendations

The Board of Directors are requested to note the work undertaken to date in relation to Nursing, Midwifery, AHP and Medical staffing.

The Board of Directors are requested to note the focus on valuing staffing through recruitment and retention processes and in supporting ongoing development of the workforce.

The Board of Directors are requested to note the impact of the Covid-19 pandemic on both patient acuity and infection control management against a backdrop of increased staff sickness (due to the impact of Covid-19).

The Board of Directors are requested to note the huge effort in response to unprecedented pressures created by Covid to ensure the safest staffing across the Trust.

Lindsey Robertson
Chief Nurse, Director of Patient Safety and Quality

Dr Deepak Dwarakanath
Medical Director

Board of Directors

Title of report:	Capital Programme Performance Q3 – 2020/21									
Date:	28 th January 2021									
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 2020 (Quarter 3) on the progress of delivering the 2020/21 capital programme, along with the current forecast position, highlighting any risks in delivery.									
Action required:	Approve			Assurance			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

Executive Summary and the key issues for consideration/ decision:

Capital Programme Delivery 2020/21

The Trust has on overall capital programme of £18.4m. At the end of month 9, the Trust has incurred capital spend of £8.0m (including Covid-19) against a year to date plan of £11.7m, which is £3.7m behind plan. Progress against the capital plan has been impacted by Covid-19 and suppliers/contractors putting their staff into furlough. Activity has significantly increased on site during Q3 and expenditure will continue to increase in Q4 to meet the overall planned spend for the year.

There are a number of capital schemes which are externally funded which will now be delayed until next financial year. This totals £2.1m and Capital and Revenue Management Group has reviewed options to spend this funding by bringing forward items from the internal capital programme for next financial year to be able to re-provide for the external funds in 21/22.

It is important we spend our capital allocation that we worked hard to secure as any underspend could have been utilised by other NHS organisations across the ICS.

A&E Front of House Project Update

The A&E front of house capital project is progressing well. The Trust received a total of £3m capital funding and it is anticipated that the project will be completed within plan. This creates a 'one door' model for Urgent and Emergency Care to alleviate any confusion for patients and support getting patients to the right place and increase capacity.

Phase 1 (Main A&E) was delivered on time and was brought into full operation on the 7th December 2020. Positive feedback from both patients and staff has been received and this will be shared in the near future. The Communication team have shared the success of service changes in phase 1, including the benefits.

Phase 2 (Paediatric area and Day Case) are progressing well and on track. A number of operational issues have been experienced but is expected to be completed by 21 February 2021.

Phase 3 is to finish the completion of the Day Case Unit and work required within Urgent Care. This is also planned to be completed by 21 February. At this point the plan for completion will remain on track for 21 February 2021.

Capital Programme 2021/22

Looking forward to 2021/22 and beyond, there will be significant pressure on capital monies available and competing priorities across the ICP and ICS. Once the national CDEL limit is set, capital monies will be allocated to the ICS for distribution to ICPs / Providers.

The Trust is planning to provide the internally funded element of our capital programme of £8.9m for each of the next 5 years (based on depreciation forecast).

The externally funded plan for 2021/22 is £7m (GDE, Digital Pathology, Digital Radiology, Care Scan, Critical Infrastructure cash reserve). From 2022/23, the Trust has planned for no external capital monies.

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

This report doesn't highlight any new risks.

Committees/groups where this item has been discussed	Capital and Revenue Management Group
Recommendation	<p>The Board is asked to;</p> <ul style="list-style-type: none"> Note the position on the capital programme at 31st December 2020.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

Capital Programme Performance Q3 2020/21

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 2020 (Quarter 3) on the progress of delivering the 2020/21 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 £18.4m for 2020/21. At the end of month 9, the Trust incurred capital spend of £8.0m (including COVID) against a year to date plan of £11.7m, which is £3.7m behind plan. Progress against the capital plan has been impacted by Covid-19 and suppliers / contractors putting their staff into furlough. Activity has significantly increased on site during Q3 and expenditure is planned to continue to increase accordingly to meet the overall planned spend for the year.

There are a number of capital schemes which are externally funded which will now be delayed until next financial year. This totals £2.1m and the Capital and Revenue Management Group has reviewed options to spend this funding by bringing forward items from the internal capital programme for next financial year to be able to re-provide for the external funds in 2021/22. It is anticipated that the plan will be recovered and the Trust staff are working closely with capital managers.

2.2 Estates

Estates schemes in total are forecasting spend of £4.4m between January and March 2021, of which £3.0m of orders have been raised. This includes estates backlog, energy centre, A&E and critical infrastructure. The Assistant Director of Estates and Capital NT&HS LLP is confident of achieving the year end forecast.

2.3 Medical Equipment

Medical Equipment in total are forecasting spend of £3.5m between January and March 2021, of which £0.6m of orders have been raised. This includes the MER internal plan £2.8m, adopt and adapt business case £900k and additional capital monies £500k. The Head of Clinical Engineering is confident of achieving the year end forecast.

2.4 Information and Technology Services and Digital Strategy

I&TS are forecasting to spend £1.4m between January and March 2021, of which £0.6m of orders have been raised. This includes, I&TS internal plan, Care scan and GDE. The Senior I.T. team are confident of achieving the year end forecast.

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

2.6 The overall financial summary for the period to 31 December 2020 is presented at **Appendix 2**.

2.7 The forecast position for 2020/21 at 31 December 2020 is presented at **Appendix 3**.

3. Capital Planning 2021/22

3.1 Looking forward to 2021/22 and beyond, there will be significant pressure on capital monies available and competing priorities across the ICP and ICS. Once the national CDEL limit is set, capital monies will be allocated to the ICS for distribution to ICPs / Providers.

The Trust is planning to provide the internally funded element of our capital programme of £8.9m for each of the next 5 years (based on depreciation forecast).

The externally funded plan for 2021/22 is £7m (GDE, Digital Pathology, Digital Radiology, Care Scan, Critical Infrastructure cash reserve). From 2022/23, the Trust has planned for no external capital monies.

4. Recommendation

4.1 The Board is requested to receive this report and note the position on capital schemes up to 31st December 2020.

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 2020/21 Capital backlog maintenance allocation has now been broken down into categories and specific projects to target the high risk backlog issues. An overall programme covering all backlog projects has been developed and project managers have been assigned for each project. A detailed spend profile project by project has been developed. This will allow monthly reporting against time and cost for the overall programme (as required by NHSI).

Reinforced Aerated Autoclave Concrete (RAAC): An urgent data collection request associated with Reinforced Autoclaved Aerated Concrete (RAAC) was issued by NHSI on 11 November 2019. A review of local records, site knowledge and review of the independent 6 Facet survey conditional appraisal (undertaken by Mott MacDonald) was undertaken. The review was completed on 12 November 2019 and no evidence of the presence of RAAC was found within the Trust Estate.

Oxygen Ring Main Reinforcement: Work commenced in April 2020 to convert the existing oxygen radial pipe-works system to a ring main, improving the capacity and resilience of the oxygen pipework system. The pipework installation is now complete. A new (temporary) vacuum Insulated Evaporators (VIE) is in situ on the former helipad; the UHH VIE has been returned and is operational. BOC (working under priority control of NHSI) carried out enhancements to the oxygen capacity of the UHNT VIE, increasing oxygen flow rate capacity from 1800l/m to 3500l/m. BOC estimated the Trust required a larger vessel than initially planned, and approval was given in December 2020 for the additional cost associated. The final vessel is expected to be delivered on site in March 2021.

Roofing repairs: The scope of works has been developed for the FY20/21 roofing repairs programme. The programme has been tendered and Group Tegula Ltd appointed. The contract is capped at £2m over a multi-year arrangement, to allow flexibility to address the high risks roofs and other roofs in emergency conditions. A proportion of the additional CIR funding will be utilised for additional roofing repairs. A significant proportion of the programme for FY20/21 has been completed. An additional quote is being obtained to address issues with the Middlefield Centre roof.

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

Concrete Repair Works - Tower Block UHNT: The scope of works will repair the damaged concrete and apply a coloured protective coating guaranteed for 10 years. The total cost of the work is £455k, split over 2 years (£195K in year 1 and £260K in year 2). Works will be undertaken between August-October in FY20/21 and FY21/22 (typically good weather periods). Phase 1 of the programme completed prior to Christmas. Phase 2 to commence in March 2021 due to poor weather conditions expected in January and February 2021. Works are now 80% complete.

Window Replacement: Replacement of the windows for consultants and wards 18 and 19 has been completed. Additional programme of works currently in development for addressing priorities at UHH.

Roads and Car Park Repairs 2020/21: The scope of works has been developed for the FY20/21. A procurement process has been completed and AWG Civil Engineering Ltd appointed. The tender scope is a multi-year arrangement. The tender to be capped at £250K to allow flexibility to tackle other emergency conditions or provide flexibility if the overall programme needs to increase spend. A phased programme has been developed. Works to

North Wing footpath and ramp, main car park and consultants' car park is complete. Work to replace paving stones on pedestrian footpaths will be ongoing until March 2021.

Fire Alarm Replacement UHNT: Installation is at 98% in December 2020. Changeover between systems planned to take place in late February / early March 2021. The existing fire alarm system continues to be fully operational until completion and changeover onto the new system.

Fire Alarm Replacement UHH: The business case was approved in May 2020. The overall cost is anticipated to be £525K with £50K of spend in FY20/21 and the remaining spend in FY21/22. Funding has already been identified within the 5-year capital backlog maintenance plan and the scheme will be brought forward to commence in Q4 of 2020/21. OJEU tender bids have been received and evaluated, and a contractor appointed. Works will commence in February 2021.

Lift Refurbishment UHNT: The overall project completion is expected in February 2021 (from October 2020). Lift 1, 2, 3, 4 and 5 on Tower block have been refurbished and have now been synchronised to improve the efficiency of response to landing calls. Overall, 7 lifts have now been replaced as part of this programme of works with one more still to be completed (North wing and theatre good lifts – planned for subsequent years of capital programme).

A proportion of the CIR funding will replace/refurbish the UHNT theatre dirty/kitchen lift. An order has been placed and works are anticipated to commence on site in Q4.

Theatre Refurbishment UHNT: Theatre 7 refurbishment and the creation of additional recovery space has been postponed to Q1 FY21/22 due to impact of Covid-19. Proposals have been developed in conjunction with the Elective Care Group and design work has taken place with Howarth. The funding for this scheme will be partly spent buying equipment in preparation for works commencing in Q1, the remaining funding will be reallocated to other estates capital needs.

The risk associated with the shared plant for theatre 1,2 & 3 has been added to Datix.

The 5-year backlog plan includes the refurbishment of two theatres per year for the remaining 4 years of the 5-year programme, in agreement with the Collaborative Care Group.

Building Management System Replacement (BMS): The BMS system that controls the hot / cold water legionella monitoring and heating systems across the Trust estate continues to be upgraded and modernised with end of life components being replaced. The overall project is now 90% complete.

Additional CIR funding will address the A&E air handler, which is not currently linked to the BMS.

Accessibility Audit 2020/21: Accessibility audits are conducted in 5 yearly cycles by an independent external accredited consultant to audit the Trust's estate to validate compliance with relevant legislation, ensuring reasonable alternatives measures are in place for all users of the building (including those with mobility, sight and hearing disabilities). Availability for consultants is limited due to Covid-19. It is expected the audit will now take place in the FY21/22 and the accessibility allocation for FY20/21 was utilised on improving decoration and signage at main entrances of the Trust estate.

2. Other Estates Capital Developments

A&E Front of House: The North East & North Cumbria ICS received a capital allocation of £22m, to be allocated to the 11 A&E sites across the ICS. The Trust submitted their scheme and funding was confirmed at £2.53m with an additional £450k to support NEAS, to be spent and the project completed in January 2021.

The creation of a 'one door' model for Urgent and Emergency Care to alleviate any confusion for patients and support getting patients to the right place and increase capacity.

Phase 1- (Main A&E) This phase was delivered on time and was brought into full operation on the 7 December 2020. Positive feedback from both patients and staff has been received and this will be shared in the near future. The Communication team have shared the success of service changes in phase 1, including the benefits. The project team have managed to continue this critical piece of work despite the on-going operational challenges.

Phase 2 - Paediatric area and Day Case are progressing well and on track. However, immediate medical gases work in EAU has needed to take priority which entails increasing the overall oxygen capacity and resilience within EAU. Due to planned contractors being diverted onto oxygen works this will slightly delay the expected completion. Additional to this, due to the increased pressures work planned within resus has also been re-phased to minimise the disruption to the resus capacity, however, the completion dates are not expected to extend any further and the overall programme is expected to be completed by 21 February 2021.

Phase 3 – The aim of phase 3 is to finish the completion of the Day Case Unit and the work required for Urgent Care. At this point the plan for completion will remain on track for 21 February 2021.

Electric Vehicle Charging: Four vehicle charging points have been installed at the Energy Centre, UHNT for Transport vehicles, and an additional four points at UHH.

Funding is allocated for the installation of 19 further staff/public charging stations across all three sites, and the Trust has now agreed on the location and number of charging points at each location. This work will be completed in Q4.

Community Services Estate Review: The Trust currently provides community services from 53 leasehold premises. NT&HS LLP is working in collaboration with the Healthy Lives Care Group and Tees Valley CCG to explore opportunities to rationalise the use of third-party properties to achieve cost savings for the health economy. A wider review of leasehold premises continues to be developed in co-ordination with the South Integrated Care Partnership (ICP). NT&HS LLP continues to support the Trust to carry out this review.

Decarbonisation: The Trust has been successful in applying for £26,134 from the SALIX managed Low Carbon Skills fund (as part of the Government's £1billion Decarbonisation Fund) to pay for the preparation of a compliant application to SALIX for project funds and to produce a Heat Decarbonisation Plan for the Trust.

Whilst the government's £1billion Decarbonisation Fund for FY21/22 has been oversubscribed, under guidance from SALIX we have submitted a limited application for £300,000 of funds for this FY20/21. We anticipate a decision by the end of January 2021.

The Trust's Sustainability Management Group will continue to work on our ambitious plan to save energy and reduce our Carbon Footprint by preparing a Heat Decarbonisation Plan which will fulfil part of the Trust's Sustainability Management Strategy.

Recharge hubs (UHNT and UHH): Utilising donations from Captain Sir Thomas Moore, the

Trust has created two staff wellbeing hubs, aptly named the Rainbow Rooms, at both UHNT and UHH. Works included a full refurb of the rooms, new comfortable furniture, kitchen facilities, and shower facilities at UHNT. The outdoor spaces will be further developed in Q4 and Q1 FY 21/22 to create an outdoor seating area with heaters and a covered canopy, which can be used year-around.

Client Project Briefs: NTH Solutions has received 2 requests to undertake capital project works outside of the agreed backlog capital programme. In line with the MSA agreement, Client Project Brief request forms have been completed by the Trust to define the requirements. NTH Solutions has provided an estimated cost and confirmed when resources are available to safely manage these works.

Client Brief forms have been completed for:

- Enhanced Care Suite – Wd42 (£35K). This was approved for Q3 but has been deferred to Q4.
- Former Creche – Staff Breakout area (£25K). Internal works have been completed and external work will be completed in Q4.

3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against the allocation of £2.5m and agreed with Care Groups. The following elements have been progressed in Q3.

Portable ultrasounds: Two Ultrasounds have been purchased for Theatres.

Bone Mill: A replacement Bone Mill machine has been ordered and delivered to the Orthopaedic Department to replace the existing one which is no longer supported.

Ultrasound machines: Two Philips Lumify ultra sound machines have been bought one for the Stroke Team and one for Lung Health. A replacement Ultrasound machine has also been purchased for Radiology.

X-ray Machines: A new x-ray machine has been purchased. This will replace the aging machine in room 6 UHNT and is due to be installed in March 2021. A portable x-ray machine has also been procured and is currently in use at UHNT.

Mammography: A replacement Mammography machine has been ordered for the OLC Middleborough and is due to be installed in March 2021.

Endoscopy Stack: A new Endoscopy stack has been purchased for Endoscopy along with two replacement scopes, which will provide a much clearer image for the Endoscopy team.

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 Programmes capital projects.

CISCO Network Upgrade: Now *complete* this is a five-year contractual plan which incorporated a full upgrade of the wired network to the latest technology and replacement of the wireless network to support Trust wide projects.

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

TrakCare Hardware refresh: Now *complete*, this was to replace the Infrastructure on which TrakCare system runs to ensure continual reliability of the system and support.

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.

Network Hardware / Infrastructure: This is an on-going scheme to replace network equipment within the Trust on a rolling basis and increase network resilience by adding more fibre-optic connection links. Work will begin on upgrading the fibre-optic cabling to the old residencies within Q4 FY20/21. Order raised with supplier (ACEDA) and are awaiting confirmation of start date.

Cyber Security: Two schemes of work to update operating systems and hardware, they are:

- Windows 10 upgrade for OmniCells devices – equipment received but not yet installed.
- Firewall hardware replacement / upgrade for remaining Out of Hospital Care Community site locations – *partially complete*.

Servers and Storage: Ongoing scheme to replace server infrastructure within the Trust on a rolling basis.

Horizon VDI – Virtual desktop technology for remote working. Horizon infrastructure will provide a seamless experience for home/remote working – Server infrastructure and licensing specification complete, along with proof of concept model.

Software: Two schemes progressed, which are to: -

- Replace the backup solution to a newer version, this is now *complete*.
- Replace the ICT Helpdesk system (Support Works) used for ICT fault logging, call handling and resolution with modern/customer centric version - Product evaluation commenced in November 2020 with ServiceNow, initial feedback is looking positive.

Telecoms: Three schemes of work to update current systems to the latest versions:

- DAKS (fire and gas alarm system) – not yet started.
- DECT (Trust resilient Phone system) scheduled for Q4 FY20/21 delivery.
- Call Logging system which audits telephony systems - scheduled for delivery in Q4 FY20/21.

5. Digital Strategy – Electronic Patient Record

The 'Digital Hospital of Things' GDEFF 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 GDEFF programme enabled NT&H NHS FT £5m Public Dividend Capital (PDC) on a matched fund 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 Global Digital Exemplar (GDE) programme in Q4 FY19/20, with the final PDC milestone payment being drawn down in the latter part of the last financial year.

In delivering our planned digital ambitions outlined in our "Digital Hospital of Things" programme, the Trust also 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 status.

FY2020/21 allocation is £2.04m of which £961k has been receipted.

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

Maintenance Upgrade – the next upgrade of TrakCare will be moving from T2017 to T2020 which is a major upgrade and will require a number of test cycles to be undertaken. Some delays were experienced with the initial install onto Trust environments but this has now been resolved. Internal testing commenced 4 January 2021 and the anticipated go live of the upgrade will take place April 2021 (COVID impact to be assessed prior to commencement approval).

The Great North Care Record (GNCR) - a way of sharing patient information with health and care staff covering the 3.2 million people living in the North East and North Cumbria.

The regional Health Information Exchange (HIE), a core module of the GNCR continues to expand. – NTHFT initially went live 17 March 2020 to view GP data, the HIE now includes acute, GP and Community data from across the region. NTHFT is seeing approx. 20,000 views/ month and are looking to share (provide) our acute data from April 2021.

GNCR PEP – (Patient Engagement Platform) baseline information provided, technical specifications being reviewed. Productive meetings have started to gain momentum. V1 of the PEP 'Core' produce has been received by NuTH and development of interfaces is underway. NuTH Go live is expected Q1 FY21/22.

Closed Loop Prescribing and Administration - a proof of concept was due to take place in March but on hold due to the COVID pandemic. Ward 24, has been nominated to support once pressure on the Trust subsides. This is a key requirement for HMSS level 6.

Vocera Phase 2 – Business Case narrative ready. This can be issued to Care Groups for discussion of responsibility for revenue implications once final internal figures are received. IT and IG concerns are being addressed to allow approval of the DPIA. The Business Case is to progress whilst development of this detail is finalised concurrently.

In addition to completion of the Business Case, work continues on the model process being defined and then implemented in a model area early 2021.

HealthCall – now live with Friend and Family (F&F), COVID-19 SMS results, Maternity Hypertension and Lateral Flow Testing (COVID-19).

Integrated Observation machines – Phase2 will enhance the current interface and provide 'at a glance' information, feedback around development and timescales are awaited by InterSystems (ISC).

A&E Observation machines– two phased approach, Central monitoring system to be installed and linked to Mindray devices. Second element is to provide an Interface between Mindray and TrakCare - awaiting project proposal from ISC. A&E to secure funding to progress with the interface work.

Pharmacy Dispensing Robot – successfully live 7 May 2020, feedback has been extremely positive. An evaluation of initial benefits is being conducted.

ITU TrakCare + Hardware – discussions still ongoing. Quotations received and further detail is required before a business case can be put forward.

Imprivata phase 2 - IG requirements for PIN complexity are being reviewed in the ICT department as a wider initiative, which will impact SmartCards. Once agreed, the complexity will apply to Imprivata too. The current 4-digit pin is seen not to be secure enough.

The Business Case will be progressed whilst this detail is reviewed and finalised in the directorate concurrently.

Theatre EPMA – Due to technical issues highlighted throughout the testing it has not been possible to go live into Theatres with EPMA. Following further discussion with the Imprivata Supplier (the solution that enables tap on / tap off) they have advised the Trust to upgrade to the latest version which may resolve the issues experienced. Initial testing does seem encouraging, however, we need to provide the update Trust-wide as a pre requisite, this is in hand and scheduled for completion February 2021.

Active Clinical Notes (ACN) – Optimisation continues in all areas live with ACN.

Paediatrics – development of non-admission documents continues with the service who have added a new document for patients with Cerebral Palsy to take priority. This, plus the other scheduled documents will be applied to live in January 2021.

A&E – the Delirium workflow went live earlier this month as planned and positive feedback received. Head injury admission updates for ED and EAU on schedule to be applied to live this month. Scope and design continues for the Hip Injury workflow.

Adult Admission continuation – a new clinical note template (red text) has been developed with Specialist Palliative Care (SPC) nurses. This is to make it SPC notes stand out for clinicians and the clinical coding team. DNAR mapping has been conducted across all specialties. Contact with Sunderland colleagues to advise on their approach to manage the process digitally.

Pathways – Scoping and design for the Pulmonary Embolism and Deep Vein Thrombosis are underway for go-live Q4 FY20/21.

EDM2 – Delay in initial forecast date from December 2020 – May 2021, due to delays in appointment of supplier. Initial Kick Off Meeting held 15 December 2020. Project board has

been appointed and first meeting planned for 13 January 2021. PID, baseline plan and initial work packages to be signed off at Project Board. Commenced preparation of migration work with ICT and incumbent supplier, ahead of Work Package sign off.

CareScan+ - Go-Live at Hartlepool Theatres has been a success. Although the second COVID wave has impacted on staff duties/rotas and service delivery all users were trained and there has been sufficient momentum to continue using CareScan+ within all elective Theatres.

Early analysis of data collected since 26 October 2020 is 338 procedures scanned / £121K approx. value of goods scanned / 599 different products used and 208 (35%) of the products used have only been used once. The Business Case review was undertaken in December 2020 by the Executive Team with continued support for a further 18 months confirmed.

Outpatient Clinic Letters - The majority of practices now receiving letters electronically. Converting practices' MESH preferences need to be amended for their DTS system. These will be rolled out when the fix is in place. Then the final @nhs.net outliers will be rolled out last.

Appendix 2 – Capital Programme Financial Position as at 31st December 2020

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Commitments 2020/21 £'000
INTERNALLY AND EXTERNALLY FUNDED CAPITAL SCHEMES AGREED BY ICS					
Estates Backlog					
Building Sub Structure	1,142	587	662	(75)	139
Climate Change	50	26	23	3	25
Compliance (including fire alarms and lift refurbishment)	671	345	72	273	124
Patient Environment	171	88	97	(9)	63
Estates Backlog Total	2,034	1,046	854	192	351
IT					
ICT	1,988	1,491	816	675	1,093
IT Total	1,988	1,491	816	675	1,093
Medical Equipment					
Medical Equipment	2,851	2,028	797	1,231	636
Medical Equipment Total	2,851	2,028	797	1,231	636
Service Developments					
Contingency	0	0	(500)	500	0
Service Developments Total	0	0	(500)	500	0
Medical Equipment					
UHH CT Scanner	116	116	116	0	4
Medical Equipment Total	116	116	116	0	4
Energy Centre / Infrastructure					
Energy Centre	447	447	449	(2)	0
Energy Centre / Infrastructure Total	447	447	449	(2)	0
Externally Funded ICT Schemes					
Carescan	250	188	13	174	118
Cyber	100	75	0	75	0
Digital Pathology	0	0	27	(27)	250
GDEFF	2,046	1,535	678	856	844
Regional Digital Radiology	604	453	19	434	0
Externally Funded ICT Schemes Total	3,000	2,250	738	1,512	1,212
ICS AGREED CONTROL TOTAL (£10.436m)	10,436	7,377	3,270	4,107	3,296
SCHEMES OUTWITH ICS AGREED CONTROL TOTAL					
IT					
Care Scan	250	188	0	188	0
Pathology	0	0	0	0	0
Regional Digital Radiology	451	338	195	143	0
IT Total	701	526	195	330	0
Donated	724	543	502	41	61
Medical Equipment					
Mobile Breast Screening Unit	50	26	14	12	0
Medical Equipment Total	50	26	14	12	0
COVID-19					
COVID 19 - Funding Approved	0	0	467	(467)	0
COVID 19 - Funding Awaiting Approval	0	0	0	0	0
Oxygen Works	0	0	107	(107)	0
COVID-19 Total	0	0	574	(574)	0
A&E National Allocation (via ICS)	2,530	1,191	1,842	(650)	941
A&E National Allocation - NEAS (via ICS)	470	221	0	221	0
Critical Infrastructure (via ICS)					
Building Sub Structure	956	492	480	11	688
Climate Change	100	51	65	(14)	16
Compliance	1,791	921	811	110	828
Patient Environment	670	344	250	94	171
Critical Infrastructure (via ICS) Total	3,517	1,808	1,607	202	1,702
EXTERNALLY FUNDED SCHEMES TOTAL	7,992	4,315	4,734	(418)	2,704
GRAND TOTAL	18,428	11,693	8,003	3,689	6,000

Appendix 3 – Capital Programme Forecast Position as at 31st December 2020

	<u>Annual Plan</u> <u>£'000's</u>	<u>YTD Plan</u> <u>£'000's</u>	<u>YTD</u> <u>Expenditure</u> <u>£'000's</u>	<u>YTD Variance</u> <u>£'000</u>	<u>Forecast Dec 20 -</u> <u>Mar 21 £'000's</u>	<u>Total actual</u> <u>and forecast</u> <u>2020/21</u> <u>£'000's</u>	<u>Forecast</u> <u>Variance</u> <u>against plan</u> <u>£'000's</u>
INTERNALLY AND EXTERNALLY FUNDED CAPITAL SCHEMES AGREED BY ICS							
Estates Backlog							
Building Sub Structure	1,142	587	662	(75)	482	1,144	(2)
Climate Change	50	26	23	3	27	50	0
Compliance (including fire alarms and lift refurbishment)	671	345	72	273	574	646	24
Patient Environment	171	88	97	(9)	75	171	0
Estates Backlog Total	2,034	1,046	854	192	1,158	2,012	22
IT							
ICT	1,988	1,491	816	675	843	1,659	329
IT Total	1,988	1,491	816	675	843	1,659	329
Medical Equipment							
Medical Equipment	2,851	2,028	797	1,231	2,054	2,850	1
Medical Equipment Total	2,851	2,028	797	1,231	2,054	2,850	1
Service Developments							
Contingency	0	0	(500)	500	3,486	2,986	(2,986)
Service Developments Total	0	0	(500)	500	3,486	2,986	(2,986)
Medical Equipment							
UHH CT Scanner	116	116	116	0	0	116	0
Medical Equipment Total	116	116	116	0	0	116	0
Energy Centre / Infrastructure							
Energy Centre	447	447	449	(2)	0	449	(2)
Energy Centre / Infrastructure Total	447	447	449	(2)	0	449	(2)
Externally Funded ICT Schemes							
Carescan	250	188	13	174	123	137	113
Cyber	100	75	0	75	113	113	(13)
Digital Pathology	0	0	27	(27)	0	27	(27)
GDEFF	2,046	1,535	678	856	196	874	1,172
Regional Digital Radiology	604	453	19	434	0	19	585
Externally Funded ICT Schemes Total	3,000	2,250	738	1,512	432	1,170	1,830
ICS AGREED CONTROL TOTAL (£10.436m)	10,436	7,377	3,270	4,107	7,972	11,242	(806)
SCHEMES OUTWITH ICS AGREED CONTROL TOTAL							
IT							
Care Scan	250	188	0	188	123	123	127
Pathology	0	0	0	0	0	0	0
Regional Digital Radiology	451	338	195	143	0	195	256
IT Total	701	526	195	330	123	319	382
Medical Equipment							
Mobile Breast Screening Unit	50	26	14	12	36	50	0
Medical Equipment Total	50	26	14	12	36	50	0
Donated	724	543	502	41	222	724	0
COVID-19							
COVID 19 - Funding Approved	0	0	467	(467)	0	467	(467)
COVID 19 - Funding Awaiting Approval	0	0	0	0	160	160	(160)
Oxygen Works	0	0	107	(107)	0	107	(107)
COVID-19 Total	0	0	574	(574)	160	734	(734)
A&E National Allocation (via ICS)	2,530	1,191	1,842	(650)	688	2,530	0
A&E National Allocation - NEAS (via ICS)	470	221	0	221	470	470	0
Critical Infrastructure (via ICS)							
Building Sub Structure	956	492	480	11	476	956	0
Climate Change	100	51	65	(14)	35	100	0
Compliance	1,791	921	811	110	980	1,791	0
Patient Environment	670	344	250	94	420	670	0
Critical Infrastructure (via ICS) Total	3,517	1,808	1,607	202	1,910	3,517	0
EXTERNALLY FUNDED SCHEMES TOTAL	7,992	4,315	4,734	(418)	3,610	8,344	(352)
GRAND TOTAL	18,428	11,693	8,003	3,689	11,583	19,586	(1,158)

North Tees and Hartlepool NHS Foundation Trust Board of Directors

Title of report:	Integrated Compliance and Performance Report									
Date:	28 January 2021									
Prepared by:	Lindsey Wallace									
Executive Sponsor:	Lynne Taylor, Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Alan Sheppard, Chief of Workforce Neil Atkinson, Director of Finance									
Purpose of the report	To provide an overview of the integrated performance 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		Well Led	x

Executive Summary and the key issues for consideration/ decision:

Summary

- The report outlines the Trust's compliance against key standards in December including quality, workforce and finance.
- The Trust continues to experience significant pressures as a result of the Covid-19 pandemic, inevitably impacting on the delivery of access standards despite escalation and recovery plans being fully implemented. Additional pressures are now faced during the peak of the second wave with multiple factors impacting on the ability to deliver of all services.
- Robust governance and monitoring of patients' pathways has been adapted to align with national and local guidance.
- The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain positive compared to national and regional position, with teams working hard to maintain business as usual alongside recovery and pandemic pressures.
- Operational efficiency and productivity remains a key focus of the Trust, ensuring outcome measures across Outpatients (DNAs and New to Review Ratios), Theatres (cancellations and utilisation) and Emergency pathways (admission avoidance, extended lengths of stay and Delayed Discharges) continue to be monitored and managed closely.
- Despite the significant pressures the Trust continues to report a positive position against the key quality indicators.
- The impact of Covid-19 'self- isolation' and 'CEV shielding' for staff continues to contribute to the overall resource pressures, together with increased infection rates.
- The Trust continues to report a positive financial position at month 9, which, based on current assumptions, forecasts to deliver a small in-year surplus of circa £3m.

Key issues

- Continued significant pressures across the Trust.
- The management of Covid-19 pressure alongside the requirement to deliver business as usual and recovery, with the Phase 3 elective recovery now indicating delays due to the increased pressures.
- Staffing sickness, a key influence on the ability to increase capacity.

- Financial impact of Covid-19 on the in-year recovery.

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

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

Committees/groups where this item has been discussed

Executive Team Meeting
Audit and Finance Committee
Planning, Performance and Compliance Committee

Recommendation

The Board of Directors is asked to note:

- Acknowledge the on-going and significant operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that is being undertaken to address these going forward.
- The performance against the key operational, quality and workforce standards during December together with the additional pressures of winter alongside the impact of staffing resource.
- Recognise the on-going financial pressures.
- The successful roll out of the Covid vaccine and lateral flow testing.

Integrated Corporate Report



January 2021

Responsible Directors

Lynne Taylor

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



The Integrated Corporate Dashboard and Board report has been reviewed, redesigned and transformed into the Trusts new Business Intelligence tool, 'Yellowfin'. 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 2020 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

Contextual Information



The impact of continuous pressures linked to the Covid pandemic across the Trust cannot be underestimated, resulting in significant operational issues during the December period and on-going.

The Trust has seen some of the highest levels of Covid admissions within the region since the start of the second wave in September, with between 100 and 200 plus beds occupied daily by Covid patients from the 1st October to date, peaking at 216 in January.

During January the higher acuity of Covid patients being admitted has seen Critical Care beds escalate into theatres, with the baseline 16 beds increasing to 26.

However, despite these pressures, the Trust has continued to deliver the safest, quality and timely services to our population, reviewing and transforming our pathways to accommodate the challenges that have arisen. Examples of this include;

- Revised bed models to accommodate Infection, Prevention and Control (IPS) measures to segregate Covid and Non Covid patients, significantly reducing the risk of nosocomial infections.
- Utilisation of Lateral Flow testing at front of house for early identification of potential Covid positive patients, enabling appropriate IPC management.
- Revised staffing models to accommodate the high level of acuity of patients on the base wards, with circa 40% of Covid patients requiring Oxygen therapies.
- Roll out of the 'Home First' model, to support early discharge of elderly patients.
- Review of available theatre capacity to enable emergency, urgent and cancer procedures to be carried out alongside the expansion of Critical Care
- Recruitment to new role of 'Support workers' to assist in non-clinical activities on the wards, providing patient engagement and support, alongside releasing clinical time to care.
- Temporary redeployment of both clinical and non-clinical staff to acute ward areas to support operational delivery
- Robust governance and oversight provided by senior leaders to enable prompt decision making.
- Enhanced health and well-being support is being provided, including a dedicated Covid advise line, access to 'break out hubs', regular refreshments on clinical areas and the availability of mental health advice and support.

Alongside the above pressures and mitigating actions, the Trust has successfully rolled out the Covid vaccination plan, with over 6,000 staff, patients and other frontline care providers vaccinated in the previous 4 weeks.

Executive Summary



SOF and Efficiency & Productivity

As recommended nationally, in line with the national 'Clinical prioritisation and Validation Programme', patients are being treated in order of 'clinical category' and 'clinical prioritisation' rather than access 'treat by dates' however with an additional focus on patients who have been waiting the longest. Close collaboration across the regional network in relation to cancer management continues, including the utilisation of the independent sector to support capacity requirements.

Whilst the Trust is focused on recovery, the increased pressures linked to the 2nd wave of the Covid pandemic is significantly impacting on the delivery of non-elective, urgent and routine services. The effect of reduced staffing resource due to further shielding requirements for clinically extremely vulnerable staff (see workforce section), Covid sickness, isolation and test and trace absences has resulted in the requirement to review elective services at the beginning of November and throughout the winter period. This has allowed the release of staff to support the pressured clinical areas' as surge in demand continues.

The sustained Covid pressures are being managed through robust resilience management, with all services under review on a daily/weekly basis within operational meetings, flexing capacity and available resource to meet the urgent demand. Appropriate Executive oversight is place to support decision making. The associated risks have been reviewed to reflect the on-going changes.

The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain positive compared to national and regional position, with teams working hard to maintain business as usual alongside recovery and pandemic pressures.

Operational efficiency and productivity remains a key focus of the Trust, ensuring outcome measures across Outpatients (DNAs and New to Review Ratios), Theatres (cancellations and utilisation) and Emergency pathways (admission avoidance, extended lengths of stay and Delayed Discharges) continue to be monitored and managed closely. Additional high level narrative is outlined within the individual sections of the report.

Quality & Safety

The latest HSMR value is currently reporting at 94.95 (November 2019 to October 2020) which has decreased from the previously unreported 94.96 position (October 2019 to September 2020). The latest SHMI value is now 98.69 (August 2019 to July 2020) which has decreased from the previously reported value of 99.00 (July 2019 to June 2020).

For December 2020 the Trust is reporting 2 Trust attributed case of Clostridium difficile infection (2 HOHA - Hospital Onset Healthcare Acquired), this has decreased from the previous reporting period when 6 cases were reported (6 HOHA - Hospital Onset Healthcare Acquired).

The Trust reported 33 hospital acquired Clostridium difficile infections April to December 2020 compared to 47 for April to December 2019, a 30% reduction.

The Trust has reported an improved position against for Cdiff, MSSA, Ecoli, Pseudomonas and Cauti's infections for the cumulative April 2020 to December 2020 period, with MRSA and Klebsiella remaining the same.

The Trust reported 11 stage 3 complaints for December 2020. This has decreased from the 14 stage 3 complaints in November 2020.

The Trust reported 37 falls resulting in an injury, but no fracture for December 2020. This has increased from the 20 falls resulting in an injury for November 2020.

Executive Summary



Workforce

In response to the government announcements, engagement with our 'Clinically Extremely Vulnerable' group of staff has continued. This is both from a wellbeing perspective and also to ensure any queries they may have can be addressed. A high proportion of CEV staff have received their Covid vaccine; with second doses being provided 3 weeks after the first vaccine. Over half of our CEV staff have expressed an interest in returning to work following the second vaccine.

Lateral flow testing commenced roll out on 24 November 2020 to frontline staff and has been extended to patients presenting at A&E and Maternity to help identify at risk patients and manage patient flow throughout the Trust.

The staff Wellbeing Hubs on both sites are now complete and were opened as planned in mid-December. The 'Listening into Action' app continues to enable the Trust to provide timely responses to staff concerns/ideas and is due to be re-launched in January. The main focus regarding health and wellbeing is 'Dry January', along with other campaigns being advertised in the Wellbeing You newsletter. The flu campaign is continuing and as of 3 January 2021, 78% of staff have been immunised.

Volunteer activities had resumed however the recent 'lockdown' meant volunteer services had to be withdrawn due to personal and health circumstances. This has led to a slight reduction in numbers, with 100 volunteers active within the Trust at the end of December. Recruitment continues, with interest especially high following a recent regional Covid 'call to arms' campaign, and numbers are anticipated to increase in coming months. There are currently a total of 65 applications under consideration (of which 15 resulted directly from the recent campaign). The Volunteer Service is working closely with participating areas to develop new roles and make improvements that will enable the most appropriate use of volunteer provision during the current pandemic. The 'Home but not Alone' project has also been paused however, the introduction of the Vaccination hub has offered new opportunities and work is underway to provide appropriate support to the teams working in this area.

Finance

The total Trust income in M9 is £27.904m.

The Trust has assumed £167k of additional central government funding to cover the costs of testing in the M9 position, which is out-with system funding. Similarly, the Trust has assumed £87 k income in respect of the Cancer Drugs Fund (CDF) for activity in M9.

M9 pay expenditure totalled £21.208m of which £0.379m is additional spend relating to the Covid-19 response and includes costs associated with Covid-19 testing.

M9 non pay expenditure totalled £4.015m of which £0.262m is additional spend related to the Covid-19 response and includes costs associated with Covid-19 testing.

Non-pay run rates (excluding Covid-19) have increased when compared to the first half of the year, as a result of elevated activity. There has been a slight decrease when compared to M8, as activity has reduced following increased Covid-19 admissions. Non-pay run rates remain below the 19/20 trend.

Based on current assumptions, the Trust continues to anticipate delivering a small in-year surplus of circa £3m. The M9 YTD position of a surplus of £1.955m is a positive position and builds upon the M8 position and provides confidence regarding the delivery of this provisional forecast outturn. However, assumed within the forecast is that the Trust continues to operate within revised control totals and receipt of income to cover temporary Covid-19 pressures, including testing and PPE.

At M9, the Group cash balance is £65.5m, driven mainly by cash received in advance from the DH for January 2021 activity and delays in the capital programme.

As at Month 9, the Trust has capital spend of £8.0m against a YTD plan of £11.7m. The Capital Performance Framework is now in place and is reported to the Executive Team and Capital & Revenue Management Group on a monthly basis.

Single Oversight Framework



North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			Narrative
New Cancer Two Week Rule (New Rules)	✓	Nov-20	92.84%	<p>Cancer</p> <p>Pressures continue to impact on the delivery of the cancer standards, with some delays to pathways unavoidable as the Trust, and patients, adhere to national guidance.</p> <p>However, despite the on-going pressures, 5 of the 8 standards were achieved in November, with the 62-day Referral to Treatment standard reporting at 78.98% (62/78.5) and the 2ww standard reported at 92.8% (263/281), with only 1 Trust in the region achieving both these of these standards.</p> <p>The 31 day subsequent treatment standard reported at 87.5% (7/8 patients) against the 94% standard, however related to one patient unavoidably breaching by 3 days.</p> <p>For the 62 day standard the regional position ranged from 62.9% to 86.05% with a North East average of 76.51%.</p> <p>The 2ww standard reported above the North East average, reporting at 77.4%, with performance ranging between 43.02% to 94.68% across the region.</p> <p>The SPC charts indicate a number of points outside the statistical control ranges in year, however in the main during the Wave 1 Covid period when national clinical guidance dictated planned reductions in some cancer screening and symptomatic services.</p> <p>All Cancer pathways continue to be monitored through robust daily /weekly operational meetings and strategically through dedicated tumour level cancer pathway groups.</p>
Breast Symptomatic Two Week Rule (New Rules)	✓	Nov-20	93.59%	
New Cancer 31 Days (New Rules)	✓	Nov-20	97.84%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Nov-20	100.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	Nov-20	87.50%	
New Cancer 62 Days (New Rules)	✗	Nov-20	78.98%	
New Cancer 62 Days (Screening)	✓	Nov-20	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✗	Nov-20	84.62%	

Single Oversight Framework



North Tees and Hartlepool
NHS Foundation Trust

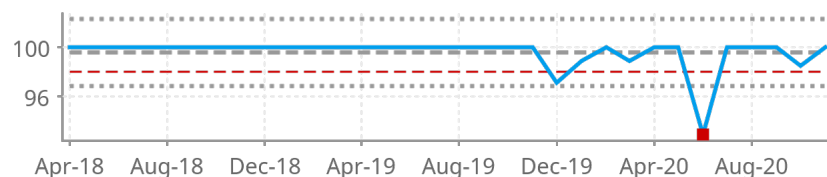
Standard	Standard Achieved			Narrative
RTT Incomplete Pathways Wait (92%)	✗	Dec-20	90.41%	<p>RTT</p> <p>Whilst the Trust continues to experience pressures in the delivery of routine elective pathways, it remains one of the top performing Trusts across the region against the 18-week Referral to Treatment standard.</p> <p>The Trust reported at 90.41% in December against a regional average of 75.79%. 52 week waits remain a key focus, with the Trust reporting 87 in December compared to 48 in November. The main impact on the increase has been the unavoidable cancellations of some routine electives due to significant Covid pressures, however putting this into context the region has reported circa 10,000 over 52 week waiters at the end of December, with individual organisations reporting over 3,000 long waiters.</p> <p>Inevitably the Trust has seen an overall rise in the RTT waiting list during the pandemic, with an additional 27% (n=3350) compared to the January 2020 position.</p> <p>The Trust is in the process of reviewing the Phase 3 recovery plans submitted in September 2020, with a proposal to implement additional weekend sessions and, in line with the national directive, utilise the available Independent Sector capacity to support the recovery of the elective programme.</p> <p>Clinicians have been reviewing patients and providing advice and guidance back to the care of the GP where appropriate, based on clinical need and priority.</p> <p>The impact of the Covid pandemic is clearly evidenced within the SPC charts, with significant peaks aligned to the pressures in year.</p> <p>Trust has, and continues to, adhere to national guidance on the rescheduling of appointments, diagnostics and treatments due to the impact of Covid, reviewing patient pathways on a case by case basis, based on clinical categorisation of urgency</p> <p>Diagnostics</p> <p>Performance Summary - The diagnostic pathway continues to maintain recovery against trajectories. SPC indicate the progress being made in achieving an improved position against the 6 week standard. The longest delays are within MRI and CT with a recovery plan in place as part of the Planning and Recovery Group.</p>
RTT Incomplete Pathways Wait (92nd Percentile)	✓	Dec-20	19.00	
Incomplete Pathways Wait (Median)	✗	Dec-20	8.90	
Incomplete Pathways Wait (>52 Week Wait)	✗	Dec-20	87	
DM01	✗	Dec-20	94.20%	
CIDS - Referral Information	✓	Nov-20	95.94%	
CIDS - Referral to Treatment Information	✓	Nov-20	98.47%	
CIDS Treatment Activity Information	✓	Nov-20	94.42%	
CIDS End of Life	✓	Nov-20	85.26%	



Statistical Process Control (SPC) Charts

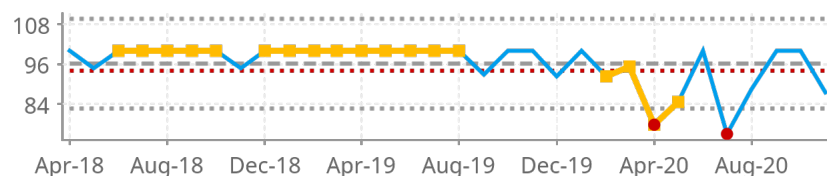
Cancer - 31 Day Drug Treatment

✓ Nov-20 100.00% Standard 98.00%



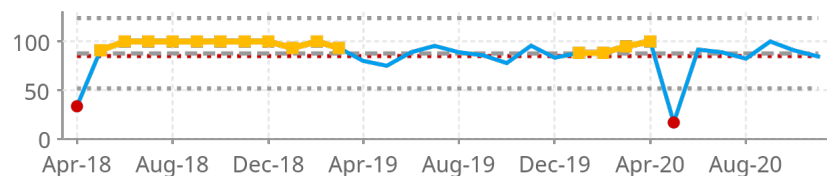
Cancer - 31 Day Surgical Treatment

✗ Nov-20 87.50% Standard 94.00%



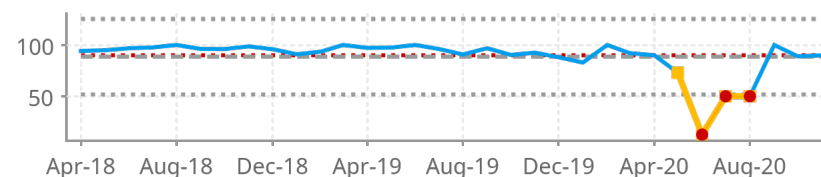
Cancer - 62 Consultant Upgrade

✗ Nov-20 84.62% Standard 94.00%



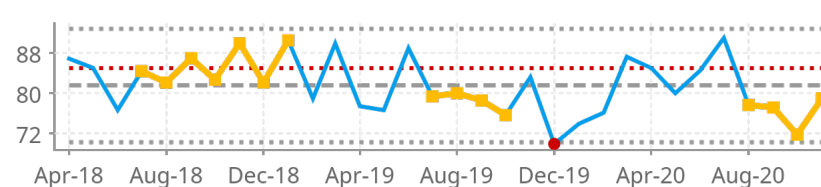
Cancer - 62 Days Screening

✓ Nov-20 90.00% Standard 85.00%



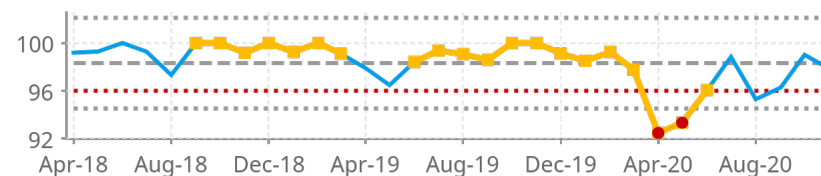
Cancer - 62 Days New Rules

✗ Nov-20 78.98% Standard 85.00%



Cancer - 31 Days New Rules

✓ Nov-20 97.84% Standard 94.00%





Statistical Process Control (SPC) Charts

Cancer - 2 Week Rule

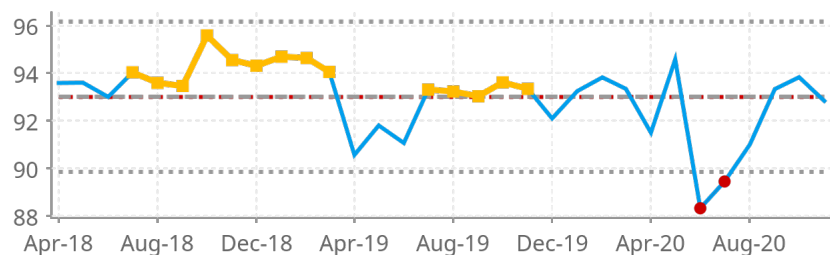


Nov-20

92.84%

Standard

93.00%



Cancer - Breast Symptomatic

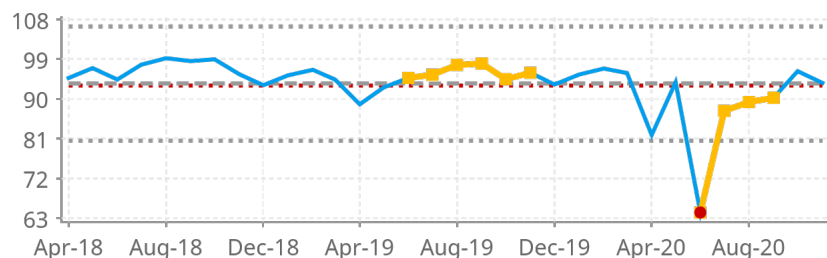


Nov-20

93.59%

Standard

93.00%



DM01 - Diagnostics

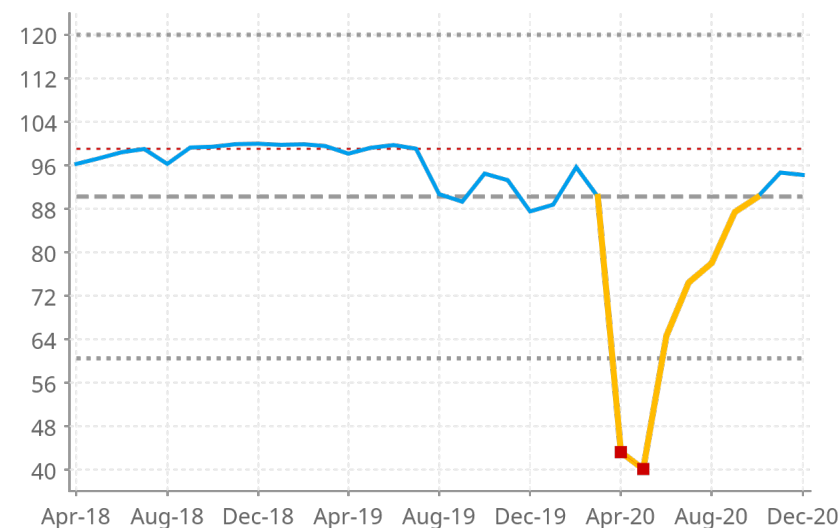


Dec-20

94.20%

Standard

99.00%



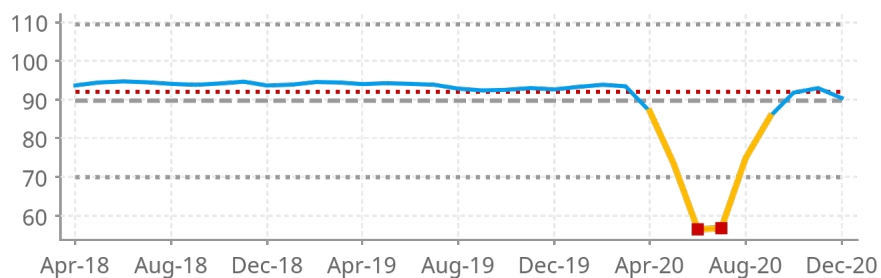
Single Oversight Framework



North Tees and Hartlepool
NHS Foundation Trust

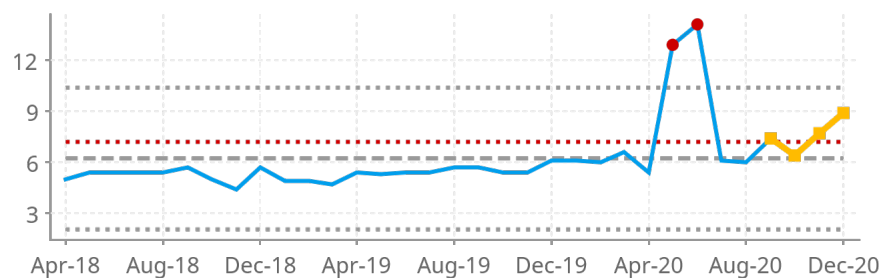
RTT- Incomplete Pathways Wait (92%)

❌ Dec-20 90.41% *Standard* 92.00%



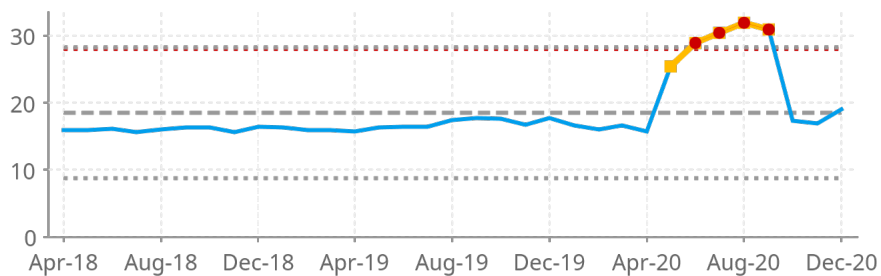
RTT- Incomplete Pathways Wait (Median)

❌ Dec-20 8.90 *Standard* 7.20



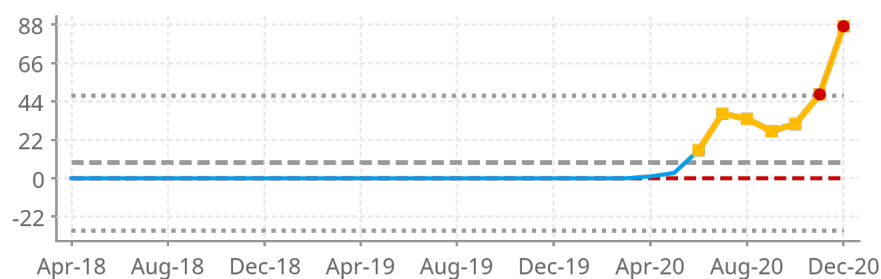
RTT- Incomplete Pathways Wait (92nd percentile)

✅ Dec-20 19.00 *Standard* 28.00



RTT- Incomplete Pathw (>52 Week Wait)

❌ Dec-20 87 *Standard* 0

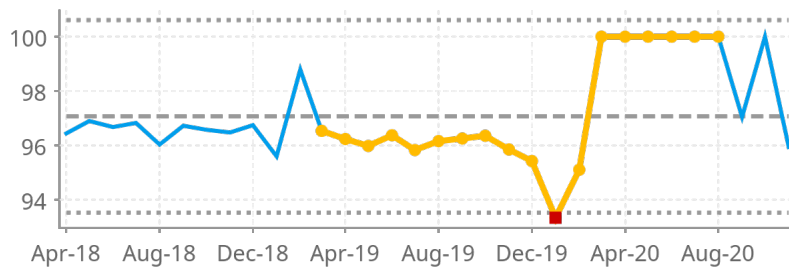




Statistical Process Control (SPC) Charts

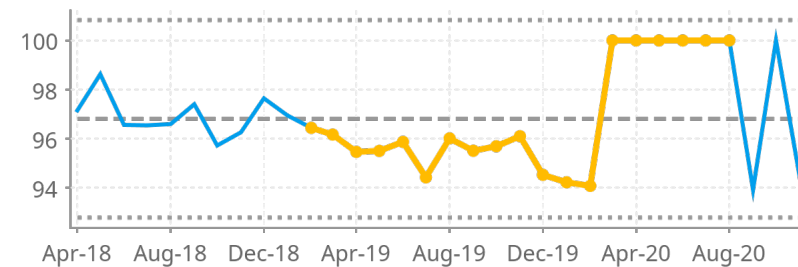
CIDS - Referral Information

✓ Nov-20 95.94% Standard 50.00%



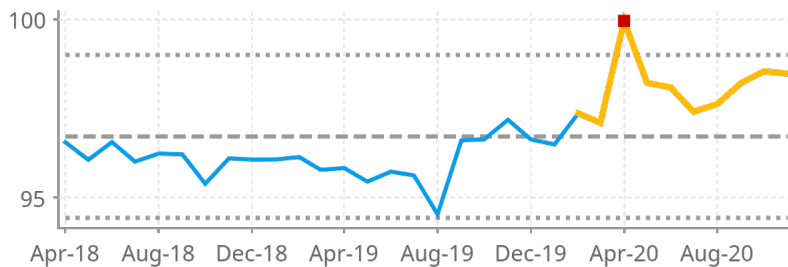
CIDS - Treatment Activity Information

✓ Nov-20 94.42% Standard 50.00%



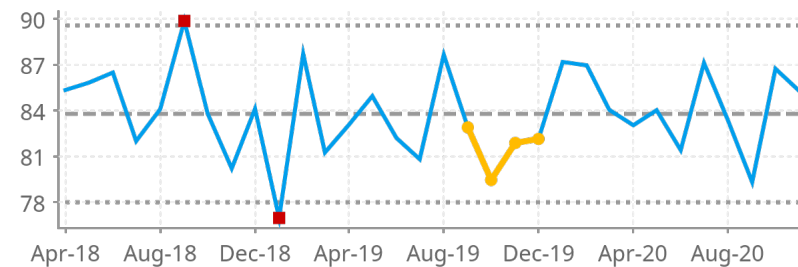
CIDS - Referral to Treatment

✓ Nov-20 98.47% Standard 50.00%



CIDS - End of Life

✓ Nov-20 85.26% Standard 50.00%



Efficiency & Productivity



Standard	Standard Achieved			Narrative
Outpatient DNA (New)	✓	Dec-20	7.02%	<p>DNA</p> <p>DNA: An overall reduction in DNA rates is evident in year. When compared to December 2019, DNA rates have seen an overall decrease of 3.23% (n=514) with 'Review' rates showing the greatest improvement with 440 (3.39%) fewer DNA's.</p> <p>Although the SPC indicate an increase since the significant drop during the Wave 1 peak, this is inevitable given the majority of face to face consultations were stopped during this period, alongside the initial pausing of the telephone reminder service together with patients not wanting to attend the hospital.</p> <p>The appointment reminder service has now been resumed.</p> <p>An Electronic portal project (regionally) is also in planning phase, which will support direct patient management of appointments.</p> <p>Lengths of Stay/Day Case rates</p> <p>Lengths of stay remain on track across both emergency and elective pathways, despite the pressures, with an increase in Day Case rates evident due to the swap out of inpatient activity to manage the elective programme.</p> <p>Delayed Transfers of Care indicate an increase over the November and December periods, however this was in the main due to the impact of the national directive to provide a 'designated setting' for Covid positive care home discharges. This has improved during January with a significant reduction in delays reported.</p> <p>Readmissions</p> <p>Emergency readmissions are reporting above the internal targets, a slight reduction is evident within the SPC since the peak in Wave 1 of the pandemic. Work is on-going within the Care Groups to identify avoidable re-admissions and how pathways can be improved to reduce going forward, however recognising the impact of the current Covid pathways and longer term influences on recovery.</p>
Outpatient DNA (Review)	✓	Dec-20	6.70%	
Average Depth of Coding	✓	Dec-20	6.74	
Length of Stay - Elective	✓	Dec-20	1.33	
Length of Stay - Emergency	✓	Dec-20	3.29	
Day Case Rate	✓	Dec-20	90.59%	
Pre-op Stays	✓	Dec-20	2.70%	
Re-admissions Rate 30 Days (Elective Admission)	✗	Oct-20	3.64%	
Re-admissions Rate 30 Days (Emergency Admission)	✗	Oct-20	15.43%	

Efficiency & Productivity



Standard	Standard Achieved			Narrative
Electronic Discharge Summaries	✗	Dec-20	89.65%	<p>Ambulance handover - The North East (NEAS) average handovers greater than 30 minutes ranged between 28-266, with the average over 60 minutes ranging between 1- 98. Internal validation of the NEAS reports indicates the Trust had 67 >30 minutes and 13 >60 minutes.</p> <p>NEAS reported the Trust at 42.6% ambulance turnaround times (valid) within 30 minutes, in comparison the North East's position at 36.6% with performance ranging between 28.4% and 45.0%.</p> <p>Increased pressures experienced within the Trust is represented within the SPC with values reaching above the upper control limit however one data point is not deemed cause for concern at this stage as this is common cause and predictable.</p> <p>DTOC - There are multiple factors that impact upon discharge management such as bed reductions and external flow. Whilst an increase is noted within DTOCs the Trust remained at an average of 64 in December with a range between 22 and 76 patients. A reduction is now being seen. The acuity of patients being admitted remains high, in the main as a result of covid however this is not truly reflected within the occupancy levels.</p> <p>The Trust continues to manage beds on a flexible basis to accommodate surges in demand across all areas to accommodate red and green flows. Resilience plans in place to flex as necessary following an increase in Covid-19 admissions. There are also plans to increase designated setting environments across North Tees and Hartlepool and Social workers are re-joining IDT team on site for care planning and early engagement.</p>
C-Section Rates	✗	Dec-20	20.10%	
Trolley Waits (over 12 hours)	✓	Dec-20	0	
Time to Initial Assessment (mean) Type 1 & 3	✓	Dec-20	7.86	
Number of Ambulance Handovers waiting more than 30 Mins	✗	Dec-20	92	
Number of Ambulance Handovers waiting more than 60 Mins	✗	Dec-20	29	
Delayed Transfer of Care	✗	Dec-20	5.45%	
Super Stranded	✗	Dec-20	64	

Efficiency & Productivity



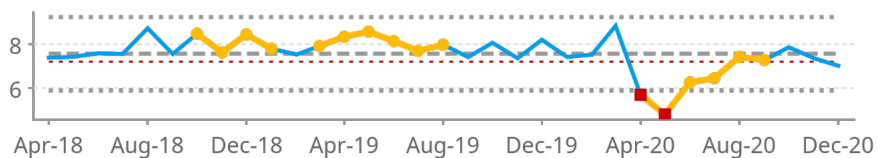
Standard	Standard Achieved			Narrative
Operation Time Utilisation	✗	Dec-20	69.00%	<h3>Theatre</h3> <p>The increased rates of Covid-19 infections have resulted in significant pressures on the Trust as a whole, including the impact on staffing resource and subsequently the ability to deliver all services to their full capacity.</p> <p>Inevitably this is resulting in cancelled elective procedures, impacting on the Trust recovery trajectories. The Trust is reviewing and assessing capacity on a daily /weekly basis with the aim of keeping cancellations to an absolute minimum wherever possible.</p> <p>Alongside the above pressures, the Trust is also working within the physical constraints of the Infection Prevention and Control standards to ensure patients admitted for a procedures are managed through an appropriate pathway, reducing the risk of Covid infection both pre admission and throughout their hospital stay.</p> <p>This has included new ways of working within theatres, accommodating PPE donning and doffing processes, plus the requirement for all patients to go through a 14-day pre-admission process to reduce the risk of infection.</p> <p>As such, the efficiency metrics are being monitored closely, with regular reviews of how processes and procedures can be adjusted to improve utilisation wherever possible.</p> <p>Robust governance processes are in place to support prompt and appropriate decision making.</p>
Run Time Utilisation	✗	Dec-20	83.56%	
Cancelled on Day of Operation	Under Development			
Late Start %	✗	Dec-20	58.37%	
Early Finishes %	✓	Dec-20	44.02%	



Statistical Process Control (SPC) Charts

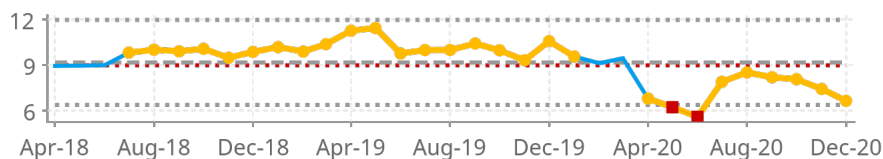
Outpatient DNA (New)

✓ Dec-20 7.02% Standard 7.20%



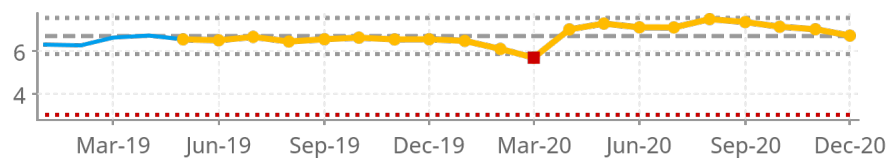
Outpatient DNA (Review)

✓ Dec-20 6.70% Standard 9.20%



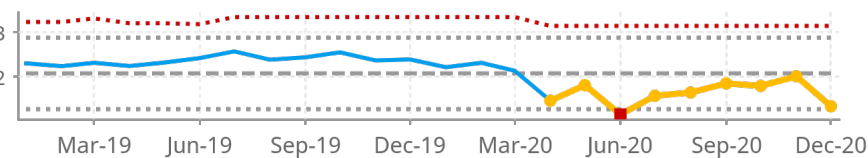
Average Depth of Coding

✓ Dec-20 6.74 Standard 3.01



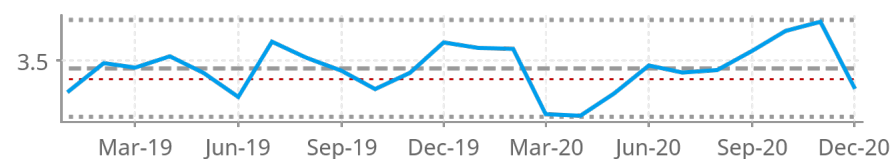
Length of Stay - Elective

✓ Dec-20 1.33 Standard 3.14



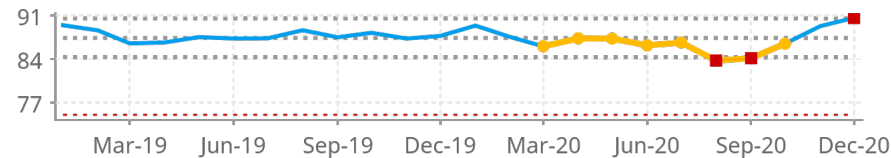
Length of Stay - Emergency

✓ Dec-20 3.29 Standard 3.35



Day Case Rate

✓ Dec-20 90.59% Standard 75.00%

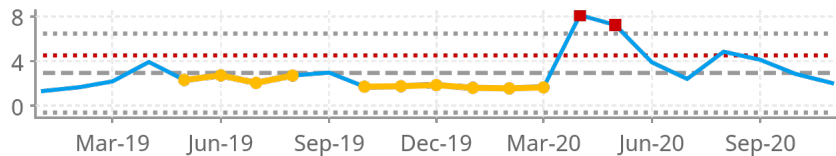


Efficiency & Productivity



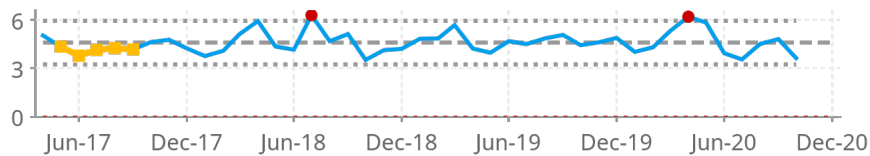
Pre-op Stays

✓ Dec-20 2.70% 7%



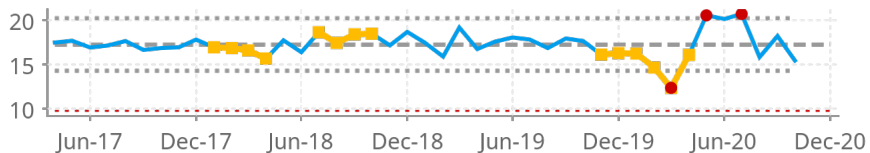
Re-admissions Rate 30 Days (Elective Admissions)

✗ Oct-20 3.64% 3%



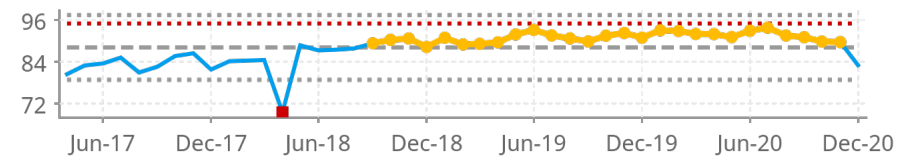
Re-admissions Rate 30 Days (Emergency Admissions)

✗ Oct-20 15.43% 13%



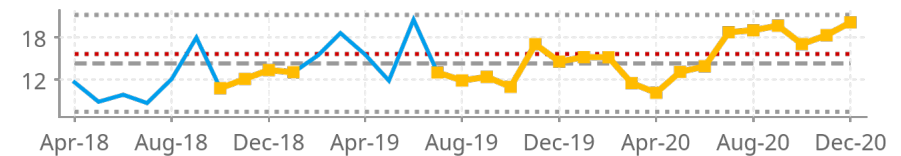
Electronic Discharge Summaries

✗ Dec-20 89.65% 100%



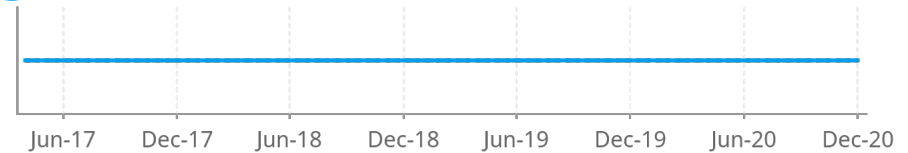
C-Section Rates

✗ Dec-20 20.10% 5.60



Trolley Waits (Over 12 hours)

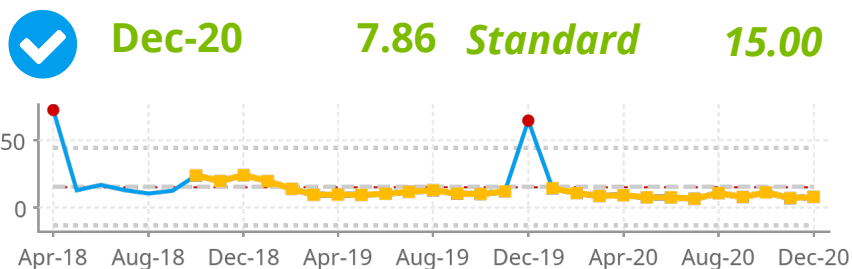
✓ Dec-20 0 0



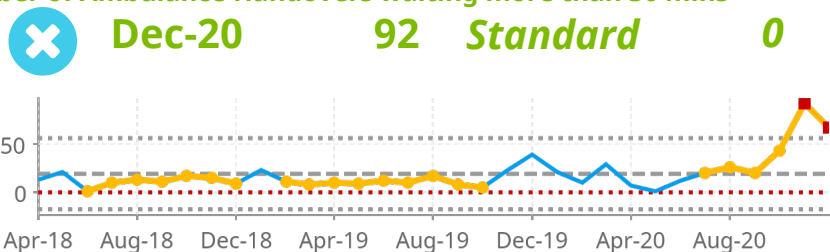


Statistical Process Control (SPC) Charts

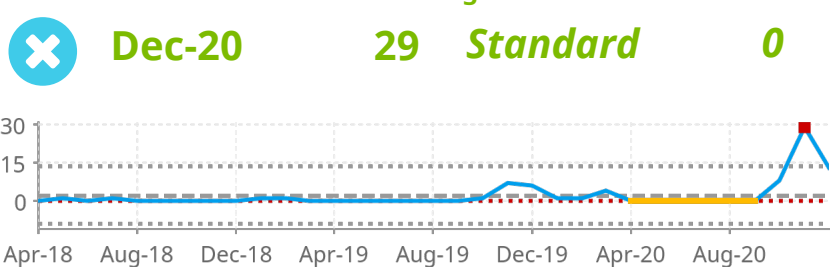
Time to Initial Assessment (mean) Type 1 & 3



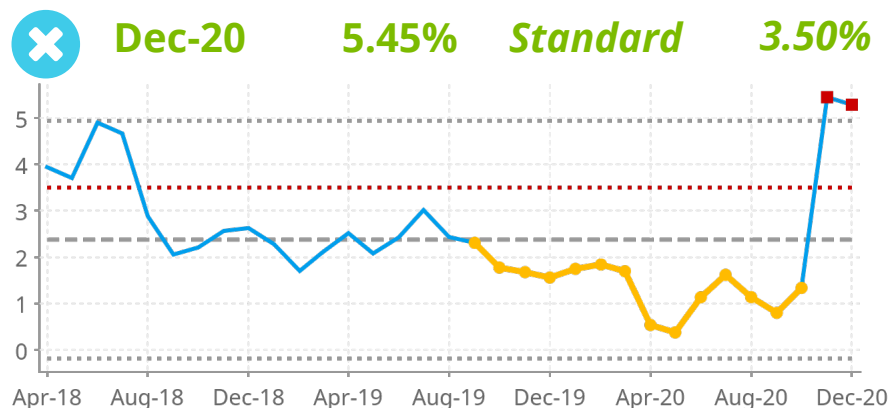
Number of Ambulance Handovers waiting more than 30 mins



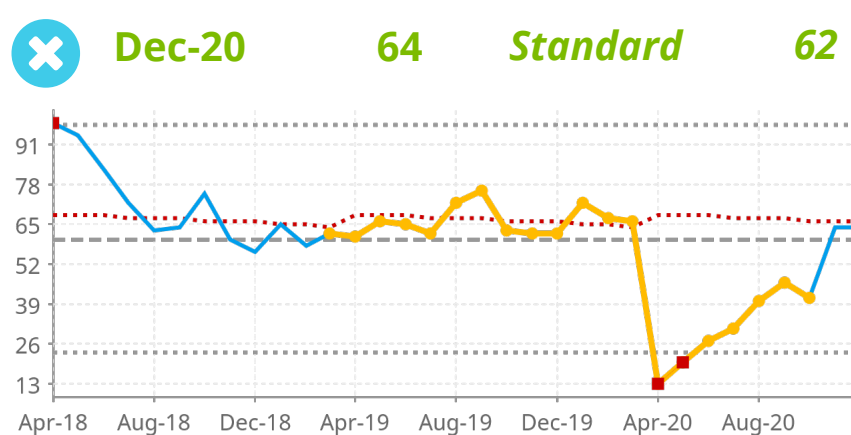
Number of Ambulance Handovers waiting more than 60 mins



Delayed Transfer of Care



Super Stranded

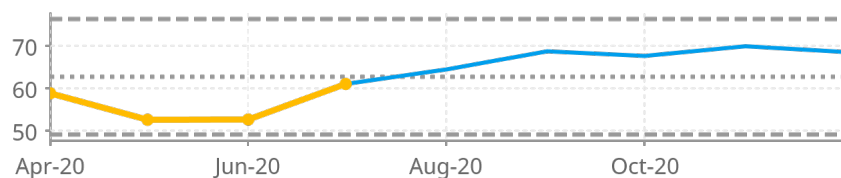




Statistical Process Control (SPC) Charts

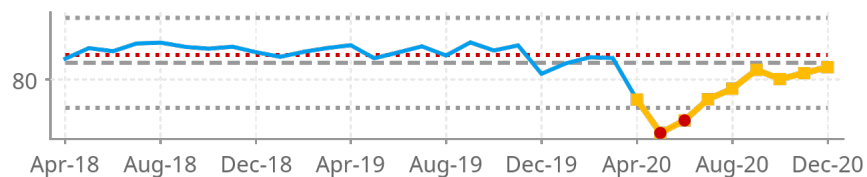
Operation Time Utilisation

❌ Dec-20 69.00% Standard 72.86%



Run Time Utilisation

❌ Dec-20 83.56% Standard 87.07%



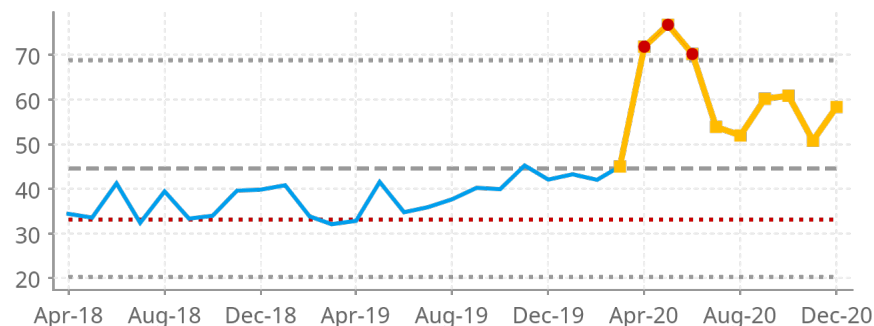
Cancelled on Day of Operation

Standard 8.80%

Under Development

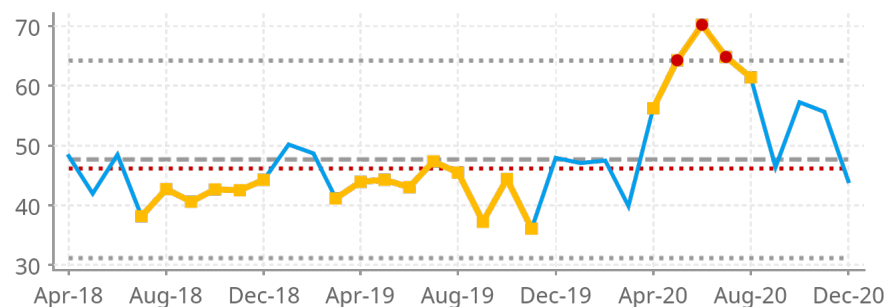
Late Start %

❌ Dec-20 58.37% Standard 33.11%




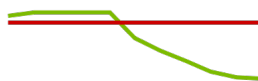
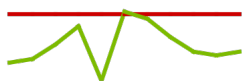
Early Finishes %

✅ Dec-20 44.02% Standard 46.13%



Efficiency & Productivity



Standard	Standard Achieved				Narrative
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool		Dec-20	97.26%		<h3>Diabetic Retinopathy Screening</h3> <p>Diabetic retinopathy screening has been affected by the pandemic due to the nature of the service with all screening services paused during the first wave in line with national guidance. As the pandemic progressed staffing resource was utilised to support the Trust however this has formed part of the recovery plan which is also nationally led which is a phased approach with limitations on invitations sent to patients and postponed appointments recalled gradually based on capacity.</p>
TCS35b - % of Wheelchair referrals not completed within 5 weeks but completed within 18 weeks		Dec-20	100.00%		
Diabetic Retinopathy Screening		Dec-20	67.53%		
The % of Patients treated within 18weeks of referral to Audiology		Dec-20	100.00%		
Audiology non-admitted wait (92nd Percentile)		Dec-20	8.00		

Efficiency & Productivity



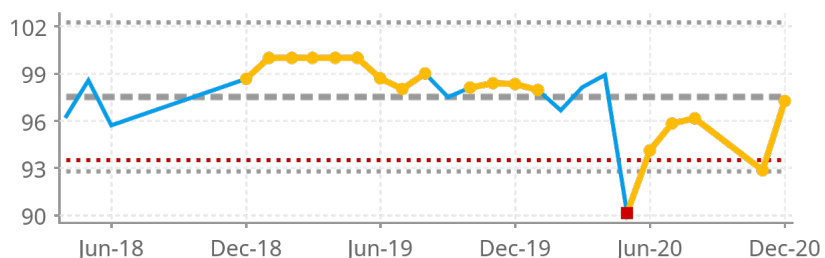
Standard	Standard Achieved			Narrative
PHQ - Emergency Admissions for Acute Conditions that should not usually require hospital admission	✓	Dec-20	92.50	<p>PHQ Indicators</p> <p>The PHQ indicators are a set of metrics which monitor the impact of community services on avoidable admissions for a set of key conditions. A year on year improvement is monitored against these indicator as a measure of avoidable admissions.</p> <p>No exceptions to report within the SPC charts, with controlled variation across all the standards, however recognising the impact of the Covid pandemic and associated changes in pathway management which is evident in the drop in activity from March 20 onwards</p>
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	✓	Dec-20	14.46	
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	✓	Dec-20	52.25	
PHQ - Unplanned hospitalisation for respiratory tract infections in under 19s	✓	Dec-20	6.67	
Stroke admissions - 90% of time spent on dedicated stroke unit.	✓	Dec-20	97.37%	
High Risk TIA assessed and treated within 24hrs	✓	Dec-20	100.00%	



Statistical Process Control (SPC) Charts

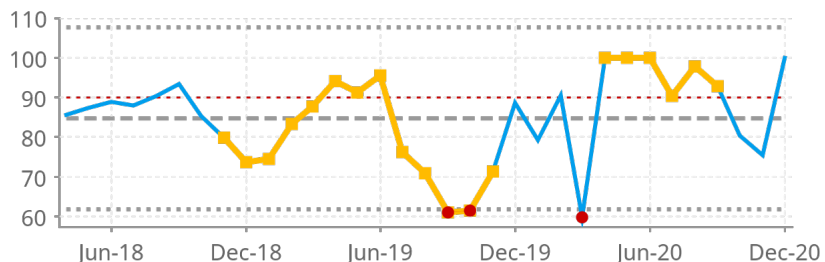
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool

✓ Dec-20 97.26% Standard 50%



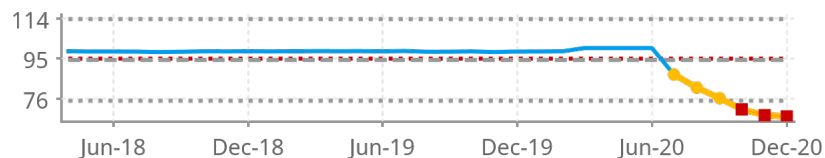
TCS35b - % of Wheelchair referrals not completed within 18 weeks

✓ Dec-20 100.00% Standard 00%



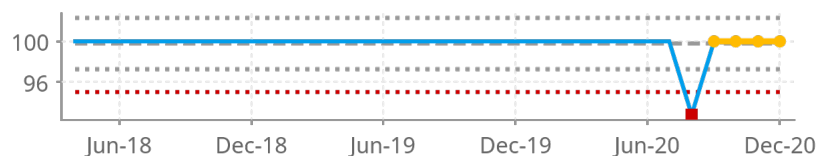
Diabetic Retinopathy Screening

✗ Dec-20 67.53% Standard 95.00%



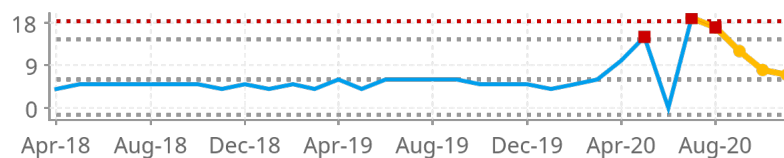
The % of Patients treated within 18 weeks of referral to Audiology

✓ Dec-20 100.00% Standard 95.00%



Audiology non-admitted wait (92nd Percentile)

✓ Dec-20 8.00 Standard 18.30

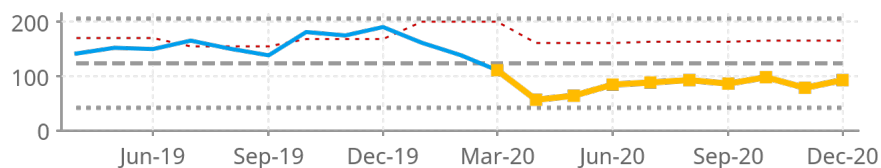




Statistical Process Control (SPC) Charts

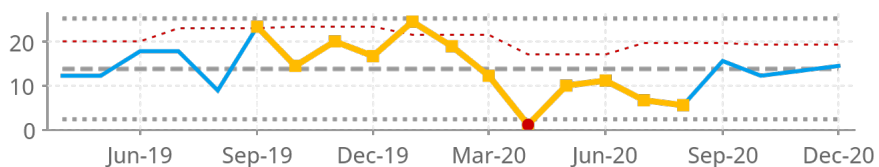
PHQ - Emergency Admissions for Acute Conditions that should not usually require hospital admission

✓ Dec-20 92.50 Standard 164.90



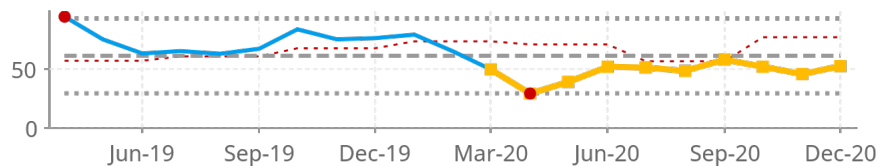
PHQ - Unplanned hospitalisation for a epilepsy in unders 19s

✓ Dec-20 14.46 Standard 19.28



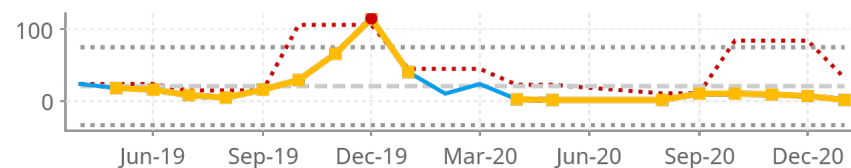
PHQ - Unplanned hospitalisation for cl care sensitive conditions (adults)

✓ Dec-20 52.25 Standard 76.80



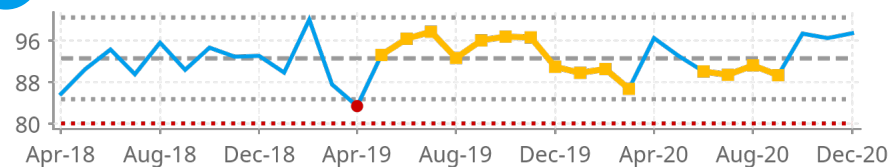
PHQ - Unplanned hospitalisation for respiratory tract infections in under 19s

✓ Dec-20 6.67 Standard 83.80



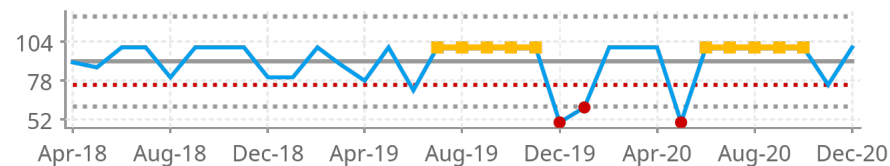
Stroke admissions - 90% of time spent on didicated stroke unit.

✓ Dec-20 97.37% Standard 80.00%











High Risk TIA assessed and treated within 24hrs

✓ Dec-20 100.00% Standard 75.00%



Safety & Quality



Standard	Standard Achieved			Narrative
HSMR	✓ Nov 19 - Oct 20	94.95		<p>Mortality</p> <p>The latest HSMR value is currently reporting at 94.95 (November 2019 to October 2020) which has decreased from the previously unreported 94.96 position (October 2019 to September 2020). The latest SHMI value is now 98.69 (August 2019 to July 2020) which has decreased from the previously reported value of 99.00 (July 2019 to June 2020).</p> <p>Complaints</p> <p>There has been a change in the process of complaints due to Covid-19 due to complainants choosing written responses rather than face to face meetings. This has therefore decreased stage 2 and increased stage 3 complaints. The majority of complaints are being affected by the restrictions in visiting and the effect on communication. Actions are being developed to mitigate this risk.</p> <p>The Trust is reporting 102 stage 1 complaints for December 2020. This value falls within the SPC control limits (46-117), and is higher than the mean of 81. The run of 5 consecutive data points above the average (mean) is not that rare for random variation.</p> <p>The Trust is reporting 2 stage 2 complaints for December 2020. This value falls within the SPC control limits (-3-11), and is lower than the mean of 4. The run of values above or below the average (mean) line represents a natural variation in the data.</p> <p>The Trust is reporting 3 stage 3 complaints for December 2020. This value falls within the SPC control limits (4-19), and is the same as the mean of 11. The run of values above or below the average (mean) line represents a natural variation in the data.</p>
SHMI	✓ Aug 19 - Jul 20	98.69		
Dementia KPI 1	✓ Dec-20	100.00%		
Dementia KPI 2	✓ Dec-20	100.00%		
Dementia KPI 3	✓ Dec-20	100.00%		
Stage 1 Complaint	✓ Apr to Dec	724		
Stage 2 Complaint	✓ Apr to Dec	14		
Stage 3 Complaint	✓ Apr to Dec	84		

Safety & Quality



Standard	Standard Achieved				Narrative
Red Risks	✓	Dec-20	1		<p>VTE%</p> <p>The Trust is reporting that 95.83% of patients admitted to hospital were risk assessed for venous thromboembolism (VTE) during December 2020, this has met the National Standard of 95.00%.</p> <p>Falls</p> <p>The trust has recently appointed a lead for falls who is reviewing the current falls management system and implementing an assurance framework. The focus is on re-enablement and the physical wellbeing of patients therefore mitigating falls risk factors.</p> <p>The Trust is reporting 100 falls resulting in no injury for December 2020 and falls out of the upper Control Limit of 99 and has seen a steady increase in monthly falls since July 2020.</p> <p>The Trust is reporting 37 Falls resulting in an injury for December 2020. The 37 falls falls out of the upper Control Limit of 30 and is well above the mean of 18 falls.</p> <p>There have been zero falls with fracture in December 2020.</p> <p>Pressure Ulcers</p> <p>November 2020 cases within all four categories of Pressure Ulcers fall within the control limits. Category one - 15 cases is on the upper control limit of 15, category two - 36 cases is just below the upper control limit of 37. Category three is demonstrating no trend and is displaying a natural variation. Finally, there have been two consecutive months where a category four ulcer has been classified.</p>
Never Events	✓	Dec-20	0		
VTE %	✓	Dec-20	95.83%		
Fall No Injury	✓	Apr to Dec	673		
Fall Injury	✓	Apr to Dec	175		
Fall Fracture	✓	Apr to Dec	4		
Pressure Cat1	✓	Apr to Nov	48		
Pressure Cat2	✓	Apr to Nov	156		
Pressure Cat3	✓	Apr to Nov	10		
Pressure Cat4	✓	Apr to Nov	2		

Safety & Quality



Standard	Standard Achieved			Narrative
Hand Hygiene	✓	Dec-20	100.00%	<p>Hand Hygiene</p> <p>The overall Trust compliance score for hand hygiene is 100% for December 2020; this has increased from 99% in November 2020. The clinical areas carry out monthly audits with a quarterly assurance check by the IPC team.</p> <p>Infections</p> <p>For December 2020 the Trust is reporting 2 Trust attributed case of Clostridium difficile infection (HOHA - Hospital Onset Healthcare Acquired), this has decreased from the previous reporting period when 6 cases were reported.</p> <p>The Trust reported 33 hospital acquired Clostridium difficile infections April to December 2020 compared to 47 for April to December 2019, a 30% reduction.</p> <p>The Trust has reported an improved position against for Cdiff, MSSA, Ecoli, Pseudomonas and Cauti's infections for the cumulative April 2020 to December 2020 period, with MRSA and Klebsiella remaining the same.</p> <p>All seven Infections continue to display natural cause variation and remain in their respective upper and lower control limits.</p> <p>The number of hospital onset Covid-19 cases increased in November 2020 when the trust reported a higher number of outbreaks, this is likely to be due; in part; to increased community transmission and the effect of the new variant. This has since significantly reduced.</p>
Cdiff	✓	Dec-20	33	
MRSA	✓	Dec-20	0	
MSSA	✓	Dec-20	18	
Ecoli	✓	Dec-20	20	
Klebsiella	✓	Dec-20	6	
Pseudomonas	✓	Dec-20	1	
CAUTI	✓	Dec-20	162	

Safety & Quality



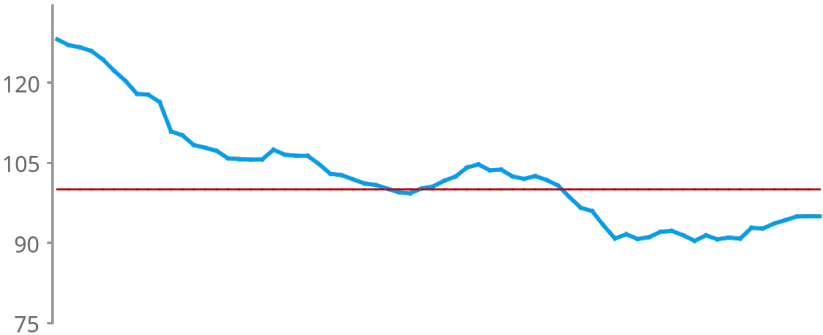
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				Narrative
FFT - Emergency	✓	Dec-20	85.00%		<p>FFT</p> <p>The FFT process changed in April 2020 to a single question with more focus on the narrative that is supplied with the feedback. This has created a wealth of information that is available for all teams.</p> <p>The Emergency Care (Accident & Emergency and Urgent Care) Friends and Family position for rating the service 'Very Good or Good' was 85% for December 2020.</p> <p>The in-patient Friends and Family position for rating the service 'Very Good or Good' was 85% for December 2020.</p> <p>The Maternity (Delivery) Friends and Family position for rating the service 'Very Good or Good' was 100% for December 2020.</p> <p>All three metrics Decembers FFT percentages fall within their relevant control limits with the recent trends displaying natural cause variation. Work continues to improve the amount of feedback.</p> <p>UNIFY</p> <p>Nursing fill rate reflects the increased demand on the workforce during Covid-19 to safely meet the needs of patients with a higher acuity. Only RN Night staffing has met the standard for December 2020 with 82.70% ($\geq 80\%$ to $\leq 109.99\%$). The three other metrics have missed their standards on the lower side.</p> <p>However, all four metrics continue to display natural cause variation and remain within their upper and lower control limits.</p>
FFT - Inpatients	✓	Dec-20	85.00%		
FFT - Maternity	✓	Dec-20	100.00%		
UNIFY - RN Day	✗	Dec-20	78.47%		
UNIFY - RN Night	✓	Dec-20	82.70%		
UNIFY - HCA Day	✗	Dec-20	75.31%		
UNIFY - HCA Night	✗	Dec-20	106.37%		

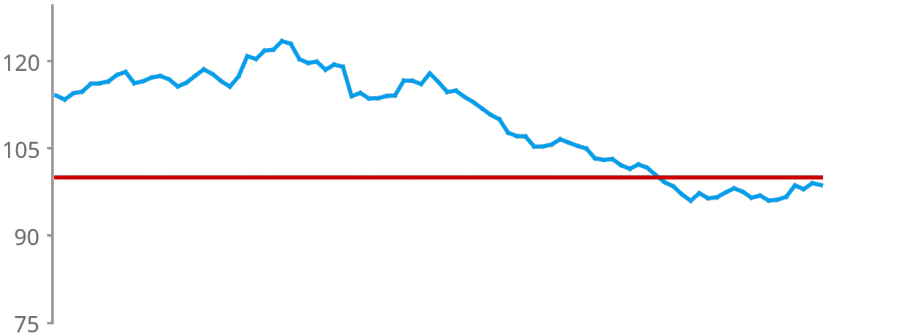


Additional Detail Charts

HSMR  Nov 19 - Oct 20 94.95



SHMI  Aug 19 - Jul 20 98.69



Dementia KPI 1  Dec-20 100.00%



Dementia KPI 2  Dec-20 100.00%



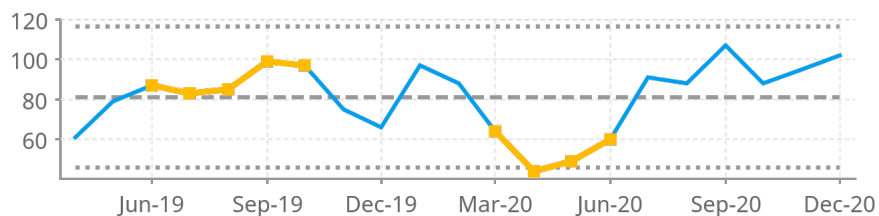
Dementia KPI 3  Dec-20 100.00%



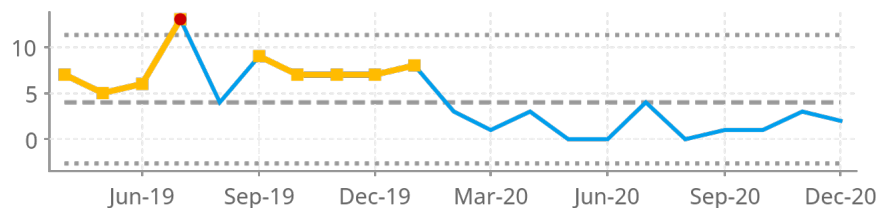


Statistical Process Control (SPC) Charts

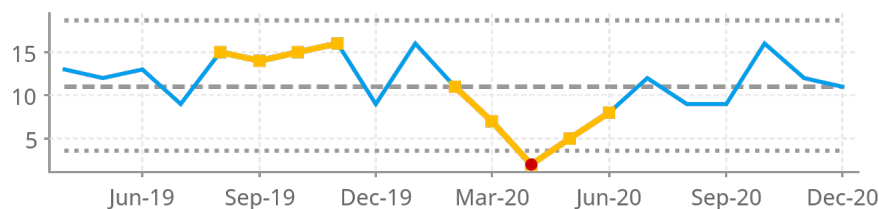
Stage 1 - Informal Apr to Dec 724



Stage 2 - Meeting Apr to Dec 14



Stage 3 - Formal Apr to Dec 84

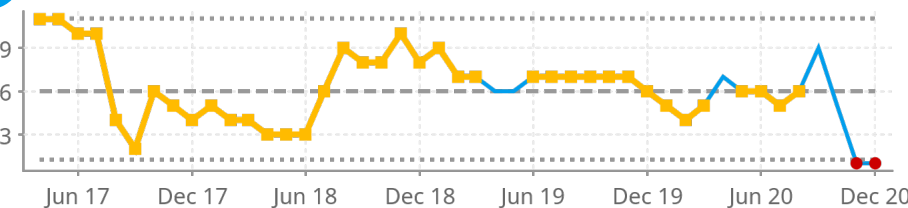


Red Risks



Dec-20

1

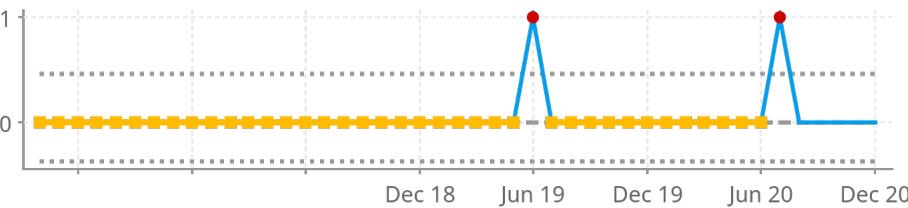


Dec-20

0

Standard

0

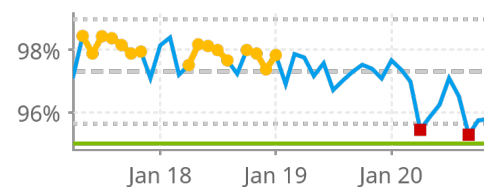


Dec-20

95.83%

Standard

95.00%



- Outliers
- Step Changes
- VTE Assessment %
- Target%
- UCL
- LCL
- Mean



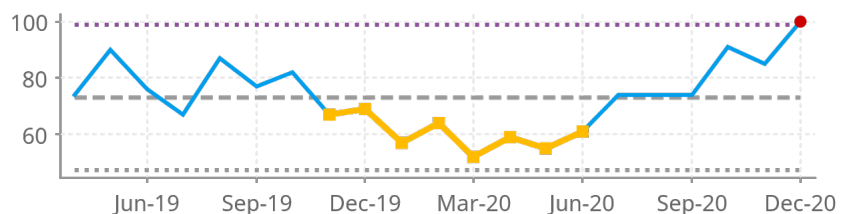
Statistical Process Control (SPC) Charts

Falls No Injury



Apr to Dec

673

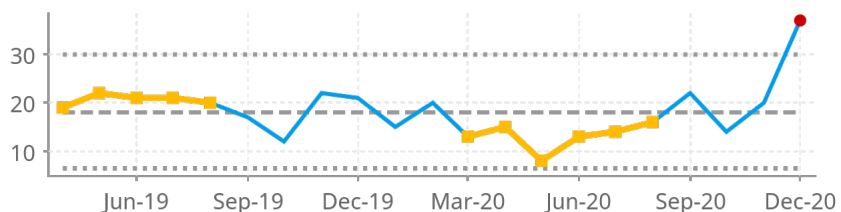


Falls Injury



Apr to Dec

175

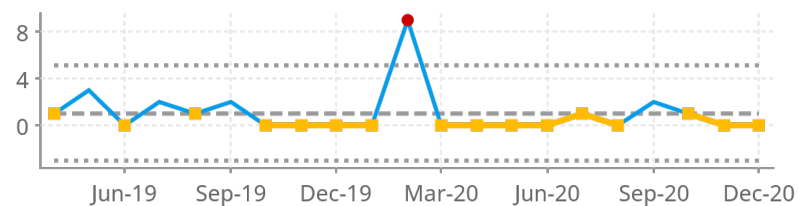


Falls Fracture



Apr to Dec

4



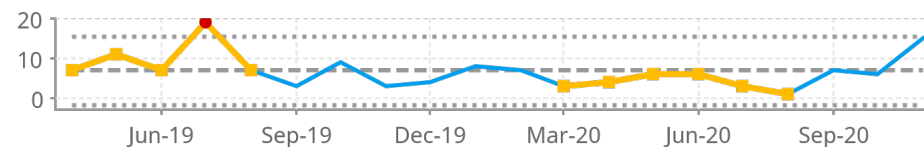
Pressure Ulcer



Apr to Nov

48

Cat 1



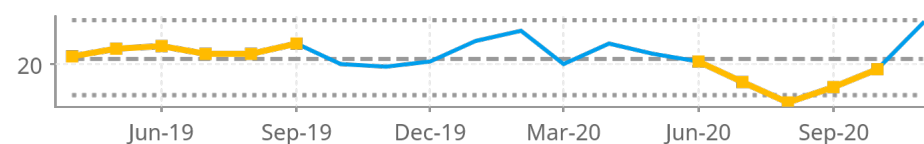
Pressure Ulcer



Apr to Nov

156

Cat 2



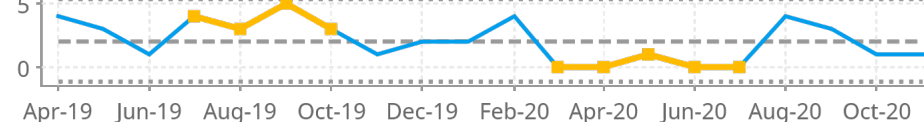
Pressure Ulcer



Apr to Nov

10

Cat 3



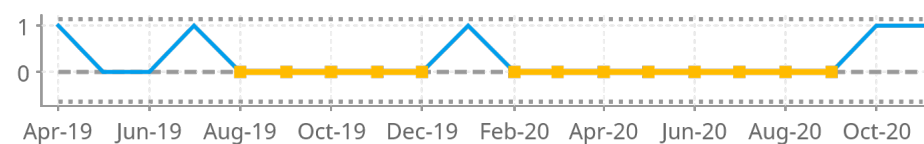
Pressure Ulcer



Apr to Nov

2

Cat 4





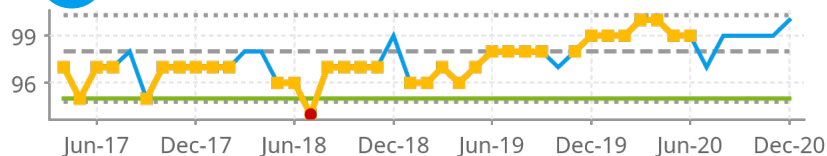
Statistical Process Control (SPC) Charts

Hand Hygiene



Dec-20

100.00%

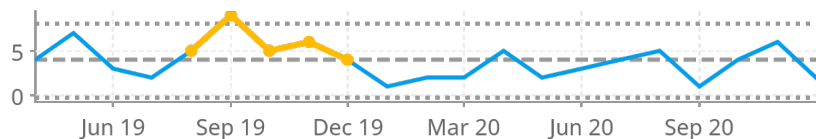


Cdiff



Dec-20

33

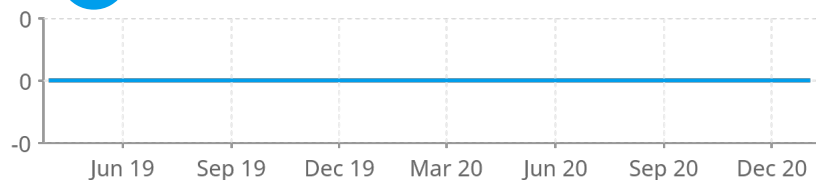


MRSA



Dec-20

0

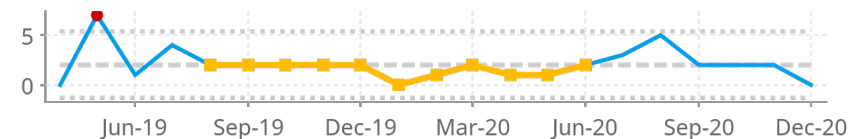


MSSA



Dec-20

18

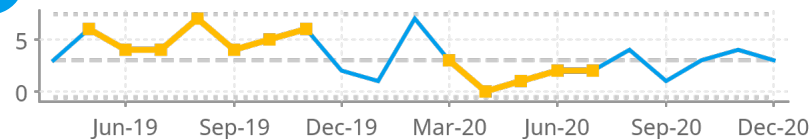


Ecoli



Dec-20

20

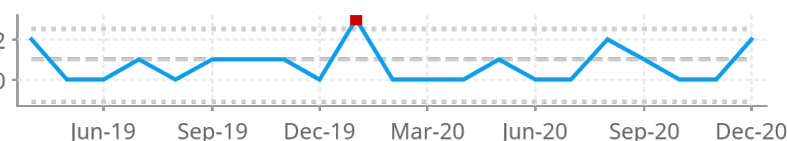


Klebsiella



Dec-20

6

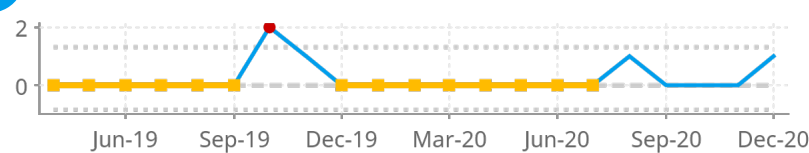


Pseudomonas



Dec-20

1

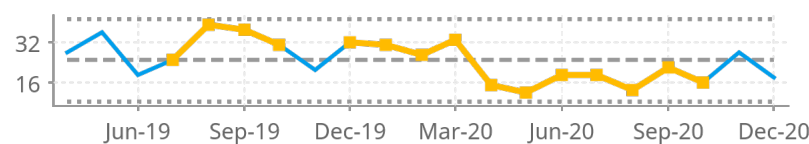


CAUTI



Dec-20

162



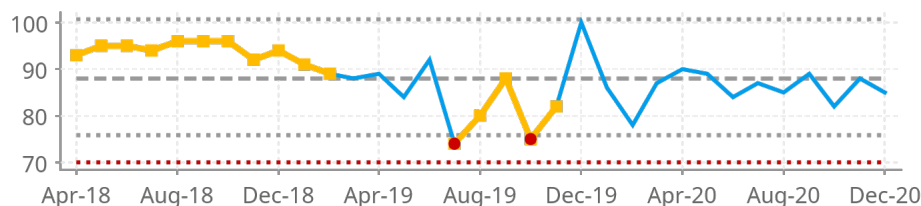


Statistical Process Control (SCP) Charts

FFT Emergency Care



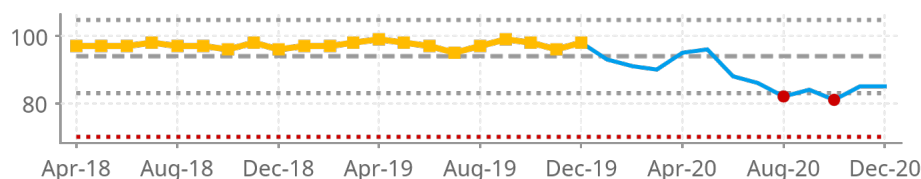
Dec-20 **85.00%** **Standard 70.00%**



FFT Inpatient



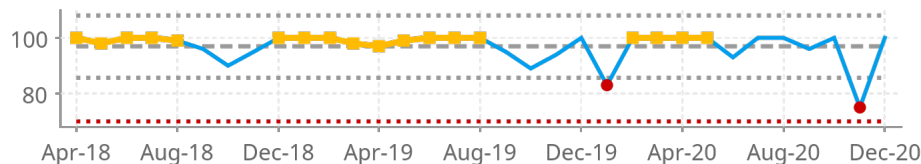
Dec-20 **85.00%** **Standard 70.00%**



FFT Maternity



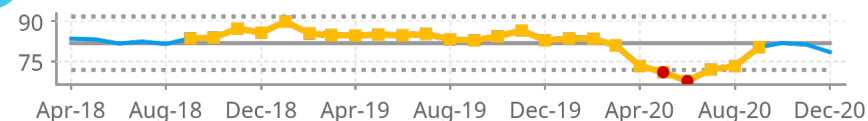
Dec-20 **100.00%** **Standard 70.00%**



UNIFY RN Day



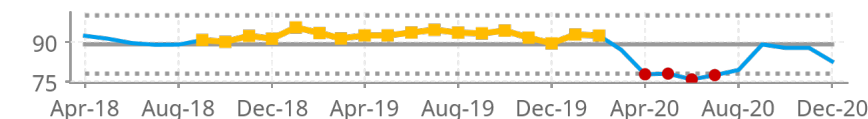
Dec-20 **78.47%** **Standard** $\geq 80\%$ and $\leq 109.99\%$



UNIFY RN Night



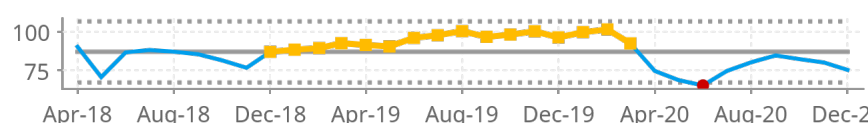
Dec-20 **82.70%** **Standard** $\geq 80\%$ and $\leq 109.99\%$



UNIFY HCA Day



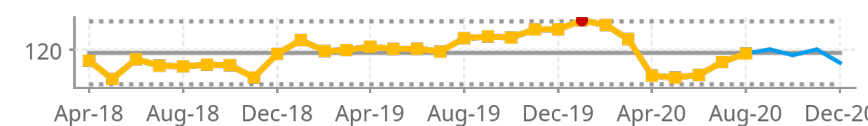
Dec-20 **75.31%** **Standard** $\geq 80\%$ and $\leq 109.99\%$



UNIFY HCA Night



Dec-20 **106.37%** **Standard** $\geq 110\%$ and $\leq 125.99\%$





Standard	Standard Achieved			Narrative
Sickness	✗ Nov-20	6.83%		<p>Performance summary - The sickness absence rate for November 2020 is reported at 6.83%, an increase of 1.66% compared to the previous month. This is broken down into 1.99% attributable to Covid-19 related sickness and 4.84% attributable to other sickness. The cost of sickness absence is reported as £539,05, an increase of £206,822 compared to October (£332,229). There were 518 further cases of Covid-19 related staff absence in December 2020, broken down into 357 staff absent for 10 days and 161 who self-isolated for 14 days.</p> <p>‘Chest & respiratory problems’ (under which Covid-related sickness is recorded) was the top sickness reason in November, accounting for 30% of days lost. ‘Anxiety/stress/depression’ was the second highest reason, accounting for 23% of sickness absences.</p> <p>Appraisal compliance is reported as 83% in December, a decrease of 1% on the November rate. Mandatory Training remained the same at 89% and Staff Turnover is 7.58%, a decrease of 0.18% on November.</p> <p>Sickness key actions:</p> <ul style="list-style-type: none"> • ‘Sickness Absence’ Clinics to support staff • Contact with all staff absent with covid related absence at 10 day interval • Contact with all CEV staff and risk assessment processes • Range of H&WB activity • Recruitment campaign for ‘support workers’ to assist clinical areas • Corporate/Community staff supporting clinical areas
Appraisals	✗ Dec-20	82.63%		
Turnover	✓ Dec-20	7.58%		
Mandatory Training	✗ Dec-20	88.55%		

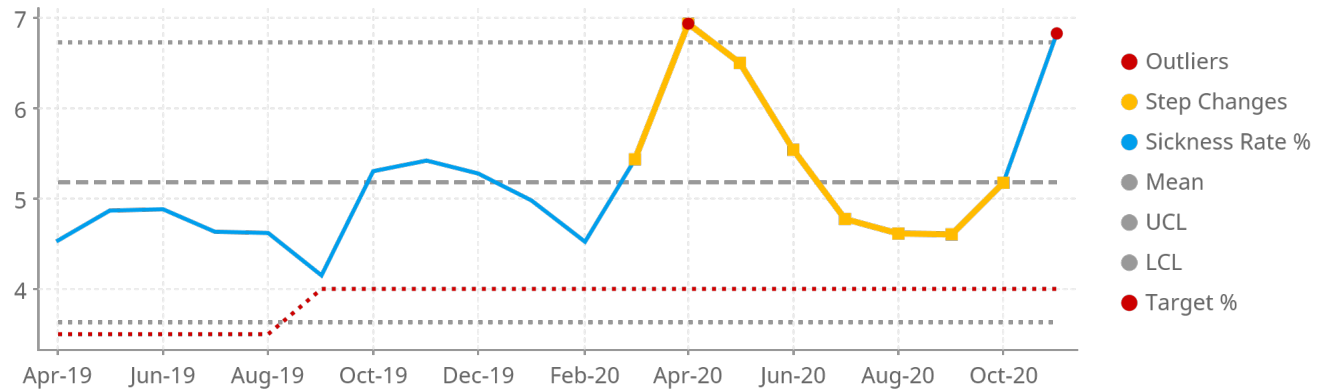


Statistical Process Control (SPC) Charts

Sickness

✕ Nov-20 6.83%

Standard 4.00%



Appraisal

✕ Dec-20 82.63%

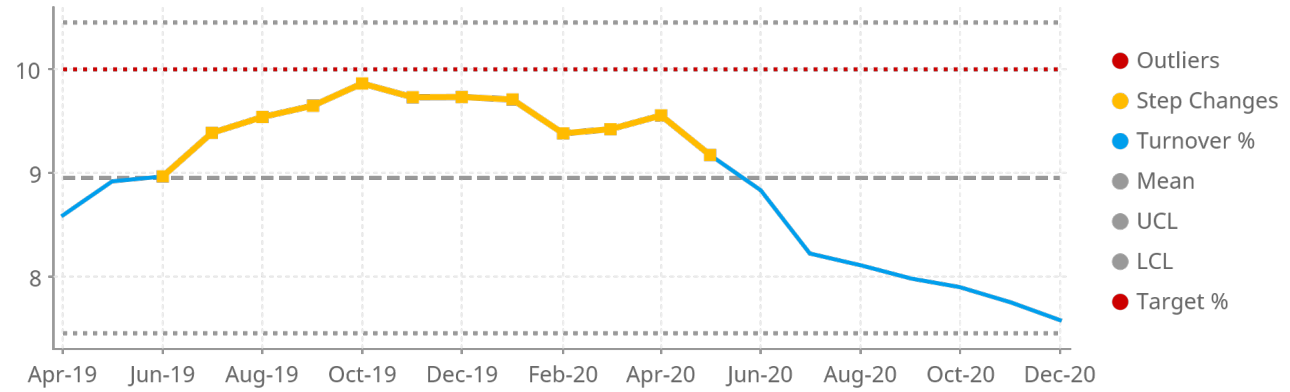
Standard 95.00%



Statistical Process Control (SPC) Charts

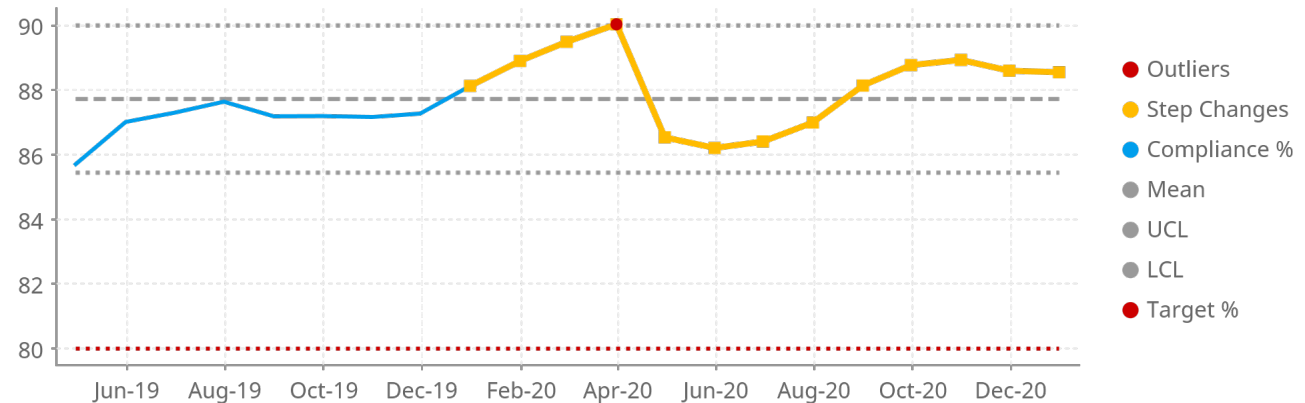
Turnover

✓ **Dec-20** **7.58%**
Standard **10.00%**



Mandatory Training

✗ **Dec-20** **88.55%**
Standard **95.00%**





Narrative

Income

The total Trust income in M9 is £27.904m and includes the following;

- £25.882m block contract payment
- £0.167m additional testing income (to be reimbursed by NHSI/E based on M9 return)
- £0.087m additional pass-through for Cancer Drugs Fund (to be reimbursed via SpecCom)
- £0.750m is Health Education England income
- £0.075m from Research & development projects, including NOVAVAX
- £0.396m is non-patient care income from other NHS bodies, such as Prime Contract and QC Lab income
- £0.547m other regular income streams

The Trust has assumed £167k of additional central government funding to cover the costs of testing in the M9 position, which is out-with system funding. Similarly, the Trust has assumed £87 k income in respect of the Cancer Drugs Fund (CDF) for activity in M9.

There is currently no financial provision made for the potential impact of the proposed Elective Incentive Scheme across the ICP . New EIS guidance issued on 23rd December 2020 stated that impacts of the Elective Incentive Scheme will not apply to Trusts and / or systems where Covid-19 bed occupancy is greater than 15% of the available bed base. The Trust is currently operating in excess of 30%.

Expenditure - Pay

M9 pay expenditure totalled £21.208m of which £0.379m is additional spend relating to the Covid-19 response and includes costs associated with Covid-19 testing.

Pay run rates (excluding Covid-19) have increased when compared to the first half of the year, as a result of elevated activity. There has been a slight decrease when compared to M8, as activity has reduced following increased Covid-19 admissions. Pay run rates remain consistent with 19/20 trend.

The Trust has agreed to pay NHSP rates at the top of band for RN Band 5 and HCA Band 2 to increase the fill rates of shifts and golden shifts are also being offered which attracts an enhanced rate to increase fill rates.

Expenditure - Non pay

M9 non pay expenditure totalled £4.015m of which £0.262m is additional spend related to the Covid-19 response and includes costs associated with Covid-19 testing.

Non-pay run rates (excluding Covid-19) have increased when compared to the first half of the year, as a result of elevated activity. There has been a slight decrease when compared to M8, as activity has reduced following increased Covid-19 admissions. Non-pay run rates remain below the 19/20 trend.

Non-pay risks for the remainder of the year include the costs of Covid-19 testing, which will need to be funded to allow run rates to be maintained. The Trust is also reliant upon NHS Supply Chain providing PPE in a timely manner.

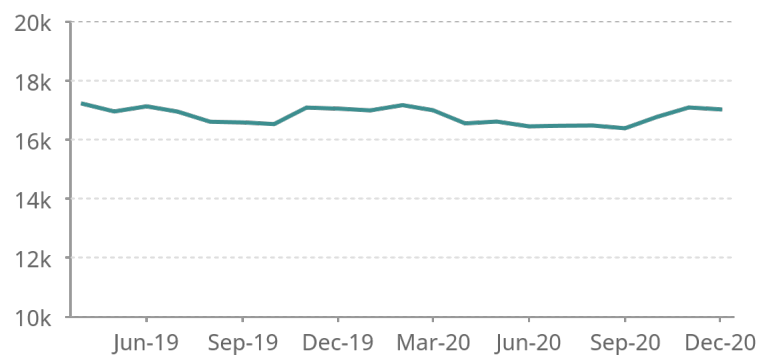
Forecast

Based on current assumptions, the Trust continues to anticipate delivering a small in-year surplus of circa £3m. The M9 YTD position of a surplus of £1.955m is a positive position and builds upon the M8 position and provides confidence regarding the delivery of this provisional forecast outturn. However, assumed within the forecast is that the Trust continues to operate within revised control totals and receipt of income to cover temporary Covid-19 pressures, including testing and PPE.

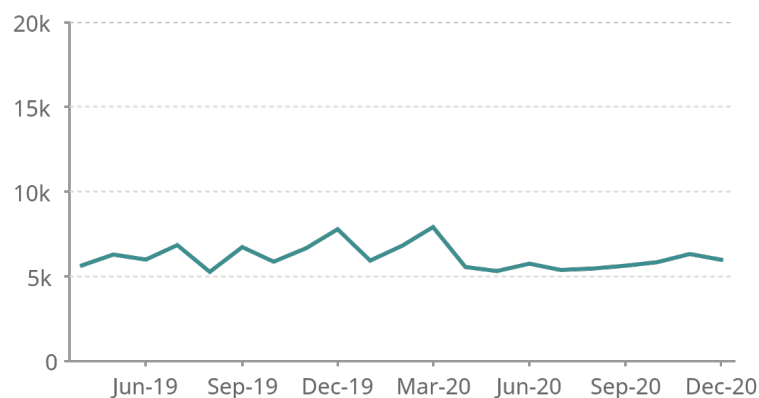


Income and Expenditure

Pay trend



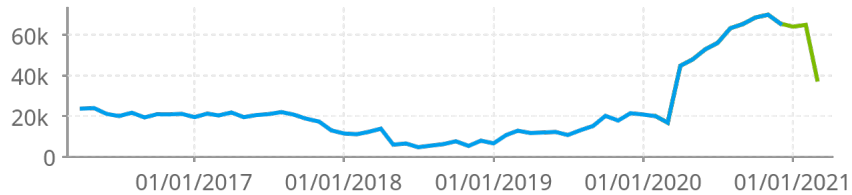
Non-Pay trend



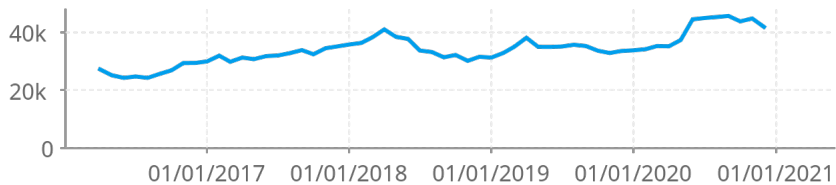
Category	Current month budget (000)	Current month actual (000)	Current month variance (000)	YTD month budget (000)	YTD month actual (000)	YTD month variance (000)
Income excluding donated asset income	28,037	27,904	-133	255,982	256,333	351
Total Pay Expenditure	18,778	21,208	-2,430	168,116	168,891	-775
Total Non Pay Expenditure	7,767	4,015	3,752	75,834	73,057	2,777
EBITDA	1,492	2,681	1,189	12,032	14,385	2,353
Post EBITDA Items exc. Impairments and donated asset depreciation	1,818	2,178	-360	12,397	12,429	-32
Total Consolidated Surplus/ (Deficit)	-326	503	829	-365	1,955	2,320
Impairments	0	0	0	0	0	0
Capital donations / grants I&E impact	0	0	0	16	0	16
Surplus/(deficit) for the year	-326	503	829	-349	1,955	2,304

Balance Sheet Metrics

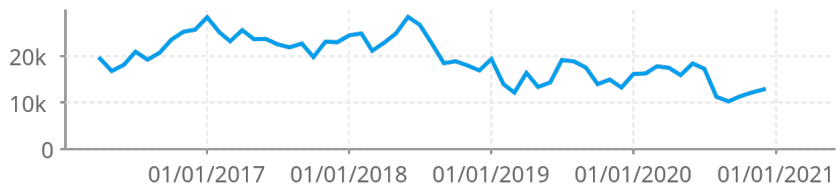
Cash and Cash Forecast



Creditors (current)



Debtors (current)



Narrative

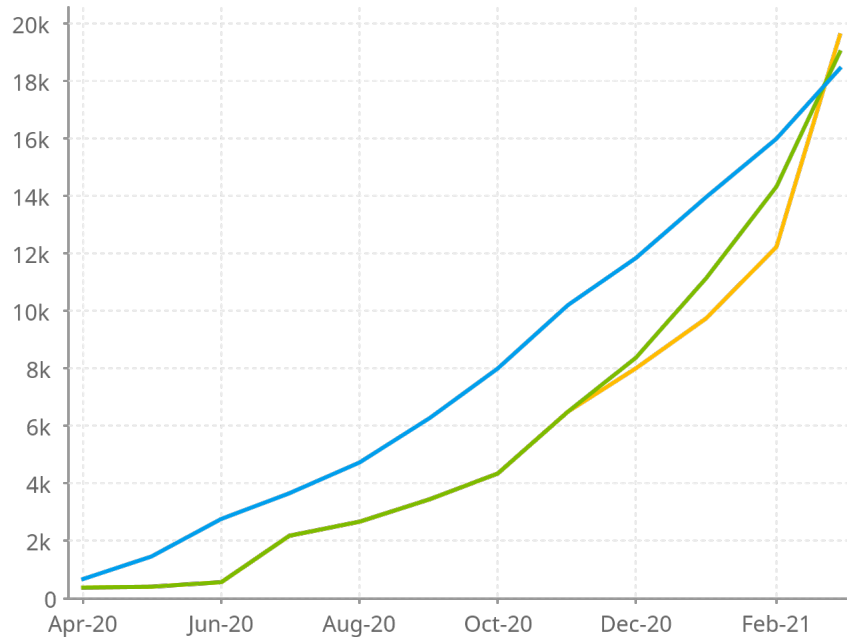
Cash

At M9, the Group cash balance is £65.5m, driven mainly by cash received in advance from the DH for January 2021 activity and delays in the capital programme.

Cash Flow Forecast

If the Trust delivers a £3m surplus position in this financial year, the cash forecast for year ended 31st March 2021 will range between £37m and £38m. This position reflects the reduction of circa £25m given the Trust received two months of block payment in advance.

Capital



- Capital internal plan (000s)
- Capital previous month additions and forecast (000s)
- Capital additions and forecast (000s)

Narrative

Capital

As at Month 9, the Trust has capital spend of £8.0m against a YTD plan of £11.7m. The Capital Performance Framework is now in place and is reported to the Executive Team and Capital & Revenue Management Group on a monthly basis.

The framework compares spend against budget for the year to date position and also spend against forecast. The framework highlights capital schemes which are materially behind plan to enable corrective action to be taken. The Trust continues to work hard to ensure we deliver the capital programme by the end of the financial year.

Integrated Performance and Compliance Dashboard - December 2020 Benchmark HED



Standard Indicator Set: Operational Efficiency						
Indicator	Trust Performance			Benchmarking		Position
	Current	Previous	Change	Peer	National	
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2020)	9.43% (Oct 2019 - Sep 2020)	9.47% (Sep 2019 - Aug 2020)	-0.04 ↓	7.74%	7.92%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2020)	2.30% (Oct 2019 - Sep 2020)	2.29% (Sep 2019 - Aug 2020)	0.01 ↑	2.23%	2.08%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2020)	5.10% (Oct 2019 - Sep 2020)	5.12% (Sep 2019 - Aug 2020)	-0.02 ↓	4.97%	4.41%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2020)	7.51% (Oct 2019 - Sep 2020)	7.54% (Sep 2019 - Aug 2020)	-0.03 ↓	7.25%	6.25%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2020)	10.41% (Oct 2019 - Sep 2020)	10.50% (Sep 2019 - Aug 2020)	-0.09 ↓	9.97%	8.43%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Dec 2020)	7.49% (Nov 2019 - Oct 2020)	7.56% (Oct 2019 - Sep 2020)	-0.07 ↓	7.33%	6.92%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Dec 2020)	2.50 (Nov 2019 - Oct 2020)	2.47 (Oct 2019 - Sep 2020)	0.03 ↑	2.50	2.24	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Dec 2020)	0.00% (Nov 2019 - Oct 2020)	0.00% (Oct 2019 - Sep 2020)	No Change	12.96%	11.84%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Nov 2020)	92.45% (Nov 2019 - Oct 2020)	92.41% (Oct 2019 - Sep 2020)	0.04 ↑	81.23%	89.96%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Nov 2020)	97.49% (Nov 2019 - Oct 2020)	97.62% (Oct 2019 - Sep 2020)	-0.13 ↓	95.52%	95.37%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Nov 2020)	79.53% (Nov 2019 - Oct 2020)	80.20% (Oct 2019 - Sep 2020)	-0.67 ↓	78.04%	75.77%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Jan 2021)	82.17% (Nov 2019 - Oct 2020)	83.81% (Oct 2019 - Sep 2020)	-1.64 ↓	69.79%	64.94%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Jan 2021)	89.51% (Nov 2019 - Oct 2020)	90.18% (Oct 2019 - Sep 2020)	-0.67 ↓	85.40%	79.95%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Jan 2021)	87.05% (Nov 2019 - Oct 2020)	86.96% (Oct 2019 - Sep 2020)	0.09 ↑	72.61%	63.48%	
Day case realisation rate (12 mth rolling) HES Inpatients (Dec 2020)	96.39% (Nov 2019 - Oct 2020)	96.47% (Oct 2019 - Sep 2020)	-0.08 ↓	94.87%	95.60%	
Day case rate (12 mth rolling) HES Inpatients (Dec 2020)	82.37% (Nov 2019 - Oct 2020)	82.69% (Oct 2019 - Sep 2020)	-0.32 ↓	83.78%	68.71%	

Integrated Performance and Compliance Dashboard - December 2020 Benchmark HED



Average excess length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.09 (Nov 2019 - Oct 2020)	0.10 (Oct 2019 - Sep 2020)	-0.01 ↓	0.35	0.43		
Average length of stay (12 mth rolling) HES Inpatients (Dec 2020)	3.25 (Nov 2019 - Oct 2020)	3.27 (Oct 2019 - Sep 2020)	-0.02 ↓	3.98	4.46		
Average elective length of stay (12 mth rolling) HES Inpatients (Dec 2020)	1.48 (Nov 2019 - Oct 2020)	1.51 (Oct 2019 - Sep 2020)	-0.03 ↓	3.64	4.53		
Average non-elective length of stay (12 mth rolling) HES Inpatients (Dec 2020)	3.46 (Nov 2019 - Oct 2020)	3.47 (Oct 2019 - Sep 2020)	-0.01 ↓	4.02	4.44		
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.21 (Nov 2019 - Oct 2020)	0.21 (Oct 2019 - Sep 2020)	No Change	0.23	0.24		
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.01 (Nov 2019 - Oct 2020)	0.01 (Oct 2019 - Sep 2020)	No Change	0.03	0.03		
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.35 (Nov 2019 - Oct 2020)	0.35 (Oct 2019 - Sep 2020)	No Change	0.41	0.45		
Average post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.90 (Nov 2019 - Oct 2020)	0.90 (Oct 2019 - Sep 2020)	No Change	1.01	0.94		
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	0.20 (Nov 2019 - Oct 2020)	0.20 (Oct 2019 - Sep 2020)	No Change	0.34	0.27		
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2020)	1.37 (Nov 2019 - Oct 2020)	1.38 (Oct 2019 - Sep 2020)	-0.01 ↓	1.64	1.63		
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Dec 2020)	35.16% (Nov 2019 - Oct 2020)	35.52% (Oct 2019 - Sep 2020)	-0.36 ↓	35.18%	33.36%		
Elective stranded rate (12 mth rolling) HES Inpatients (Dec 2020)	3.99% (Nov 2019 - Oct 2020)	4.18% (Oct 2019 - Sep 2020)	-0.19 ↓	13.14%	12.49%		
Emergency stranded rate (12 mth rolling) HES Inpatients (Dec 2020)	17.40% (Nov 2019 - Oct 2020)	17.27% (Oct 2019 - Sep 2020)	0.13 ↑	18.19%	20.34%		
Elective super-stranded rate (12 mth rolling) HES Inpatients (Dec 2020)	0.46% (Nov 2019 - Oct 2020)	0.48% (Oct 2019 - Sep 2020)	-0.02 ↓	2.49%	3.31%		
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Dec 2020)	93.13% (Nov 2019 - Oct 2020)	93.13% (Oct 2019 - Sep 2020)	No Change	77.09%	77.32%		
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Dec 2020)	0.34% (Nov 2019 - Oct 2020)	0.34% (Oct 2019 - Sep 2020)	No Change	1.02%	0.92%		
Relative risk length of stay (12 mth rolling) HES Inpatients (Dec 2020)	83.95 (Nov 2019 - Oct 2020)	83.46 (Oct 2019 - Sep 2020)	0.49 ↑	102.33	99.88	Low (>95%)	



Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT November 20										
Incomplete Pathways waiting <18 weeks	68.2%		93.4%	88.2%	98.7%	75.9%	70.6%	86.1%	63.9%	70.0%
Half of patients wait less than	10		7	5	4	9	10	9	12	11
Half of admitted patients wait less than	11		5	13	N/A	6	7	9	7	11
19 out of 20 patients wait less than	52+		44	49	N/A	42	52+	46	52+	52+
Half of Non admitted Pathways waited less than	6		3	4	3	4	6	5	4	4
19 out of 20 patients wait less than	46		23	34	17	37	46	39	44	38

Cancer 62 Day Standard November 20	National	North East	North Tees & Hartlepool	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
Breast	Data not available	85.19 (115/135)	100 (29.5/29.5)	80 (2/2.5)	62.5 (5/8)	73.17 (15/20.5)	92.86 (13/14)	88 (22/25)	100 (14/14)	81.4 (14.5/21.5)
Lung		66.67 (46/69)	66.67 (7/10.5)	75 (6/8)	92.31 (6/6.5)	57.14 (4/7)	63.64 (7/11)	100 (5/5)	55.17 (8/14.5)	46.15 (3/6.5)
Gynae		70.45 (31/44)	60 (1.5/2.5)	100 (5.5/5.5)	40 (2/5)	76.47 (6.5/8.5)	100 (5/5)	75 (3/4)	55 (5.5/10)	85.71 (2/3.5)
Upper GI		68.85 (42/61)	81.82 (4.5/5.5)	60 (4.5/7.5)	66.67 (4/6)	100 (3/3)	58.33 (7/12)	75 (4.5/6)	67.74 (10.5/15.5)	72.73 (4/5.5)
Lower GI		52.44 (43/82)	80 (4/5)	63.64 (3.5/5.5)	64.71 (5.5/8.5)	37.5 (3/8)	36.36 (4/11)	62.86 (11/17.5)	46.15 (6/13)	51.85 (6/13.5)
Uro (incl testes)		73.47 (126/171.5)	62.5 (10/16)	93.15 (34/36.5)	61.54 (12/19.5)	43.48 (5/11.5)	84.38 (27/32)	81.63 (20/24.5)	56.45 (17.5/31)	100 (0.5/0.5)
Haem (incl AL)		68 (34/50)	40 (2/5)	77.78 (7/9)	60 (3/5)	71.43 (2.5/3.5)	76.47 (6.5/8.5)	100 (7/7)	25 (1/4)	75 (5/8)
Head & Neck		90.91 (30/33)	66.67 (2/3)	100 (7.5/7.5)	100 (2/2)	0 (0/0)	95.83 (11.5/12)	0 (0/0)	85.71 (6/7)	66.67 (1/1.5)
Skin		92.66 (164/177)	100 (1/1)	100 (3/3)	82.35 (14/17)	0 (0/0)	92.31 (60/65)	100 (10/10)	91.43 (32/35)	97.83 (44/46)
Sarcoma		50 (2/4)	100 (0.5/0.5)	0 (0/0)	0 (0/1)	0 (0/0)	50 (1/2)	0 (0/0)	100 (0.5/0.5)	0 (0/0)
Brain/CNS		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Children's		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Other		70 (7/10)	0 (0/0)	100 (1/1)	0 (0/0)	0 (0/0)	57.14 (2/3.5)	66.67 (1/1.5)	100 (1/1)	66.67 (2/3)
All		76.51 (640/836.5)	78.98 (62/78.5)	86.05 (74/86)	68.15 (53.5/78.5)	62.9 (39/62)	81.82 (144/176)	83.08 (83.5/100.5)	70.1 (102/145.5)	74.89 (82/109.5)

Board of Directors

Title of report:	Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust - Published 10th December 2020										
Date:	28 January 2021										
Prepared by:	Lindsey Robertson, Chief Nurse										
Executive Sponsor:	Lindsey Robertson, Chief Nurse										
Purpose of the report	To provide the Trust Board with the emerging findings; the immediate and essential actions and Trust Gap Analysis										
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				
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 Ockenden independent maternity review focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at the Shrewsbury and Telford Hospital.. The cases include stillbirths, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies. In addition, a small number of early cases emerged which are being reviewed by the independent team wherever medical records are available. The total number of families to be included in the final review and report is 1,862. The report, arises from 250 cases reviewed to date. The number of cases considered so far, also includes the original cohort of 23 cases.</p> <p>Following the publication of the report NHSE/I mandated that Trust assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of <i>effective</i> implementation to Board, Local Maternity System and NHS England and NHS Improvement regional teams.</p>											
How this report impacts on current risks or highlights new risks:											
None											
Committees/groups where this item has been discussed	Executive Team										
Recommendation	The Trust Board is asked to: <ul style="list-style-type: none"> Note the report and findings Note the gap analysis and assessment in appendix 1 Note the high priority of Maternity Services at National level and the requirement for Board oversight. 										

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

Summarised Findings of the Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust Published 10th December 2020

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

1. Introduction and Background

- 1.1 The Ockenden independent maternity review focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at the Shrewsbury and Telford Hospital.. The cases included stillbirths, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies. In addition, a small number of earlier cases emerged which are being reviewed by the independent team wherever medical records are available. The total number of families to be included in the final review and report is 1,862. The first report, arises from 250 cases reviewed to date. The number of cases considered so far, also includes the original cohort of 23 cases.
- 1.2 The review panel has identified important themes which must be shared across all maternity services as a matter of urgency and have formed **Local Actions for Learning** and make early recommendations for the **wider NHS Immediate and Essential Actions**.

2. Findings

2.1 Review of the Trust's maternity governance processes

- Inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.
- Inconsistent multi-professional engagement with the investigations of maternity serious incidents.
- In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care.
- Lack of objectivity in Serious incident reviews and a lack of consideration of the systems, structures and processes in the reports.
- Limited evidence of feedback to staff following incident review

Examples of failure to learn lessons and implement changes in practice. This is notable:

- In the selection of, or advice around, place of birth for mothers the management of labour overall
- The injudicious use of oxytocin
- The failure to escalate concerns in care to senior levels when problems became apparent
- Continuing errors in the assessment of fetal wellbeing.
- Incidents not investigated in a timely manner
- Serious incidents not investigated using a systematic and multi-professional approach
- Lack of evidence that lessons were learned and applied in practice to improve care.

2.2 Trust Board oversight

Turnover of Executive leadership impacted organisational knowledge and memory.

2.3 Midwifery and Obstetric issues identified

2.3.1 Compassion and kindness

- Lack of kindness and compassion seen in women's medical records, and in letters sent to families.
- There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to.

2.3.2 Place of birth: Assessment of risk

- At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth.
- Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate.
- All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision-making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.
- Women should have information regarding anticipated transfer time to the obstetric led unit might be in case of a complication during childbirth should she choose to birth in an environment away from the labour ward.

2.3.3 Clinical care and competency: management of the complex woman

- Clinical care and decision making of the midwives did not demonstrate the appropriate level of competence.
- Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.
- There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24-hour period. The ward round must include the labour ward coordinator and must be multidisciplinary.
- The labour ward should have regular safety huddles and multidisciplinary handovers.
- The labour ward should have regular in-situ simulation training.
- Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.

2.3.4 Escalation of concerns

- Failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants.
- When concerns were escalated, they were not then acted upon appropriately or escalated further to the appropriate level.
- Multidisciplinary communication and collaboration and/or senior clinical supervision are key.

2.3.5 Management of labour: monitoring of fetal wellbeing, use of oxytocin

- Intermittent auscultation and in the interpretation of CTG traces. Maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.
- Fetal monitoring leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines.
- Implementation of recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines should include regional peer reviewed learning and assessment.
- These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.
- Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
- Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.
- The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour.
- Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour including the siting of an epidural.

2.3.6 Traumatic birth

- Obstetricians should follow established local or national guidelines for safe operative delivery.

2.3.7 Caesarean section rates

- The caesarean section rate was consistently between 8%-12% below the England average.
- Women should have freedom to express a preference for caesarean section or exercise choice on their mode of delivery.

3. **Bereavement care**

- Maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care
- The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

4. **Governance**

- The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.

- The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework.

5. Maternal Deaths

- Maternity services must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician.
- There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.
- Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.
- There must be a named consultant with demonstrated expertise with overall responsibility for the care of high-risk women during pregnancy, labour and birth and the post-natal period.

6. Obstetric Anaesthesia

- The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work.
- The number of women requiring advanced levels of medical and anaesthetic care from maternity services
- The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.
- The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.
- Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards.
- Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.
- Adherence to guidelines by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited.
- Any changes to obstetric anaesthetic clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.
- Obstetric anaesthesia services develop or review existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance.
- Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service.
- Quality improvement methodology should be used to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.
- Ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participates in maternal incident investigations and that there is dissemination of learning from adverse events.

- Ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

7. Neonatology

- Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team.
- Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.
- There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.
- The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.
- Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

8. Immediate and Essential Actions to Improve Care and Safety in Maternity Services across England

8.1 Enhanced Safety

- Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.
- Clinical change where required must be embedded across Trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
- An LMS cannot function as one maternity service only.
- The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

8.2 Listening to Women and Families

- Maternity services must ensure that women and their families are listened to with their voices heard.
- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome

- Each Trust Board must identify a nonexecutive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.
- Maternity services must ensure that women and their families are listened to with their voices heard.

8.3 Staff training and working together

- Staff who work together must train together.
- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, three times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

8.4 Managing Complex Pregnancy

- There must be robust pathways in place for managing women with complex pregnancies through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.
- Women with complex pregnancies must have a named consultant lead.
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
- This must also include regional integration of maternal mental health services.

8.5 Risk assessment throughout pregnancy

- Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.
- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

8.6 Monitoring fetal wellbeing

- All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
 - Improving the practice of monitoring fetal wellbeing
 - Consolidating existing knowledge of monitoring fetal well being
 - Keeping abreast of developments in the field raising the profile of fetal wellbeing monitoring
 - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported

- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle and subsequent national guidelines.

8.7 Informed Consent

- All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.
- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.
- Women's choices following a shared and informed decision-making process must be respected.

9. Recommendations

9.1 Following the publication of the report NHSE/I mandated that Trust assess their current position against the 7 Immediate and Essential Actions (IEAs) in the [Ockenden Report](#) and provide assurance of *effective* implementation to Board, Local Maternity System and NHS England and NHS Improvement regional teams.

9.2 The Trust Board is asked to:

- Note the report and findings
- Note the gap analysis and assessment in Appendix 1
- Note the high priority of Maternity Services at National level and the requirement for Board oversight.

Lindsey Robertson
Chief Nurse, Director of Patient Safety and Quality

Title: OCKENDEN REVIEW OF MATERNITY SERVICES

Care Group:1 Healthy Lives Department: Maternity Developed by: Dr E Gouk, S EL-Malak, R Eggleston, A Collighan, J Verity, A Scott, L Astwood, M Matchett and M Banks Date: 15/12/2020

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
1. Enhanced safety	a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly		<ul style="list-style-type: none"> Review and Implement once received. 			
	b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	<p>Summary Compliant with reporting to Trust Board. Reporting to LMS boards process confirmed by LMS 16/12/2020.</p> <p>Detail</p> <ul style="list-style-type: none"> Trust Policy; RM14 Reporting and Dealing with Serious incidents inclusive of never events 				<ul style="list-style-type: none"> RM14 HSIB case reports SI Reports and Action plans Attendance at Regional network meetings Safety Panel

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<p>is utilised for all potential or actual SI's</p> <ul style="list-style-type: none"> SI's reviewed weekly by Associate Director/Deputy of Clinical Governance, Medical Director/Deputy and Director of nursing/ and midwifery patient safety and quality/Deputy SI-Process is supported by the NHS England, Patient Safety Domain (2015) Serious Incident Framework HSIB: Patient Safety Team Make timely referrals to HSIB and upload the case note to HSIB's secure Maternity Investigation Database and Support System (MIDAS). If the trust has reported this as a serious incident (SI), the trust remains responsible for completing a 72-hour report and StEIS (it's a 				<ul style="list-style-type: none"> PS&QS HSIB submission report & SI Network /LMS letter to Trust

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<p>national requirement that serious incidents are reported using the Strategic Executive Information System within three days).</p> <ul style="list-style-type: none"> The incident are reported to Each Baby Counts, NHS Resolution – Early Notification Scheme and MBRRACE-UK where required. Where cases meet the criteria for reporting to the Perinatal Mortality Review Tool, HSIB complete this in collaboration with the trust once the investigation is complete. Regional maternity networks provide forum for shared learning events from SI's, HSIB cases, with LMS board members present and aware of local issues. 				

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<ul style="list-style-type: none"> Trust quarter/Monthly/bi-weekly up-date meetings with HSIB Invites and requests for external reviews are sort through regional maternity networks for SI Terms of reference/PMRT reviews and MDT case reviews. Clinical over views are considered and requested. Maternity SIs are presented at the weekly Trust Safety Panel which has non-executive director representation. The SI reports are shared with the Board Patient Safety & Quality Standards (PS&QS) Committee on a monthly basis All cases fulfilling the HSIB reporting criteria are reported promptly to HSIB by the Maternity Patient Safety Team and they are also 				

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<p>investigated as a SI and follow the SI reporting governance process of being shared at Safety Panel and PS&QS Committee.</p> <ul style="list-style-type: none"> Currently the Maternity SIs are not shared with the LMS. The process for sharing all SIs with the LMS Board is currently being developed through the Northern England Maternity Network. It is confirmed as of the 16th December 2020 that the process for sharing with LMS boards is in place 				
2. Listening to Women and their Families	a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	<p>Summary Mechanisms exist within the organisation for gathering service user feedback.</p> <ul style="list-style-type: none"> NT&H MVP is currently under development. Lay chair have been appointed development of role has been delayed during COVID overall. 15 steps and launch of 	<ul style="list-style-type: none"> Support MVP Lay –chair to develop Quarterly service users meeting, with professional and service user attendance, to ensure coproduction of services. Ensure processes for funding 		HOM/ O&G Operational Manager	

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<p>CoC Team attended by MVP</p> <ul style="list-style-type: none"> • Lay Chair has direct communication link to professional to raise concerns or request information from service. • MVP secure email • LMS MVP chair Involvement-Local maternity satisfaction survey's utilised within service. • Regional LMS MVP meetings attended by professional leads and lay –Chair • Engagement during covid-19 pandemic through the MVP leads, development of COVID information leaflet, guidance and parent education videos. • Involving patients throughout the investigation of incident process. • Publishing of themes from the birth reflections service. 	<p>expense for training exists – 1 month</p> <ul style="list-style-type: none"> • The development of family and friends in line with the Trusts text system for gathering feedback – 3 months 			

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
		<ul style="list-style-type: none"> Non- executive director does direct patient feedback visits to clinical areas 				
	b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named Non-Executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	<ul style="list-style-type: none"> Chief Nurse Patient Safety and Quality AB NED Maternity and Neonatal champions process in place including board level champion. 				<ul style="list-style-type: none"> Maternity & Neonatal Safety Champions Meeting Notes-Minutes from meetings Quarterly Maternity Voices meeting chaired by AB AB-Monthly meeting with HOM and General manager

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
3. Staff Training and working together	a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	<ul style="list-style-type: none"> The maternity team are fully compliant with multidisciplinary twice-daily ward rounds on the labour ward 7 days a week. Handover includes the full multidisciplinary team for maternity services. 				<ul style="list-style-type: none"> Sign in document for attendance
	b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	<ul style="list-style-type: none"> Scheduled multidisciplinary SIMM team training is in place for the department. In situ simulation training is implemented, which is multi-disciplinary. Training is recorded via ESR/RAG report. Training compliance is monitored by Educational lead and area Managers/HOM and CD Agenda SMT CG1 				<ul style="list-style-type: none"> Simms-in-situ training records and attendance log
	c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity	<ul style="list-style-type: none"> The CNST MIS refund is allocated to maternity and used for safety improvement plans 				<ul style="list-style-type: none"> CNST spending plan Healthy Lives Care

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
	Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	<ul style="list-style-type: none"> CNST spending plans are in place and any funds allocated for training are used for training. 				Group Business Plan
4. Managing complex pregnancy	a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	<ul style="list-style-type: none"> All complex pregnancies have a named Consultant lead. 	<ul style="list-style-type: none"> Undertake local audit to provide assurance – audit underway Electronic recording system to be looked into with regards to audit – timeframe 1 month 		HOM	<ul style="list-style-type: none"> Maternity Hand held notes Maternity triage forms Local audit reports
	b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	<ul style="list-style-type: none"> There are pathways in place for referrals to the tertiary centres for women with certain complex medical comorbidities We participate in the Northern England Maternal Medicine Maternity Network to support development of specialist centres. 				<ul style="list-style-type: none"> Regional and local guidelines for referrals
5. Risk Assessment	a) A risk assessment must be completed and recorded at	<ul style="list-style-type: none"> A risk assessment is completed at booking, 	<ul style="list-style-type: none"> Audit compliance of risk assessment at 		HOM	<ul style="list-style-type: none"> Antenatal risk assessment

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
throughout pregnancy	every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	and it will be reviewed at every antenatal contact. <ul style="list-style-type: none"> Maternity Hand held notes provide documentation for this to be completed and reviewed at every contact. Intended place of birth is discussed at booking, 28 weeks and 36 weeks. Documentation is include within hand held notes. 	every contact – audit underway <ul style="list-style-type: none"> Audit intended place of birth discussions – audit underway Update of written notes whilst working towards seamless Electronic maternity records for collection of data, to aid compliance and assurance with accurate data collection. – 3 months 			<ul style="list-style-type: none"> Hand held notes Audit results once available
6. Monitoring Fetal Wellbeing	a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a	<ul style="list-style-type: none"> Currently there is not a lead Midwife, however, this has been put forwarded as part of the CNST funds. Education Lead supports Fetal monitoring training at mandatory training sessions 	<ul style="list-style-type: none"> Recruitment of lead midwife post in progress. Job description developed and funding in place. 2 months Formalise Lead Obstetrician role - 1 month 		HOM/ O&G Operational Manager	<ul style="list-style-type: none"> Mandatory Training programme ESR compliance CTG case review training records

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
	lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	<ul style="list-style-type: none"> • PMA provides 0.2 wte training to support mandatory training • There are two training sessions per year. • K2 package is being introduced April 2021, funded by CNST. • In-situ MDT reviews on delivery suite take place led by an Obstetrician • E-learning package for GROW which is undertaken yearly. • Training is monitored through ESR for each staff member. 				
7. Informed Consent	a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and	<ul style="list-style-type: none"> • Pathways of care are not shared on the Trust website. • LMS website can facilitate further sharing of pathways of care. 	<ul style="list-style-type: none"> • Pathways to be shared via the Trust website – 2 months • Further development of trust maternity site -2 months 		HOM/ O&G Operational Manager	

Immediate Action Category	Action	Current Position	Action required and time frame for completion	RAG	Responsibility for completion of action plan	Evidence
	Westminster website.					
Workforce	Trust boards to confirm that they have a plan in place for the BirthRate Plus (BR+) standard by 31 st January 2021 confirming timescales	BR+ Plan required 15/12/20: Maternity Service – BR+ 2019 Compliant. Budget Secure. Current Vacancy RM 2.45 WTE Currently out to advert. Band 3 JD awaiting approval with HR/Staff side.	Timescales required		•	<ul style="list-style-type: none"> Finance reports BR+ 2019 Report
Sign off required	Chair of Local LMS Regional Chief Midwife	Chief Executive J Gillan				

Board of Directors

Title of report:	Learning from Deaths Report, Quarter 3, 2020-21										
Date:	28 January 2021										
Prepared by:	Mr S Miranda / Janet Alderton										
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				
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"> 1. The Trusts HSMR value in the latest period has increased slightly to 95.91 (October 2019 to September 2020, the SHMI has increased slightly to 98.69 (August 2019 to July 2020). 2. There has been a sustained improvement in the level of care being documented which has helped sustain the current reported national mortality statistics. The impact of recent changes in coding to include specific Covid codes, is currently unknown but it may lead to an increase in mortality statistics. 3. For 2019-20, 80% of the compulsory mortality reviews identified using the Trust Learning from Deaths policy have been reviewed. During 2020-21, to the end of quarter 3, 18% of compulsory reviews have been completed. Additional scrutiny by the Medical Examiners team means that 11% of all deaths this year have had reviewed. 4. There are a number of work streams in place, to support ongoing clinical and service improvements. There is an update in relation to the current progress for implementation of the Medical Examiners and also reviews of the Covid-19 mortalities. Due to the Covid-19 pandemic other updates information have been deferred and will be added in future reports along with any nationally required monitoring in relation to the pandemic. 											
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"> • Trust Outcome Performance, Delivery and Operational Group • Patient Safety & Quality Standard Committee 										
Recommendation	<ol style="list-style-type: none"> 1. The Board of Directors is asked to note the content of this report and to derive assurance that there is continued focus to ensure in depth multidisciplinary learning being is obtained from mortality review processes. 2. The Board is asked to recognise the continued sustained levels in the national mortality statistics. 										

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 January 2021

Learning from Deaths Report, Q3, 2020-21

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 are related to the provision of safe and effective quality care. It is considered that if such safety and quality improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.
- 1.3 The information presented in this report provides an overview of learning from deaths that has been obtained from mortality reviews undertaken by the Trust. The Trust policy identifies some key areas where all deaths will be reviewed and also identifies additional randomly selected cases will also be included in the review process. Some compulsory review areas have small numbers; therefore, learning is presented as a summation of all reviews to reduce the risk of identifying cases directly.
- 1.4 During the Covid-19 pandemic clinical teams have not been able to provide all of the updates that would generally be included in this report. It is planned that these updates will be obtained gradually for future reports, these will also take into account any national requirements introduced in relation to mortality reviews during and following the pandemic.

2. Mortality Data

- 2.1 Information related to mortality is gathered from data provided routinely by the Trust to a 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 **95.91** (October 2019 to September 2020), this has slightly increased from the previously unreported **94.98** (August 2019 to July 2020). The value of 95.91 continues to remain inside the ‘as expected’ range.
- 2.3 The Trust currently has the 31st lowest HSMR value from the 137 Trusts nationally, and the lowest value out of the 8 North East Trusts.
- 2.4 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,

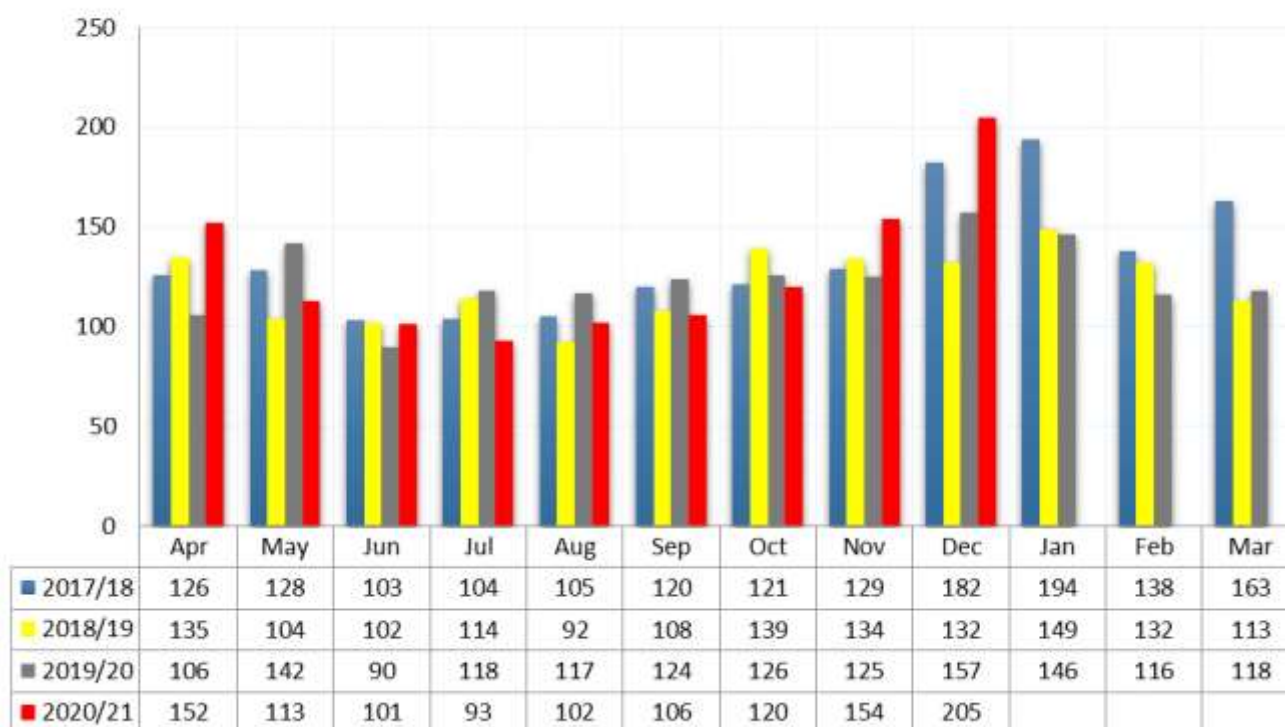
age, admission method, admissions in the last year and diagnosis being treated for the last admission.

- 2.5 The latest SHMI value is now **98.69** (August 2019 to July 2020), this has increased slightly from the previously reported value of **98.20** (May 2019 to April 2020). The value of 98.69 continues to remain inside the 'as expected' range.
- 2.6 The Trust currently has the 48th lowest SHMI value from the 137 Trusts nationally, and 2nd lowest value out of the 8 North East Trusts.
- 2.7 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.
- 2.8 The increased focus on this should allow the Trust to maintain clearer clinical records but also maintain the current statistical mortality rates during the Covid-19 pandemic when there are nationally more deaths occurring.

3. Mortality reviews

- 3.1 The Trust uses mortality review tools is based on the "PRISM" methodology, one of the review tools recommended in the national guidance. This is a structured review of a case record, carried out by clinicians not involved in the patient's care, to determine whether there were any problems in care. Case record review is undertaken routinely to learn and improve in the absence of any concerns, with all directorates undertaking their own specialty based mortality and morbidity meetings. This is because it can help identify issues where there are no initial concerns. It is also used where concerns exist, such as when bereaved families or members of staff raise issues about care.
- 3.2 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. Since April 2017 the Trust has reported the following deaths:

In-Patient and A&E Deaths



3.3 The following chart shows the monthly trend and fluctuations in mortalities since April 2016 to December 2020:



3.4 The Trust policy identifies specific cases where a compulsory review is required; these include:

- Where requests are made by families to undertake a case review.
- Where staff request a case review.
- All deaths in the Intensive Care Unit (ICU).
- All deaths linked to complaints about significant concerns in relation to clinical care.
- All deaths linked to Serious Incident investigations.
- All deaths where the patient was admitted for elective treatment.

Compulsory case reviews are also undertaken for the following cases, which are linked to specific national review processes, some of these reviews are not yet recorded in the Trust mortality system and this is an area of ongoing development:

- 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.

There are also additional reviews that are undertaken either as a random selection or in response to requests internal or external to the Trust.

The current Trust “Learning from deaths” policy is being reviewed to ensure it reflects the scrutiny being applied to in-patient deaths following the introduction of the Medical Examiners team. The impact of Covid-19 also needs to be considered in relation to the agreeing which mortality scrutiny and reviews are to be completed.

- 3.4 Where a patient's death immediately raises concern, this should be reported and escalated through the Trusts incident reporting and investigation process, implementing Duty of Candour procedures as required. This includes informing senior staff of the case and the identified concerns; 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.

During 2019-20, there were 19 cases identified to be investigated as serious incidents, all of these were identified prior to mortality reviews being completed. One case has been identified, following investigation, and a completed Coronal review, as having a Hogan score of 4 which is "probably preventable". Overall 5 of the cases remain under review, requiring information from the Coroner to complete the review and the investigations and three of the cases are also linked to the Child Death Overview Panel. The overall outcomes will be reported in future reports. During the Covid-19 pandemic the Coroner has undertaken limited inquest numbers. There are some cases with identified dates for inquests to be completed, however there are others that have been postponed further.

To the end of quarter 3, 2020-21, there have been 14 cases reported and investigated as serious incidents, all were identified prior to mortality reviews being completed. Two remain under investigation and seven require information from the Coroner to complete the investigations, the overall outcome will be reported in future reports.

- 3.5 The data presented in the appendix provides detail of all case reviews undertaken since April 2019. There are cases that may not have been identified immediately but have come to light as a result of the receipt of complaints and family requests through the Trust Bereavement survey; as a result, there are some reviews pending completion and details may change slightly for each report.
- 3.6 The following table provides a summary of the data by financial quarters, to date, for 2019-20; a more detailed monthly breakdown is included in appendix 1.

2019-20 end Q3 2020-21	Q1	Q2	Q3	Q4	Total
Total deaths in scope	338	359	408	380	1485
Deaths in compulsory criteria	38	37	45	38	158
Compulsory case reviews completed (no.)	34	30	36	25	125
Compulsory case reviews completed (%)	89%	81%	80%	68%	80%
Compulsory reviews pending	4	7	9	12	32
Additional reviews completed	4	10	12	14	40
Total of reviews completed (no.)	38	40	48	39	165
Total of reviews completed (%)	11%	11%	12%	10%	11%
Reviewed Deaths considered avoidable (no.)	0	1	0	0	1
Reviewed Deaths considered avoidable (%)	0%	2%	0%	0%	1%
Reviewed Deaths considered not preventable (no.)	38	39	48	39	164
Reviewed Deaths considered not preventable (%)	100%	98%	100%	100%	99%

The following table provides a summary of the data by financial quarters, to date, for 2020-21; a more detailed monthly breakdown is included in appendix 2. The numbers of mortality cases given scrutiny by the Medical Examiners team, during this latest quarter, has been included in the chart below to demonstrate the integration of the two approaches to reviewing care given. The ME team can refer any cases into the overall mortality review system for further interrogation of clinical care, as necessary.

2020-21	Q1	Q2	Q3	Q4	Total
Total deaths in scope	366	301	479		1146
Deaths in compulsory criteria	42	46	50		138
Compulsory case reviews completed (no.)	18	0	7		25
Compulsory case reviews completed (%)	44%	0%	14%		18%
Compulsory reviews pending	23	46	43		112
Additional reviews & ME scrutiny completed	15	0	82		97
Total completed (no.)	33	0	89		122
Total completed (%)	9%	0%	19%		11%
Reviewed Deaths considered avoidable (no.)	0	0	0		0
Reviewed Deaths considered avoidable (%)	0%	0%	0%		0%
Reviewed Deaths considered not preventable (no.)	33	0	89		122
Reviewed Deaths considered not preventable (%)	100%	0%	100%		100%

- 3.7 The numbers of mortality reviews undertaken by the Trust has been reduced as a result of the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. There is ongoing work to undertake the relevant compulsory reviews; however, many are delayed. As advised earlier in the report the Trust “Learning from Deaths” policy is being reviewed; this may result in a change in the compulsory reviews identified by the Trust over and above the requirements of the national guidance. This will also be impacted on by the need to review details and data linked to Covid deaths.

3.8 Covid-19 deaths

From March to the end of December 2020, the Trust has notified 348 deaths where patients were recorded as testing positive for Covid-19. The Trust is collating information to support an understanding of the trends in the information and management of patients who have succumbed to Covid in our care; including looking at co-morbidities such as diabetes and chronic lung disease. A significant amount of this information is being provided for national data collection. Many of the Trusts clinical teams are actively involved in large research studies to improve the knowledge base in relation to Covid, this supports rapid improvements in management and clinical care that can be offered. Summary information from these studies and case reviews will be included in future reports along with any actions taken as a result of the learning obtained.

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 following national guidance and taking stringent measures to protect patients, visitors and staff in the hospital. As the numbers of Covid in the community have increased this has become increasingly difficult. Details are being collated related to any deaths where there is a possibility of the patient dying as a result of Covid transmission whilst in hospital. Following analysis of the data a summary will be provided to the Trust Board within the next report.

4. Medical Examiners (ME)

The Trusts team of Medical Examiners have been in post for 6 months, they are covering 6 clinical sessions each week; the service has been introduced in Wards 40, 41 and 42. The ME team have recently appointed two Medical Examiner Officers (MEOs) to provide additional support; once these staff are in post the service will gradually roll out to the rest of the wards. The MEOs will have local induction and in-house training in relation to the overall ME service, but they will also have to complete external training through the regional network.

The Trust ME team continues to have support from the Regional ME and MEO; this is creating strong links with ME colleagues serving the hospitals south of the Tees. In addition to the re-design of the internal ME processes the team are working with the newly appointed Trust Mortality Lead in further development of the overall Learning from Deaths programme. There is an opportunity to redesign the overall strategy for mortality reviews, linking scrutiny screening, undertaken by the MEOs, and structured judgment reviews, to quality improvement. This will also link into the review of the Trust policy as previously detailed.

The MEOs are providing support to medical staff from ward areas in providing death certificates. There have been some delays in these being issued and as a result the mortuary and bereavement teams have reviewed their processes. The introduction of an appointment system has improved the timeliness.

Additional training sessions in relation to the MEOs role and death certification, have been developed and held virtually; these are open to the doctors in training as well as final year medical students. Updates on the ME role and the relevant service changes have been delivered in the Trust to the Community and Surgical group meetings, with training for junior doctors also being included in the education programme within Medicine.

At this time there are difficulties recognised in relation to the implementation of the ME; the medical staff providing this service have a wealth of clinical expertise and experience; this means they are required to support the increasing activity required during the Covid pandemic. These are similar to the reduction in capacity, due to Covid, for clinical staff to undertake the mandated reviews of cases.

With assistance from IT, the electronic records and laboratory systems support teams, the Trust is aiming to be the first in the North East to be a fully digital ME service integrated within the electronic patient records (EPR) and wider patient safety systems. The Trust is including local partners in the Coroner's office, Registrars and Crematoria within this significant move towards a paper minimal approach. As a result of identifying delays when post mortems are required, the ME team have arranged for the Pathologists appointed by the Coroner to have access to and training in relation to the electronic records system Trakcare. Provision of these records electronically allows the Pathologists to review A&E and medical records in a timely fashion; nursing records continue to be provided currently as paper records.

The MEOs and Bereavement Officers have worked with the Estates team to enhance the area outside the Woodlands Offices on the ground floor to offer a quiet, confidential area for bereaved families to sit. These changes are supporting discussions being held by MEOs, MEOs and Bereavement Officers to ensure they are confidential and uninterrupted. This also creates a clear identifiable area readily linked to the Woodlands Suite in the floor below.

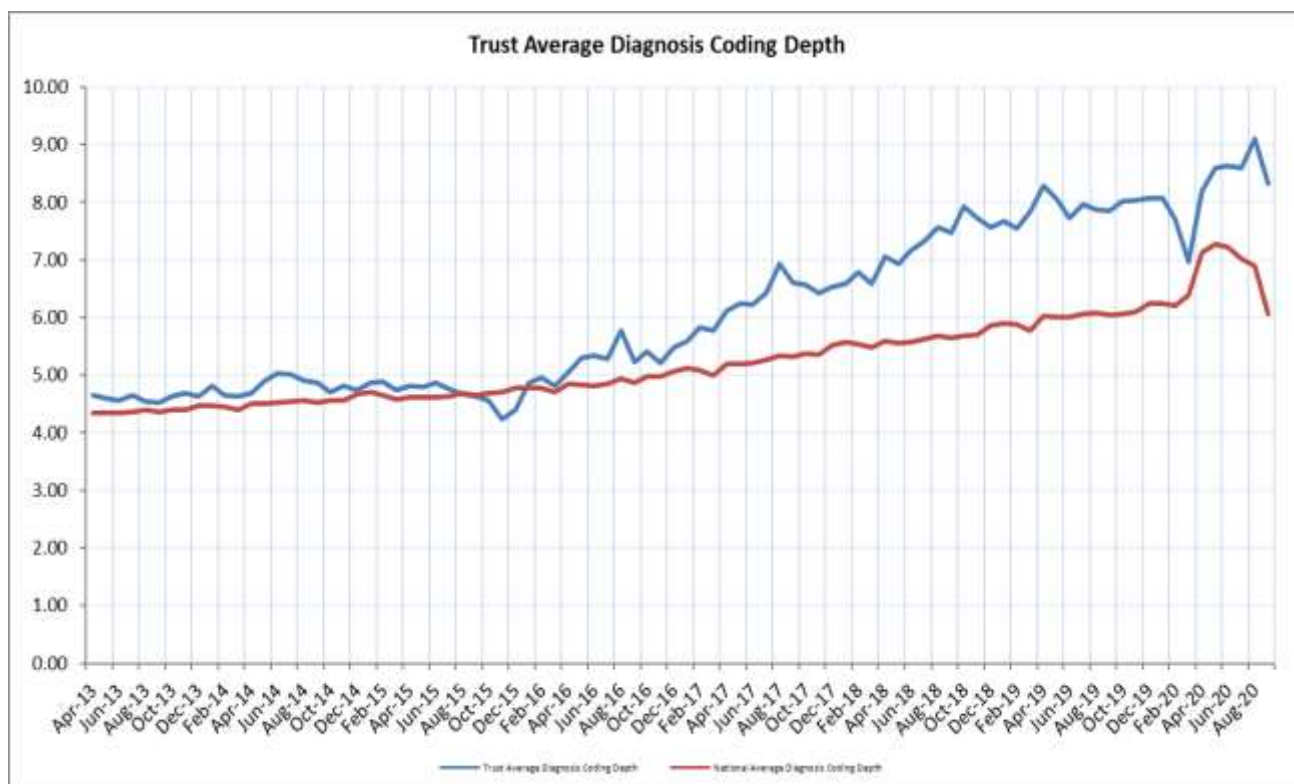
5. Improved coding practices

- a. Increased coding from case notes, this is to be rolled out in phased manner, starting with areas of highest priority, as directed by clinical audits led by senior clinical staff.
- b. Senior clinical input is provided as a regular source of support to the clinical coders, this helps them to resolve uncertainties in relation to clinical information without undue delay. There have been capacity difficulties in providing this support during the Covid pandemic.

The Trust has implemented the use of automated software to identify potential missed comorbidities followed by clinician validation, this is leading to improved depth of coding and is reflected in the chart below which shows the Trust average depth of coding since 2015 against the national average. There are exceptions for the month of March and more recently September 2020 which are potentially as a result of Covid 19 activity.

From March 2020 onwards, a random sample (40%) of patients who have been diagnosed with Covid have been regularly audited to ensure optimal recording and coding practices in place. There are also ongoing rolling audits in areas where Active Clinical Notes (ACN) have been recently deployed. These have all identified no significant loss of information capture within the healthcare records during the pandemic, which is assuring.

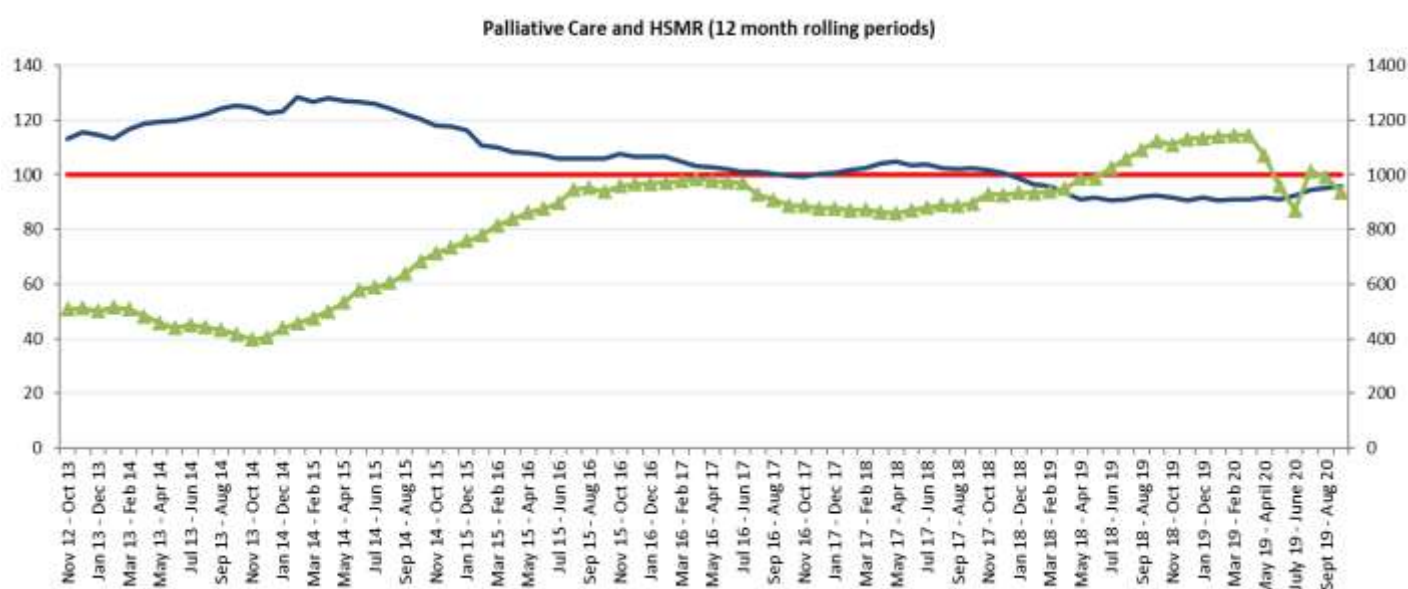
However, from November 2020, there has been a change to the coding for patients admitted with Covid-19; as the numbers of patients admitted have significantly increased over the last 2 -3 months this will have an impact on the clinical coding picture and also the HSMR. The overall impact on both measures will not be clear until the data from November onwards is included in these statistics.



The Trust recognises that patients at the end of their life benefit from improved clinical care as a result of the involvement of the Specialist Palliative Care team (SPCT), not only to support the

patients and their families but also to assist clinical staff providing the required care. In order to accurately understand and monitor, how many patients, the SPCT provide support to, there has been an improved capture of palliative care input with SPCT coding being continuously updated via data from SystmOne.

The chart below shows the overall improvement in the Palliative care involvement and subsequent coding since 2013. The numbers relate to patient discharged, alive or deceased during the given period, who have been seen by the Specialist Palliative Care team. There have been fluctuations in the palliative care referrals during the Covid pandemic reflecting the overall change in in-patient activity across the organisation.



6. Conclusion/Summary

- 6.1 The Trusts HSMR value in the latest period is **94.98** (August 2019 to July 2020), the SHMI is currently **98.20** (May 2019 to April 2020).
- 6.2 There has been a sustained improvement in clinical documentation to support multidisciplinary working but also to support the increased data the Trust are able code and subsequently provide for the national mortality statistics. There has been a recent addition of specific Covid codes during November 2020, this may impact on the HSMR and coding depth as data is included in the statistical analysis.
- 6.3 The Trusts Medical Director has recently appointed a new Mortality Lead for the organisation; this is an opportunity to review the current processes in place in relation to mortality and the policy covering learning from deaths. These changes will also reflect the requirements for reviewing deaths linked to Covid; details of policy updates will be reflected in future reports
- 6.4 Of the compulsory case reviews identified in the Trusts policy 80% were reviewed during 2019-2020, an overall 11% of all deaths. During 2020-21 to date 18% of compulsory reviews have been completed to date, the scrutiny applied by the ME team to additional cases means that 11% of all death so far this year have been reviewed in some form. This percentage is less than expected as a result of the impact of winter and the current Covid-19 pandemic, both of which reduce the clinical staff's ability to complete the reviews. As the ME team increase the wards being covered this will increase the number of cases being scrutinised.


- 6.5 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.
- 6.6 There are 19 cases which were investigated as serious incidents during 2019-20, five remain under review awaiting Coroners inquests to complete these effectively, three of the cases are also linked to the Child Death Overview Panel. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately. There was one case identified as being “probably being preventable”.
- 6.7 There are 14 cases which are being investigated as serious incidents during 2020-21 to date. Two remain under investigation and seven are awaiting Coroners inquests to complete the reviews effectively. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.
- 6.8 The Trust has appointed and implemented a team of Medical Examiners role; this team is becoming established into practice and supporting families and also staff at the time of bereavement.
- 6.9 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.

7. Recommendations


- 7.1 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.
- 7.2 The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation; but to also be aware of the impact of the changes to Covid coding as future statistics are published.

Dr D Dwarakanath
Medical Director

Appendix 1

 North Tees and Hartlepool NHS Foundation Trust Mortality Review Data 2019-20												
Month of death	Total No of deaths	Deaths meeting inclusion criteria	Deaths reviewed meeting inclusion criteria		Pending Review	Additional Reviews	Total Reviewed	Overall % Reviewed	Death judged as avoidable (>50% likelihood of avoidability)		Deaths reviewed judged as not preventable	
		No.	No.	%	No.	No.	No.	%	No.	%	No.	%
Apr 19	106	15	12	80%	3	1	13	12%	0	0%	13	100%
May-19	142	12	12	100%	0	3	15	11%	0	0%	15	100%
Jun-19	90	11	10	91%	1	0	10	11%	0	0%	10	100%
Quarter 1	338	38	34	89%	4	4	38	11%	0	0%	38	100%
Jul-19	118	11	7	64%	4	5	12	10%	0	0%	12	100%
Aug-19	117	18	16	89%	2	4	20	17%	1	7%	19	93%
Sep-19	124	8	7	88%	1	1	8	6%	0	0%	8	100%
Quarter 2	359	37	30	81%	7	10	40	11%	1	2%	39	98%
Oct-19	126	14	11	79%	3	2	13	10%	0	0%	13	100%
Nov-19	125	18	15	83%	3	5	20	16%	0	0%	20	100%
Dec-19	157	13	10	77%	3	5	15	10%	0	0%	15	100%
Quarter 3	408	45	36	80%	9	12	48	12%	0	0%	48	100%
Jan-20	146	17	12	71%	5	4	16	11%	0	0%	16	100%
Feb-20	116	12	9	75%	3	1	10	8%	0	0%	10	100%
Mar-20	118	8	4	50%	4	9	13	0%	0	0%	13	100%
Quarter 4	380	37	25	68%	12	14	39	0.3%	0	0%	39	100%
Totals	1485	157	125	80%	32	40	165	11%	1	1%	164	99%

Appendix 2

 North Tees and Hartlepool NHS Foundation Trust Mortality Review Data 2020-21												
Month of death	Total No of deaths	Deaths meeting inclusion criteria	Deaths reviewed meeting inclusion criteria		Pending Review	Additional Reviews & Scrutiny	Total	Overall %	Death judged as avoidable (>50% likelihood of avoidability)		Deaths reviewed judged as not preventable	
		No.	No.	%	No.	No.	No.	%	No.	%	No.	%
Apr 20	152	27	13	48%	14	10	23	15%	0	0%	23	100%
May-20	113	5	0	0%	5	4	4	4%	0	0%	4	100%
Jun-20	101	10	5	50%	5	1	6	6%	0	0%	6	100%
Quarter 1	366	42	18	44%	23	15	33	9%	0	0%	33	100%
Jul-20	93	18	0	0%	18	0	0	0%	0	0%	0	0%
Aug-20	102	11	0	0%	11	0	0	0%	0	0%	0	0%
Sep-20	106	17	0	0%	17	0	0	0%	0	0%	0	0%
Quarter 2	301	46	0	0%	46	0	0	0%	0	0%	0	0%
Oct-20	120	22	5	23%	17	13	18	15%	0	0%	18	100%
Nov-20	154	13	0	0%	13	35	35	23%	0	0%	35	100%
Dec-20	205	15	2	13%	13	34	36	18%	0	0%	36	100%
Quarter 3	479	50	7	0%	43	82	89	0%	0	0%	89	0%
Jan-21												
Feb-21												
Mar-21												
Quarter 4												
Totals	1146	138	25	18%	112	97	122	11%	0	0%	122	100%

Board of Directors

Title of report:	Guardian of Safe Working Hours Report									
Date:	28 January 2021									
Prepared by:	Mr Pud Bhaskar, Guardian of Safe Working hours									
Executive Sponsor:	Deepak Dwarakanath, Medical Director and Deputy Chief Executive Officer									
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 August to November 2020.									
Action required:	Approve		Assurance	✓	Discuss	✓	Information	✓		
Strategic Objectives supported by this paper:	Putting our Population First		Valuing 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 support our doctors, obtain feedback, and address or escalate concerns. Frontline staff are being offered COVID-19 self-testing with the aim of reducing spread, they are also being offered the vaccine.</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. Rest rooms and recharge hubs are available to staff, in addition to a listening in action app and support line.</p> <p>Concerns relating to the availability and location of equipment in clinical areas need further investigation so that they can be addressed. Other concerns relating to the approval of study leave will be conveyed to the Northern Foundation School.</p>										
How this report impacts on current risks or highlights new risks:										
<ul style="list-style-type: none"> Issues relating to the availability of personal protective equipment have been addressed and no longer appears to be a concern amongst doctors in training. The situation should continue to be monitored. Possible disruption to educational and training opportunities due to subsequent pandemic surges. Possible breaches to safe working hours and rest requirements resulting in fines 										
Committees/groups where this item has been discussed	Patient Safety and Quality Standards Committee									
Recommendation	The Board of Directors is asked to note and accept the content of this report.									

Guardian of Safe Working Report

August to November 2020

Executive Summary

This report focuses on Doctors in Training (DiTs) and forms part of the reporting requirements of the 2016 contract for doctors and dentists in training. It aims to provide the Board of Directors with a summary on the working hours and practices during the reporting period, providing assurances on safe working and highlighting areas of concern. It concludes that the organisation continues to meet the demands of the contract and that there is no evidence to suggest current working practices amongst trainees at the Trust are unsafe.

The pandemic continues to have an impact on working arrangements and training opportunities. To ensure doctors feel supported during this time, the frequency of the doctors' forum has been increased to bi-monthly and continues to be delivered virtually through Microsoft Teams. This has resulted in increased engagement and attendance. Many areas are also offering virtual departmental teaching sessions which are recorded and can be accessed by trainees unable to attend.

During the most recent forum, trainees advised that they are being included in discussions around workforce issues and rota adjustments. They feel engaged and that rotas are being managed well. There were no further concerns raised relating to the availability of personal protective equipment (PPE), and previous issues appear to be resolved.

New concerns relate to the availability or moving of supplies in clinical areas, resulting in trainees searching for equipment. This is a particular issue when working in COVID areas and having to remove and put on PPE to go to other areas. Trainees in Obstetrics and Gynaecology raised issues with the lack of availability of the shuttle service from North Tees to Hartlepool in time for the start of early theatres sessions. This is being explored further to understand demand and whether any other areas are impacted.

Foundation trainees raised concerns around approval of study leave requests. Following guidance from the Northern Foundation School, courses not related to their current training programme or curriculum are not approved. However, trainees are concerned that this may impact on future applications for specialist or core training, as courses relating to specialised areas are not being approved. They felt that the application process is more favorable to those able to demonstrate attendance at such courses and they could be put at a disadvantage. This is being fed back to the Foundation School.

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.

A total of 43 exceptions were reported between August and November 2020 by 15 doctors. The majority of exceptions continue to highlight trainees working above their contracted hours for which time in lieu is agreed in most cases. Where this is not possible payment is given. High workload remains the main issue identified for working the additional time.

In some cases, trainees are submitting several exceptions to highlight multiple issues in particular areas, such as lack of support in addition to workload. Where a trainee submits an unusual large number of exceptions, training leads are meeting with them to explore further, offer support, and ensure issues are being addressed.

There has been a continued drive to raise the awareness around the revised contract by attending junior doctor's induction and teaching sessions and encourage exception reporting. With the aim of addressing concerns such as a fear that reporting will damage working relationships, or they will be seen as problematic trainees, or that reports will be used against them at ARCP.

Reviews of exception reports by Educational or Clinical Supervisors are usually completed in an appropriate time frame. However, there have been a number of reports significantly overdue which the Guardian has addressed. Where it is no longer possible for the trainee to take time back, payment has been given. Delays are thought to be related to COVID absences, changes in email addresses, and supervisors requiring support in specialties that don't receive many exception reports. Moving forward, delays will be addressed through educational leads meetings.

No new fines have been levied during this reporting period, however, there are two exceptions which require further investigation to identify whether they breached safe working hours. An update will be provided in the next report.

As a thank you for their support during a difficult year, trainees and Trust doctors received a £10 meal voucher to be used on either site. Adequate rest facilities are available, such as the doctors lounge, rest rooms, and on-call rooms. In addition to this, the Trust has launched the recharge hubs known as the 'Rainbow Rooms'. Other support offered during the pandemic includes the listening in action app, and the support and wellbeing hotline.

Overall there have been no significant exceptions resulting in new fines and there are no major concerns relating to safe working hours at present. Where concerns have been highlighted, work is on-going to ensure that they are addressed. The exception reporting process continues to enable the compensation of additional hours worked and ensures trainees are compensated appropriately.

The following new recommendations are made to the board:

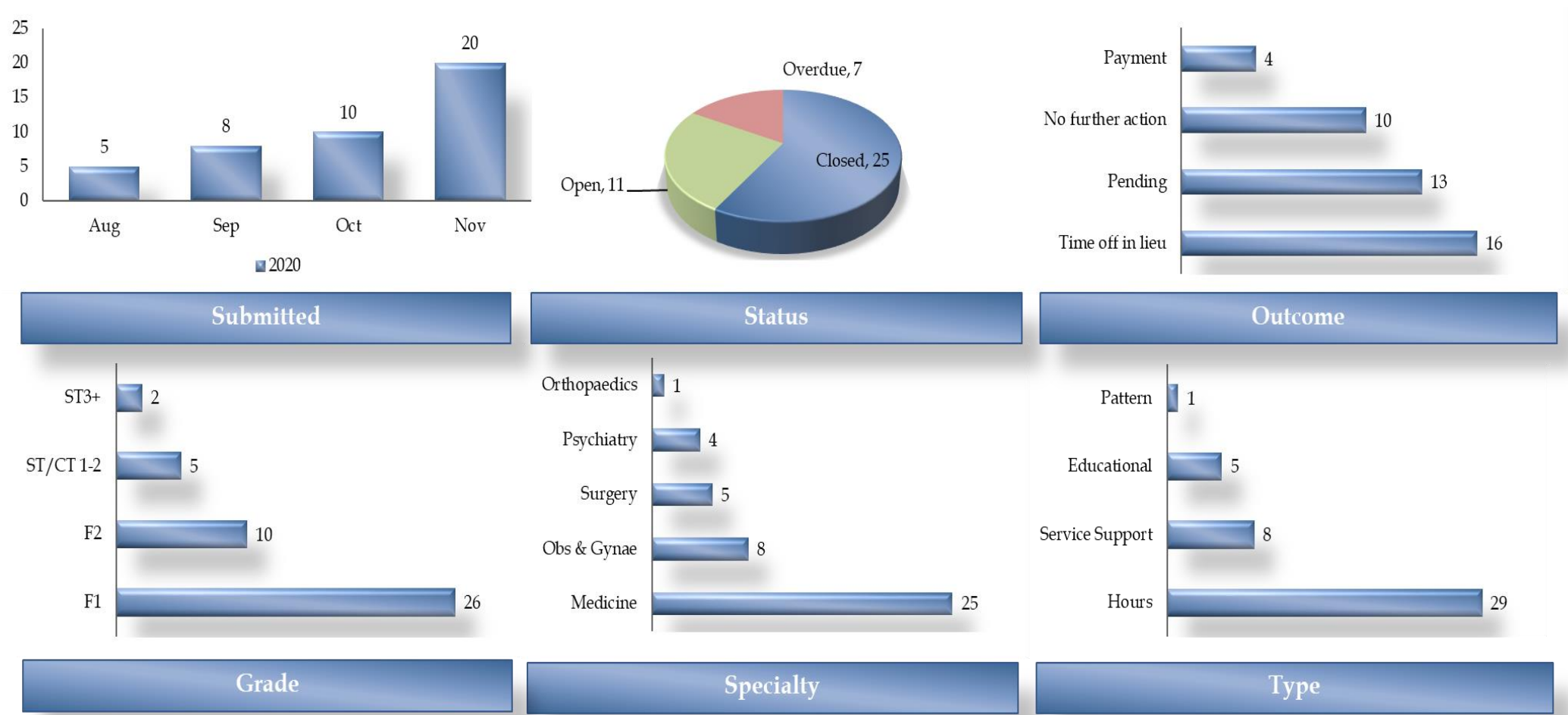
1. Continue to monitor personal protective equipment arrangements
2. Continue to encourage exception reporting
3. Exception reporting engagement sessions to be held with supervisors
4. Issues around availability of equipment in clinical areas to be addressed by ward matrons
5. Concerns relating to approval of study leave to be conveyed to the Foundation School.

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

Mr Pud Bhaskar, Guardian of Safe Working Hours

January 2021

Appendix One: Exception Reporting Dashboard Screenshot – August to November 2020



43 Exception reports submitted by 15 doctors