North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Wednesday, 8 June 2022
at 9.30am

Boardroom
University Hospital of North Tees
and via MS Teams

NHS
North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
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30May2022

Dear Colleague

A meeting of the **Board of Directors** will be held in public, on **Wednesday, 8 June 2022 at 9.30am** in the **Boardroom, University Hospital of North Tees.** This meeting has been deferred from 26 May 2022.

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(9.30am)	Apologies for Absence	Chair
2.	(9.30am)	Declaration of Interest	Chair
3.	(9.30am)	Patient Story	L Robertson
4.	(9.50am)	Minutes of the meeting held on, 28 April 2022 **(enclosed)**	Chair
5.	(9.55am)	Matters Arising and Action Log **(enclosed)**	Chair
Items for Information			
6.	(10.00am)	Report of the Joint Chair **(enclosed)**	Chair
7.	(10.10am)	Joint Partnership Board Update **(verbal)**	S Hall
8.	(10.15am)	Report of the Chief Executive **(enclosed)**	J Gillon
Performance Management			
9.	(10.30am)	Board Assurance Framework 2022/23 Quarter 1 Interim Report **(enclosed)**	H Heslop
10.	(10.35am)	Integrated Compliance and Performance Report **(enclosed)**	L Hunter, L Robertson, N Atkinson & S Cook

Professor Derek Bell, OBE
Chair

Julie Gillon
Chief Executive

Strategic Management

11. (10.50am)	Annual Report and Accounts 2021/22 **(to be tabled)**	H Heslop & N Atkinson
12. (11.00am)	Safe Staffing Update **(enclosed)**	L Robertson

Operational Issues

13. (11.10am)	Annual Operating Plan and Annual Self-Certifications 2022/23 **(enclosed)**	L Hunter, N Atkinson & H Heslop
14. (11.20am)	External National Reports - Maternity Update **(presentation)**	L Robertson
15. (11.30am)	Freedom to Speak Up Update and Annual Report 2021/22 **(enclosed)**	L Robertson
16. (11.40am)	Guardian of Safe Working Hours Report **(enclosed)**	D Dwarakanath

Items to Receive

17. 11.50am)	Adult, Children & Young People Vulnerability Annual Report 2021/22 **(enclosed)**	L Robertson
18. (11.55am)	Director of Infection, Prevention Control Annual Report 2021/22 **(enclosed)**	L Robertson
19. (12 noon)	Any Other Business	Chair

Date of next meeting
(Thursday, 28 July 2022, Boardroom, University Hospital of North Tees)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing People

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

Transforming Our Services

- Continually review, improve and grow our services whilst maintaining performance and compliance with required standards
- Deliver cost effective and efficient services, maintaining financial stability
- Make better use of information systems and technology
- Provide services that are fit for purpose and delivered from cost effective buildings
- Ensure future clinical sustainability of services

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors held on Thursday, 28 April 2022 at 10:30 at the University Hospital of Hartlepool / Via Video Link

As part of the ongoing preventative measures regarding Covid-19, Board of Directors meetings have been conducted both in person and via videoconferencing in order to meet national social distancing guidance.

These minutes represent a formal record of the meeting.

Present:

Professor Derek Bell, Joint Chair*	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	Vice Chair
Ann Baxter, Non-Executive Director*	AB
Julie Gillon, Chief Executive*	CE
Fay Scullion, Interim Non-Executive Director*	FS
Ian Simpson, Interim Non-Executive Director*	IS
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Neil Atkinson, Director of Finance*	DoF
Levi Buckley, Chief Operating Officer* *[via video link]*	COO
Graham Evans, Chief Information and Technology Officer *[via video link]*	CITO
Hilton Heslop, Head of Strategy and Corporate Affairs *[via video link]*	HoS&CA
Linda Hunter, Interim Director of Performance and Planning	IDoP&P
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality**[via video link]*	CN/DoPS&Q
Ruth Dalton, Associate Director of Communications & Marketing [via video link]	ADoC&M

In Attendance:
Sarah Hutt, Company Secretary CS
Abi Smith, Personal Assistant *[note taker]*
Danielle Murray, *[via video link – for agenda item 3. patient story]*
Posmyk Boleslaw, Chair Tees Valley CCG *[via video link]*
Natalie MacMillan, Interim Chief People Officer (Item BoD/4766)

BoD/4752 Apologies for Absence / Welcome

Apologies for absence were noted from, Christopher Macklin, Interim Non-Executive Director*.

The Joint Chair welcomed everyone to the Public Board of Directors meeting.

BoD/4753 Declaration of Interests

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

BoD/4754 Patient Story

The CN/DoPS&Q introduced Danielle Murray (DM) to the group to present her story regarding her maternity journey and experiences and highlighting the importance of receiving feedback in order to learn lessons.

DM had recently become mother to a lovely baby boy.

As part of DM's Professional working role being customer focussed and identifying areas of improvement it was important to highlight her observations whilst being a patient under the care of the Trust.

* voting member

- Although the birth of her son was classed as her first childbirth however DM had previously experienced a miscarriage during lockdown and felt this should have been taken into account.
- DM registered her pregnancy online as part of the midwife process, and included in the given bundle of information at her first appointment, there was a leaflet on Hypnobirthing which had been recommended by a friend.
- The course was fantastic and enabled an enhanced experience with DM feeling both empowered, supported and excited for the birth. DM felt Rowan Suite was the right place for her to give birth and that the staff are completely person centred.
- Unfortunately at 39 weeks DM noticed reduced baby movements and was advised to be induced, DM felt there should have been better communication.
- The Midwife at North Tees was fantastic and did her best to help DM set up the delivery room in line with DM wishes trying to replicate the Rowan Suite where possible. The birthing team were also very supportive and kept her partner informed. Following birth DM needed surgical intervention and the experience was positive. The overnight staff on Ward 22 were helpful and supportive, and DM had more opportunity to be involved in the decision regarding her care.
- DM encountered mixed experience with breast feeding.

Overall DM felt she had an incredible experience and understood operational constraints lead to time limitations however it was important how staff interacted with patients and their family. The PET team were involved and wanted to learn from her experiences.

The Joint Chair thanked Danielle for sharing her story. The CE thanked Danielle for being honest about her story highlighting that one of the objectives from the Ockenden report was to ensure a patient orientated focus. There were lessons to be learnt from this experience. Noted that Danielle had been invited to be part of the Maternity Voices.

Resolved: that, the patient story be noted.

BoD/4755 Minutes of the meeting held on, Thursday, 27 January 2022

Resolved: that, the minutes of the meeting held on, Thursday, 24 March 2022 be confirmed as an accurate record.

BoD/4756 Matters Arising and Action Log

There were no matters arising and an update was provided against the action log.

Resolved: that, the verbal update be noted.

BoD/4757 Report of the Joint Chair Update

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

- Regular visits in Hartlepool with Governors and feedback from the Governors was positive.
- North East Chairs Group Meeting - key focus on Health & Wellbeing of staff within the NHS. The introduction of car parking charges had also been discussed in relation to the rise in the cost of living.
- NHSE/I review was ongoing, and the Trust was still awaiting report.
- The Trust had recently appointed Interim Non-Executive Directors, Ian Simpson, Fay Scullion and Chris Macklin.
- The 100 Leaders Event was well received with some original ideas suggested by staff. The 100 Leader Programme was designed to support staff. The Joint Chair conveyed thanks to all staff involved.

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

BoD/4758 Joint Partnership Board Update

The Vice Chair provided an update from the Joint Partnership Board (JPB) which met on 20 April 2022. And provided assurance that work within the Joint Partnership Board was continuing and moving towards a more centred leadership model. Plans were in place for both Boards to take part in two facilitated sessions externally.

Resolved: (i) that, the verbal update be noted; and
(ii) that, two facilitated Board to Board meetings were scheduled on 18 May 2022 and 15 June 2022.

BoD/4759 Report of the Chief Executive

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

- COVID 19 – there were currently 45 positive patients in the Trust and no patients in ITU. Although the acuity of the illness has changed, it still was impacting on admission rates and community prevalence and therefore there was a need to maintain preventative practices.
- Hospital Activity was returning to pre Covid levels, however the Trust was seeing complex patients with high acuity.
- The Trust was 2nd lowest in the region in respect to ambulance handover delays and was working closely with North East Ambulance Services.
- Elective recovery continued against trajectory with no patients waiting more than 78 or 104 weeks, however some challenge remained around 52 week waits. Increased referrals from Primary Care were being seen and there was a requirement to work in a transformational manner towards a waiting well approach.
- The Health and Wellbeing Strategy has now developed which triangulated all the offerings in place to support the overall health, wellbeing and safety of staff going forward, understanding the pressures experienced during the pandemic.
- The NHS National Staff Survey – the Trust had achieved the second highest response rate in the region, and looking at new ways of engaging with staff.
- Research & Development opportunities continue with a broadening portfolio of studies and working in partnership across Teesside and Durham with the Durham Tees Valley Research Alliance.
- Sam Allen, ICB Chief Executive, to visit the Trust on 27 May 2022.
- North East and North Cumbria Provider Collaborative continues to focus on governance and Clinical Services Strategy across ICS. Locally progress was being made with the workforce and digital operability.
- NHSE/I White paper - published in February with proposals for a system wide approach supporting accelerated elective recovery and tackling health inequalities.
- Community Diagnostic developments to enhance diagnostic services and improve access for patients continued with final site provision planned by the end of 2025.
- The Ockenden Report - the Trust would continue to report to the Board and was working through the recommendations and essential actions
- The Faculty for Leadership and Improvement – the Faculty had supported the first cohort of participants starting the Quality, Service Improvement and Redesign programme.
- Estate Strategy continued to be developed to support plans for a new hospital.
- Breast screening; commend the team who have worked hard to reduce the Covid related backlog.

SH commended staff for their high achievements throughout the pandemic.

The CE drew attention to the 100 Leaders as a good way to recognise and reward staff, listen to staff and make a difference going forward. Non-Executives were invited to attend future 100 leadership events.

FS sought to understand the ways in which the views of staff were obtained. The CE explained that there were various ways, which included a Board to ward approach, freedom to speak up, the National

NHS Staff Survey and the Trust was planning the reintroduction of the Pulse Surveys and ways to support the People Promise.

Resolved: that, the contents of the report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model be noted; and

BoD/4760 Board Assurance Framework 2021/22: Quarter 4 Report

The ADoS&CA presented the Board Assurance Framework (BAF) Interim Report for Quarter 4 and highlighted the key points.

- There were 12 risk domains against the 4 strategic objectives.
- Three operational risks were linked to the BAF; these risks would reduce in Q1 and Q2
- One strategic risk had been and would reduce to moderate risk in relation to improvements regarding the management of employee relation cases, which would continue to be monitored.
- All strategic risks were monitored via the committee structure.
- There were currently six principle risks that included a high risk rating. .

Clarification regarding the Provider Collaborative is not currently included as a risk, however it would be reviewed as part of transforming services and monitored closely.

Resolved: that, the Board Assurance Framework 2021/22: Quarter 4 Report be noted.

BoD/4761 Integrated Compliance and Performance Report

The IDoP&P provided an overview of the Integrated Compliance and Performance report which outlined the Trust's compliance against key standards in March 2022 including quality, workforce and finance and was aligned to the Board Assurance Framework. The IDoP&P highlighted key points.

Performance:

- Challenges remained to deliver against cancer standards with the two-week rule and 62-days standards not met. However, this was comparable both regionally and nationally,
- A significant improvement against the 28 day faster diagnosis standard.
- A national consultation had been undertaken to combine the 9 key cancer standards into 3, which included 28 day faster diagnosis, 62 day and 31 day decision to treat. The consultation closed on 6 April however, no outcome had been received as yet.
- The Trust had seen an increase in the overall waiting list. However, the number of over 52 week waits was reducing with 44 patients in March. There were no 78 week and 104 week waits.
- Work was ongoing with NEAS to improve compliance with ambulance turnaround times.
- It was noted that the Trust had received a significant number of requests for mutual aid and deflections in emergency pathways.

Quality and safety:

- An overall positive positon across key areas, the hand hygiene score remained above the 90% standard with all but one of the infection standards met.

Workforce:

- The sickness absence rate was above target at 6.44% which was a reduction on the previous month. Work was ongoing to further understand and tackle the drivers to reduce sickness absence levels.
- An increase in turnover was reported at 12.10%, however, a review of on board processes was being undertaken to improve the retention of staff.

Finance:

- At end of Month 12 the Trust was reporting a surplus of £4.8m and a Year-end provisional surplus of £12.5m.

- The Capital spend was £29.9m against the CDEL target of £30.5m.

Resolved: (i) that, the Trust's performance against the key operational, quality and workforce standards be noted; and
(ii) that, the significant ongoing operational and workforce pressures and system risks to key performance indicators and the intense mitigation work being undertaken to address this be noted; and
(iii) that, the good recovery at both a regional and national level against trajectories submitted as part of the 2021/22 Priorities and Operational Planning Guidance be noted.

BoD/4762 Capital Programme Performance 2021/22: Quarter 4 Report

The DoF provided an overview of the Capital Programme Performance 2021/22: Quarter 4 Report and it was noted that the late receipt of some funding elements in March had created a challenge, however the most part of the plan had been achieved which was positive. The DoF highlighted key points

- The Trust had an overall Capital Programme of £32m (CDEL and donated assets) for 2021/22. At Month 12 the Trust had spent £29.9m against the plan, which included £29m CEDL.
- An overview of the Estates backlog maintenance, infrastructure and medical equipment replacement schemes was provided including the new Respiratory Ward and creation of an Endoscopy Academy at the University Hospital of Hartlepool.
- The Trust had undertaken two material disposals for the benefit of the ICS during 2021/22: South Tees Diagnostic Hub (£5.366m) and Digital Pathology (£1.352m).

The CITO provided an overview and background on the digital aspect of the Capital Programme report highlighting key points:
An ongoing programme of work to upgrade and replace infrastructures, networking, hardware, and other equipment.

- The majority of work being delivered as part of the digital programmes was included in the Great North Care Record, HealthCall and Active Clinical note.
- The Trust delivered its planned digital ambitions outlined in the Digital Hospital of Things programme, achieving level 5 maturity status.

Resolved: (i) that the content of the report be noted; and
(ii) that, the Capital Programme Performance 2021/22progress to date be noted; and
(iii) that, the Trust's incurred gross capital expenditure of £29.9m against the total plan of £32m be noted; and
(iv) that, the Trusts had spent £29m against the CEDL plan of £29.9m be noted; and
(v) that, two material deposits in 2021/22 (South Tees Community Diagnostic Hub disposal of £5.366m and Digital Pathology and Radiology disposal is £1.532m be noted.

BoD/4763 Priorities and Operational Planning Guidance 2022/23

The IDoP&P provided an overview of the Priorities and Operational Planning Guidance 2022/23 and highlighted key points.

- The 2022/23 priorities and operating planning guidance set out the requirement for a number of submissions in terms of financial, workforce, provider activity and operational planning, alongside a detailed narrative.
- Guidance included 10 priorities of delivery with key areas of focus including: workforce investment, tackling elective backlog and reducing long waits, improvement of health services and services for people with learning disabilities, develop the population health approach and tackle health inequalities.
- A draft submission was required on 3 March 2022 with a final submission made on 14 April 2022.

- Key deliverables included 104% of pre-pandemic elective recovery, eliminating 78 and 104 week waits and reduce 52 week waits, reduce cancer 62-day waits.
- Waiting list to be pre-pandemic levels; and 25% reduction in outpatient follow-ups, prompting discussion.

The Joint Chair conveyed thanks for the work involved in the submission and recognised the hard work during the recovery phase.

Resolved: (i) that, the work to date, in relation to the 2022/23 submission be noted, and
(ii) that, the plans to deliver recovery against RTT, Cancer and Diagnostic standards be noted; and
(iii) that, the cancer objectives set through 2021/22 H2 planning guidance be built upon in 2022/23; and
(iv) the significant focus on outpatients standards be noted; and
(v) that the need prioritise support for the NHS workforce is noted; and
(vi) that, the implementation of a focused delivery against planning group to ensure governance, assurance and monitoring against all standards be noted.

BoD/4764 Capital and Revenue Budgets 2022/23

The DoF presented the Capital and Revenue Budgets 2022/23 and highlighted key points.

- Overview of financial plan and budget setting articulates financial arrangements and allocations for the next full financial year.
- Due to a delay in the publication of the national planning guidance, the usual timetable was delayed with final plans submitted on 19 April 2022.
- A key challenge for 2022/23 was the transition from national interim arrangements to fair share allocations resulting in a significant reduction in non-recurring funding.
- The system was required to achieve overall financial balance in 2022/23.
- The Trust plan included a deficit of £1.4m as a result of inflationary pressures relating to energy costs; a CIP mainly recurrent of £9.3m and a capital plan of £21m.
- The key risks from 2021/22 will remain in 2022/23 and will continue to be reviewed via the Board Assurance Framework.

The CE commended the DoF on the plan, noting that the Health Inequalities allocation from an Integrated Care Plan perspective was still to be agreed. The Joint Chair queried whether some of the green and sustainability schemes could be a focus for 100 Leaders.

The Joint Chair commended staff for the Trust's continuing positive financial position.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the draft capital and revenue budgets for 2022/23 are approved; and
(iii) that, the £1.4m deficit plan for the Trust in 2022/23 is approved; and
(iv) that, the Board support the Trust in working with the designate ICB Executive Director of Finance to develop a plan to achieve breakeven across the ICS.

BoD/4765 Elective Recovery 2021/22 Update and 2022/23 Trajectories

The COO provided an overview of the Elective Recovery 2021/22 Update and 2022/23 Trajectories and highlighted key points.

- The Trust had largely delivered against submitted activity plans.
- The Trust was seeing higher referral rates in comparison to other organisations in the region which was being monitored weekly with zero, 78, week and 104 week waits and a small number of 52 week waits due to the impact of the additional Omnicron COVID wave.
- Key challenges for the Trust to wider system continued to be with plans to address recruitment and retention in place.
- There were clear plans for delivery of the elective trajectories in 2022/23.

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

Resolved: (i) that, the strong year end performance including the provision of capacity for the wider Tees valley be noted; and
(ii) that, the detailed planning for 2022/23 to deliver the national elective trajectories of 104% of baseline activity be noted; and
(iii) that, the analysis of current risk and mitigation plans be noted; and
(iv) that, the monthly monitoring of the elective recovery trajectories through the Executive Management Team be noted.

BoD/4766 NHS Annual Staff Survey Results 2021

The CE handed over to the ICPO to present the NHS Annual Staff Survey Results for 2021 and highlighted key points.

- Staff survey was used as an indicator to give understanding and awareness across the Trust.
- The Trust was placed mid-table within the Regional and aspired to be top with scores in each line being in the top range.
- The results demonstrated key areas of success, which should be celebrated, and exploring what was being done in particular areas that makes them successful with a view of lessons learnt from good practices. Specific focus on success as a compassionate organisation was noted.
- The results also provided insight into areas where further work was required.
- Work was ongoing in the Care Groups to review their data and devise action plans with support from the OD team.
- Monthly monitoring would be undertaken through the Executive Team meeting.
- An appreciative enquiry approach was being adopted to understand the results.

Clarification was provided regarding difference in between organisations. It was noted Northumbria used a sample of staff to take part in the survey, hence an understanding of high response rate.

Resolved: (i) that the contents of the report are noted; and
(ii) that the commitment for Care Group leads to engage and be involved in the formulation and delivery of any improvements or transformation in their service area be supported; and
(iii) it be noted that the strategic themes that emerge from the Care Groups will be mapped across the People Plan and People Promise to ensure one overarching strategy, to ensure staff survey results continue to inform the People Plan; and
(iv) that, work is underway with the Communications teams is noted; and
(v) that, it is noted that Executive Team meeting received a progress update on a monthly basis and the People Committee at every meeting

BoD/4767 Learning from Deaths 2021/22: Quarter 4

The MD/DCE provided an overview of the Learning from Deaths 2021/22 Quarter 4 report and highlighted the importance of improved coding and more accurate mortality data. The Trust HSMR value was 85.28 (January-December 2021) and the SHMI value was 96.12, both remained within expected ranges. The Medical Examiner role was now established and were reviewing the Trusts learning from deaths policies and documentation.

One mortality case had been reported during 2021/22 in Quarter 4, which was being investigated.

Resolved: (i) that, the contents of this report be noted and the information provided in relation to the identification of trends to assist learning lessons from mortality reviews be noted; and
(ii) that, the ongoing work programme to maintain mortality rates within expected rates be noted; and

(iii) that, the current business case to support collection of data to support analysis and learning to support identification of quality improvements is supported by the Board.

BoD/4768 Any Other Business – there was no other business reported.

Resolved: that, there was no other business discussed.

BoD/4769 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 26 May 2022 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 12:57 pm.

Signed:  Date: 8 June 2022

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
27 May 2021	BoD/4537	***NHS Resolution Clinical Negligence Scheme for Trusts (CNST)*** Market place event to be considered to showcase the great work being done within Maternity Services	L. Robertson			As restrictions continue to ease planning will commence for an event in the summer.
27 January 2022	BoD/4701	***Joint Partnership Board Update*** Revised Terms of Reference for the Joint Partnership Board to be presented back to a future meeting for approval by the Board of Directors	S. Hutt			Terms of Reference will be reviewed during Quarter 1, and will be presented once approved by the Joint Partnership Board.
27 January 2022	BoD/4701	***Joint Partnership Board Update*** Update on the Joint Partnership Board to be provided at each board meeting going forward	B. Bright		16 March 2022	This is now a standing agenda item on the Public Board Agenda.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Chair's Report										
Date:	8 June 2022										
Prepared by:	Sarah Hutt, Company Secretary										
Sponsor:	Professor Derek Bell, Joint Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss		Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

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

Key issues for Information:

- Joint Partnership Board;
- NHS England / Improvement;
- Department and site visits;
- Ockenden Visit;
- Board Walkabouts;

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

There are no risk implications associated with this report.

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

8 June 2022

Report of the Joint Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Joint Partnership Board

The first of two facilitated Joint Board Away Days with the Boards of South Tees Hospitals NHS Foundation Trust and the Trust took place on 18 May 2022, which was well attended. The event was productive, creating a good platform for the second event on 15 June 2022.

2.2 NHS England / Improvement

The report detailing the outcomes and recommendations of an investigation carried out by NHS England / Improvement was still in progress.

2.3 Department and site visits

The programme of monthly visits to the University Hospital of Hartlepool continue. The Lead Governor and I visited the Day Case Unit. Staff were very positive.

2.4 Ockenden Report

The Trust were visited by the Ockenden National Team on 19 May 2022. It was a successful visit with the organisation commended on the positive culture. I would like to place on record thanks to all the Team for hard work and to Ann Baxter, our Maternity Board Safety Champion for her valuable input.

2.5 Board Walkabouts

As the COVID-19 restrictions begin to ease the programme of Board Walkabouts will recommence to enable the Board as a whole the opportunity to meet with staff and patients.

3. Recommendation

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

Professor Derek Bell
Joint Chair

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Chief Executive Report										
Date:	8 June 2022										
Prepared by:	Julie Gillon, Chief Executive Donna Fairhurst, Personal Assistant										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

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

- COVID-19 current position, emergency care challenges and continued recovery
- Health and Wellbeing Strategy and Staff Survey
- Collaboration across the ICS on Prevention, Population Health and Health Inequalities
- Health and Wellbeing Strategy
- Research and Development
- Integrated Care System and Integrated Care Board
- North East and North Cumbria Provider Collaborative
- Tees Provider Collaborative
- Community Diagnostic Centre
- Endoscopy Training Academy
- Service and Estates Developments
- Ockenden Review
- International Day of the Midwife
- Faculty for Leadership and Improvement
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy
- Consultant Appointments
- Helping our Population be Active

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

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

Committees/groups where this item has been discussed	Items contained in this report are discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.
Recommendation	The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

8 June 2022

Report of the Chief Executive

1. Introduction

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

2. Strategic Objective: Putting our Population First

2.1 Key Issues and Planned Actions

2.1.1 COVID-19 Current Position and Continued Recovery

2.1.1.1 COVID-19 Current Position

As at 19 May 2022, the Trust is caring for 23 COVID-19 positive patients, one of which require critical care intervention. The gradual reduction in covid positive patients reported to the Board in April has continued into May. This reduction in positive cases and community infection rates has also resulted in reduced staff absence. The organisation continues to review local implementation of Infection Prevention Control Guidance to ensure a balance between safety of staff and patients and effective and responsive delivery across services.

2.1.1.2 Emergency Care Challenges

Providers across the North East and North Cumbria (NENC) have continued to experience operational pressures through April and into May.

To ensure the safety and quality of services the Trust continues to develop and enhance resilience, escalation and coordination of services. This has been further enhanced in May with the opening of a new Integrated Coordination Centre (ICC) which brings together the patient flow team, clinical site managers, bed managers and integrated discharge team in a central location. This has promoted improved collaboration, information sharing and decision making.

The teams have developed a focus on 'Predicting, planning and optimising patient flow through a process of continuous dynamic interaction supported by live up to date information available to support decision making.'

The vision and success of the patient flow team is recognised at a local and national level of the Trusts' approach to integrated hospital discharge. During May the Trust has hosted a series of events at regional and national level including collaboration with North East Commissioning Support and Palantir on the development of the Optica Discharge Optimisation Tool which provides a multi-agency, interactive tool to support rapid decision making in support of patients' discharge to an appropriate setting in a timely manner with the right level of support and care.

The Trust's achievements will receive further recognition during June when the National Director for Urgent and Emergency Care, and members of the national NHS team will be visiting to understand the discharge model and the opportunities to share best practice at a national level.

2.2 Collaboration across the ICS on Prevention, Population Health and Health Inequalities

I had the opportunity to meet the Deputy Chief Medical Officer (DCMO) Dr Jeanelle de Gruchy on the 9 May 2022 as part of her visit to the North East in my role as Senior Responsible Officer across the NENC for Health Inequalities. I was part of a team co-ordinated by the Office of Health Improvement

and Disparities (OHID) that provided the DCMO with an overview of the North East and North Cumbria ICS work on Prevention, Population Health and Health Inequalities, in particular the contribution of the OHID.

2.3 Strategic Objective: Health and Wellbeing

2.3.1 Health and Wellbeing Strategy

The revised Health and Well-being Strategy has three headline objectives; Putting our People First, Leadership and Culture and Engagement. The strategy devised by the Executive Team and shared with the People Committee supports the 'back to basics' approach from the Board. Key measurables are being developed by the wider workforce team and operational and corporate departments to drive delivery and ensure monitoring and effective implementation. The strategy is aligned to and part of a more comprehensive approach to the staff survey and to the overarching People Plan and the People Promise. The strategy has a clear foundation of knowledge and understanding of the overarching areas which ensure staff feel safe and healthy and ready for the future.

2.3.2 Staff Survey

2.3.2 Research and Development

2.3.2.1 Research and Development Update

Recruitment in this financial year has commenced with 84 patients recruited across 13 specialities. There is anticipation of very high levels of recruitment this year due in part to two high recruiting studies in Obstetrics and Gynaecology.

The iGBS3 study of women's natural immunity against GBS (Group B Streptococcus) has now opened. All pregnant women in the Trust. Potential recruitment could be >1500 for this study alone.

THE INGRID study, another large scale screening study will identify infants who are at risk of developing type 1 diabetes.

Congratulations to research midwife Sharon Gowans who has become is one of the Trust's Principal Investigators (PI) for research studies. She is the first ever PI who is a non-medic to be placed in the research network's top five highest recruiters.

2.4 Strategic Objective: Transforming our Services

2.4.1 Integrated Care System (ICS)

2.4.1.1 Integrated Care Board (ICB)

The ICB journey in the Integrated Care System moved forward with a key milestone at the end of April as the Health and Care Act 2022 completed the parliamentary process and received Royal Assent. This will see the formal establishment of the North East and North Cumbria Integrated Care Board (ICB) and Integrated Care Partnership (ICP) on 1 July 2022. This is an important step to deliver a shared ambition across the region and provide the best care for communities.

The recruitment process to the Integrated Care Board continues with the appointment of an Executive Director of Strategy and Oversight, whilst an announcement on the final Board appointment to the Chief Nurse role is expected in due course.

2.4.1.2 North East and North Cumbria Provider Collaborative Development Session (PvCv)

The NENC Provider Collaborative (PvCv) continues to focus on explicit governance and on the work plan in readiness for the new ICS formal structure with a memorandum of understanding and associated supporting documents under development to establish effective delivery potential in the

new statutory and regulatory regime. Two members of the North East and North Cumbria Provider Collaborative will join the Integrated Care Board.

2.4.2 Tees Provider Collaborative

North Tees and Hartlepool and South Tees Hospitals Foundation Trusts continue to develop partnership working to benefit patients, with a focus on advancing the successes, a common purpose and key objectives such as the clinical strategy and pathway collaboration, financial sustainability, workforce ambition and digital interoperability.

2.4.3 Service and Estate Developments

2.4.3.1 Community Diagnostic Centre – Proposed Plans Tees

Following the announcement of a strategic plan for the health system in Tees to develop diagnostic capacity, including a proposed new build Community Diagnostic Centre (CDC) by the end of 2025, a programme board has been established which reports to the Clinical Services Strategy Board. Following a competitive process Dr Phil Woolfall, North Tees and Hartlepool NHS Foundation Trust and Dr Simon Milburn, South Tees NHS Foundation Trust have been jointly appointed to the CDC Clinical Lead role.

Approval of both the outline business case and full business case will be subject to a timeline up to 31 March 2023. Due to the value of the scheme, there is a requirement to follow a full Outline and Full Business Case processes. Specialist healthcare architects have completed an independent site appraisal across Tees Valley, using NHSE CDC Design Principles Guidance and success criteria set by the programme to identify potential sites for locating the permanent CDC. The report has been concluded and a site recommendation from the independent review is due to be considered by Tees Valley Clinical Commissioning Group in May. Professional expertise to support the development of the business case on behalf of Tees Valley has been secured working closely with stakeholders across the programme.

2.4.3.2 Endoscopy Training Academy

Building work on the new Endoscopy Training Academy at the University Hospital of Hartlepool is due to be completed by 18 June 2022. Dr Chris Wells, has been appointed as Clinical Director for the Endoscopy Training Academy programme across the North East and North Cumbria. Recruitment of clinical and administrative staff to support operational delivery of the academy is underway utilising funding provided by Health Education England, Northern Cancer Alliance and the Trust. The Academy will be delivered collaboratively with South Tees NHS Foundation Trust.

2.5 Strategic Objective: Valuing our People

2.5.1 Ockenden Review

Following the publication of the final report into the findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Foundation Trust, the Trust continues to work through the essential actions with regular updates presented to the Board of Directors. A support visit facilitated by the Regional Midwifery experts and Local Maternity and Neonatal System (LMNS) was hosted on 19 May 2022.

2.5.2 International Day of the Midwife

On 5 May 2022 midwives from the across the world celebrated the International Day of the Midwife. It was great to see so many tributes to midwives shared through internal, regional and national media and I couldn't be prouder of them. We know how difficult the last couple of years in particular have been on the frontline and our dedicated teams continue to provide outstanding care to the population we serve.

2.5.3 Faculty for Leadership and Improvement

The second cohort of the 100 Leaders Programme launched on 27 April at Hardwick Hall. Pack Leaders have begun to refine their courageous changes, supported by Executive sponsors and the faculty team. Michael West, CBE, Visiting Fellow at the Kings Fund, London provided an inspiring keynote speech on compassionate leadership concluding that the one habit for all to take forward is to be present in every interaction with patients and colleagues.

NHSE/I have delivered the Quality, Service Improvement and Redesign (QSIR) programme to the first cohort of staff and dates for a further two cohorts have been finalised to take place in September and November. The faculty will work with the cohort to facilitate the delivery of their chosen QI project. One of the projects relates to the introduction and embedding of the LifeQI; an electronic platform to record all QI activity in the Trust. This is a key step to enhancing oversight of the improvement work that we know is happening across our services and will support shared learning between teams.

2.5.4 North Tees and Hartlepool NHS Trust Estate Strategy

The Trust is working on refining the estates strategy and on building the case for investment for future provision within the ambition of a new hospital. This includes case for change, vision for the future and the value proposition and benefits realisation.

In recent weeks, the Trust has worked on the development of an options appraisal in order to inform the preferred way forward. This has been supported by a robust demand and capacity model in addition to a draft economic and financial model. The first draft of the Strategic Outline Case (SOC) is expected to be complete by June.

2.5.4 Consultant Appointments

Since the last meeting on 28 April 2022, the Trust has appointed Dr Rachel Miller into the post of Consultant in Acute Medicine.

2.5.5 Helping our Population be Active

Leanne Mitchell, a former paediatric specialist physiotherapist and now outpatient therapies team lead, has reflected on her role as ‘Physical Activity Clinical Champion’ for the North East. In the two years in the role, she has carried out peer-to-peer training for health professionals across a host of organisations, giving them knowledge and skills to include the issue of physical activity advice into their everyday practice.

3. Recommendation

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

Title:	Board Assurance Framework Quarter 1: 2022/23										
Date:	8 June 2022										
Prepared by:	Hilton Heslop, Associate Director of Corporate Affairs & Strategy										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	The aim of this paper is to provide assurance to the Board of Directors on the progress made to mitigate and manage the strategic risks within the Board Assurance Framework (BAF) for Quarter 1; 2022/23 and the actions for addressing the identified gaps in controls and assurance.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

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

There are currently 4 principal risks that include a **high** risk rating within one or more of the threats:

Strategic Risk 1A has a high risk (6434) aligned that relates to the ability to learn from national safety alerts linked to procurement and the inability to easily identify and quickly identify real time stock position in response to patient safety alerts / product recalls. This is being managed by the LLP in conjunction with the Trust and is monitored through the Patient Safety and Quality Standards Committee and the Master Services Agreement. An additional high risk (5818) linked to potential on-compliance with IG mandatory training is currently managed through Care group internal monitoring and management of compliance.

Strategic Risk 1A & 2A (6379) – has one associated risk relating to Pathology Consultant Staffing with challenges experienced due to vacancies, inability to recruit and increasing demand. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future.

Strategic Risk 3C has one associated high risk identified through the work of the Finance Committee in December 2021. Delivery of Savings (6188) and the challenges to deliver the CIP programme for 2021/22, the current rate of progress to identify CIP for 2022/23, and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions. Previous HIGH rated risks i.e. Cost Containment (6203) and Wider Health Economy Issues

(6205) were both downgraded to MODERATE following monitoring by the Finance Committee.

Strategic Risk 3E reflects two threats to the principal risk as being 'High' with reference to the completion of the ICP Clinical Services Strategy and the progression of the Tees Valley and North Yorkshire Provider Collaborative due to the uncertainty faced across the ICS and this will continue to be monitored and reflected in the BAF. There are no other current or emerging 'High' risks relating to performance and compliance during the current period.

The risks and threats outlined above are reflected in minutes of relevant committees in addition to Executive Director summary papers. All sub-committees to the Board of Directors will provide routine reporting through the Executive Team Risk Management meeting to ensure there is oversight with appropriate actions being taken to mitigate the risks A BAF Risk Radar is attached at Appendix 1 to demonstrate the breadth of risks currently monitored and managed by the trust. The radar will be updated on a quarterly basis to illustrate movement of risk ratings.

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

In Quarter 1 no individual strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated threats linked to operational risks.

The Corporate Risk Register has 3 risks reporting a current risk rating of >15 (high) as follows:

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6379	Insufficient Microbiology and Histology Consultant staff with substantive availability to support / advise clinical services.	1A/2A	20	16	4
6434	Procurement – Inability to easily identify real time stock position	1A	15	15	5
6188	Delivery of Savings	3C	16	16	9

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

8 June 2022

Board Assurance Framework, Quarter 1 Interim Report May 2022

1 Purpose

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

2 Background

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

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

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

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

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

2.5 The Board Assurance Framework provides a 'good' level of assurance that the Trust's risks are managed effectively with a high level of compliance within the control framework. *(AuditOne, Internal Audit, March 2022).* All sub-committees to the Board of Directors will provide routine reporting through the Executive Team Risk Management meeting to ensure there is oversight with appropriate actions being taken to mitigate the risks.

3 Details

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

3.2 There are currently four (4) principal risks that are assessed with a **high** risk rating within one or more of the threats. There has been no change to the strategic risk ratings since the last report. A summary of the individual high rated risks is noted below.

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

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

3.5 High Rated Risks/threats – Quarter 1: 2022/23

Strategic Risk Patient Safety 1A

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

Strategic Risk Patient Safety 1A & Workforce 2A

3.7 This one associated risk (6379) – Pathology Consultant Staffing with challenges being experienced due to vacancies, inability to recruit and increasing demand. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future. The Pathology Collaborative is progressing and workforce challenges forms part of ongoing discussions both within this group as well as the wider clinical services strategy.

Strategic risk Finance 3C

3.8 The Trust Finance Committee met on 23 May 2022 and reviewed all HIGH rated risks/threats in the previous quarter 4. Whilst Delivery of Savings (6188) remains HIGH on the risk register, Cost Containment (6203) and Wider Health Economy Issues (6205) were both downgraded to MODERATE. This is related to:

- The challenges to deliver the CIP programme for 2021/22,
- The current rate of progress to identify CIP for 2022/23.
- The potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions.

3.9 A planned audit of CIP processes for 2021/22 by AuditOne is in progress. As with all other risks related to Finance, the Finance Committee will retain overall management of the risks and provide assurance through the nomal channels for Board. A risk reduction plan is in place for all risks rated 15 or above.

Strategic Risk 3E – Innovation and Integration

3.10 There are two high rated threats to the overall strategic risk to innovation and integration at an external level:

3.11 **ICP Clinical Strategy** - Delivery of quality, equitable clinically sustainable services for patients of the Tees Valley and the failure to fully utilise and make best use of resources across the system;

Tees Valley & North Yorkshire Provider Collaborative - Changes to organisational form/structure may impact on the Trust quality, financial, clinical, workforce and

operational delivery resulting in potential impact upon regulatory status including NHSI Single Oversight Framework, financial control total delivery and CQC quality rating.

3.12 Work to deliver the clinical strategy at ICP and ICS level continues and is in alignment with the progress and work programme of the Provider Collaborative. The Board will be aware of the process of transition that surrounds the Provider Collaborative in line with the governance structures that have been implemented and are currently being exercised through the Joint Partnership Board. However, it is clear that the Tees Provider Collaborative needs time to embed the structure, governance and cultural changes, including any changes to the proposed legislation that may result from the amendments to the Bill from July 2022, to ensure a committed and collaborative vehicle for improving health and care across the wider geography of North Yorkshire and Tees Valley.

3.13 The risks and threats outlined above are reflected in the minutes of the relevant Committees alongside Executive Director summary reports. A BAF Risk Radar is attached at Appendix 1 to demonstrate the breadth of risks currently monitored and managed by the trust. The radar will be update on a quarterly basis to illustrate the movement of risk ratings.

4 Significant Risks

4.1 In Quarter 4 no overall strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated specific threats as noted above.

4.2 In respect to linked risks from the Corporate Risk Register, the following have been identified as a significant risk based on a current risk rating of >15 (High):

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

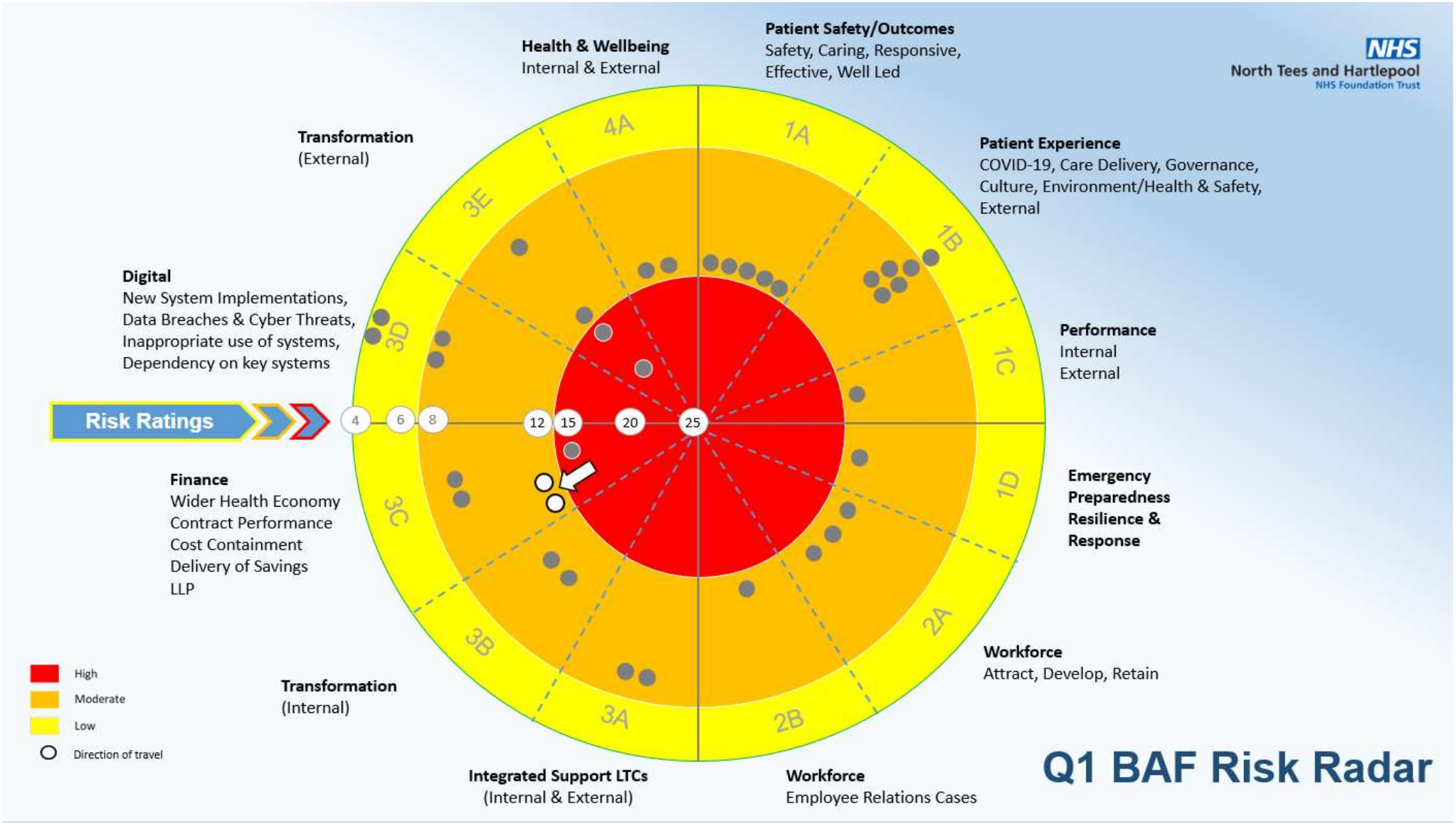
5. Recommendations

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

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

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

Appendix 1


Health & Wellbeing
Internal & External
Patient Safety/Outcomes
Safety, Caring, Responsive, Effective, Well Led
NHS
North Tees and Hartlepool
NHS Foundation Trust
Transformation
(External)
Patient Experience
COVID-19, Care Delivery, Governance, Culture, Environment/Health & Safety, External
Digital
New System Implementations, Data Breaches & Cyber Threats, Inappropriate use of systems, Dependency on key systems
Risk Ratings
4
6
8
12
15
20
25
Performance
Internal
External
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings
LLP
Emergency Preparedness Resilience & Response
Workforce
Attract, Develop, Retain
Transformation
(Internal)
Integrated Support LTCs
(Internal & External)
Workforce
Employee Relations Cases
High
Moderate
Low
Direction of travel
Q1 BAF Risk Radar

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Integrated Compliance and Performance Report										
Date:	8 June 2022										
Prepared by:	Lindsey Wallace – Interim Deputy Director of Planning & Performance Mark MacDonald - Interim Head of Strategy, Planning & Performance Keith Wheldon – Business Intelligence Manager										
Executive Sponsor:	Linda Hunter, Interim Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Susy Cook, Interim Chief of People Officer Neil Atkinson, Director of Finance										
Purpose	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our population First	x	Valuing our People	x	Transforming our Services		Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

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

Summary

- As we move into the new financial year the Integrated Performance Report has been fully refreshed to reflect the requirements outlined in the 2022/23 Priorities and Operational Planning submission. The opportunity has also been taken to refresh dashboards and remove any appropriate metrics, although it must be noted that the report continues to align to the System Oversight Framework

- Operational and workforce pressures continued in April, affecting performance against key standards.

- The Trust continues to respond to surges in demand and pressures within services including IPC guidelines. Additional beds opened within available resource.

- Performance and Quality standards continue to be monitored closely through the established and robust internal governance structures, which supports further development of improved clinical pathways, quality and patient safety across the Trust.

- The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI and infection control measures, however Klebsiella has seen a spike against trajectory for this month.

- A slight reduction in performance against DNA rates noted in April (when compared to March) with an upward trend evident.

• Staff sickness continues to be a key challenge, however recovery continues to be noted. • Workforce continues to review recruitment and retention rates across the Trust	
How this report impacts on current risks or highlights new risks:	
Continuous and sustainable achievement of key access standards across elective, emergency and cancer pathways, alongside a number of variables outside of the control of the Trust within the context of system pressures and financial constraints and managing Covid-19 pressures, recovery, winter and staffing resource. Associated risks are outlined within the Board Assurance Framework	
Committees/groups where this item has been discussed	Executive Team Meeting Audit Committee Planning, Performance and Compliance Committee
Recommendation	The Board of Directors is asked to note: • The performance against the key operational, quality and workforce standards. • Acknowledge the on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation.

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report

May 2022

Responsible Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Linda Hunter
Interim Director of Planning & Performance

- System Oversight Framework
- Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

- Safety & Quality

Susy Cook
Interim Chief People Officer

- Workforce

Neil Atkinson
Director of Finance

- Finance

Introduction

NHS
North Tees and Hartlepool
NHS Foundation Trust

Performance highlights against a range of indicators including the System Oversight Framework (SOF) and the Foundation Trust terms of licence remains. The report is for the month of April 2022 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

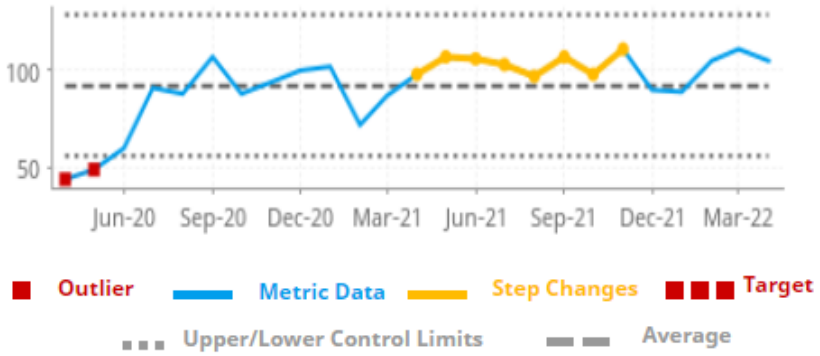
Statistical Process Control (SPC) Charts

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

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

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

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



Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

SOF and Efficiency & Productivity

As we move into the new financial year the Integrated Performance Report has been fully refreshed to reflect the requirements outlined in the 2022/23 Priorities and Operational Planning submission. The opportunity has also been taken to refresh dashboards and remove any appropriate metrics, although it must be noted that the report continues to align to the System Oversight Framework

The changes relating to the System Oversight Framework and the Efficiency and Productivity sections include

- all SPC's have been realigned to 7 data points, in line with NHSE 'Making Data Counts' as it is suggested that this is long enough to decide if the data represents any special cause variation and if intervention is required.
- the removal of some theatre metrics, PHQ indicators and TCS standards with the efficiency and productivity section being aligned to the recent 2022/23 Priorities and Planning submission.
- Cancer standards reporting remain unchanged until results of the national consultation are received.

Any metrics removed are now monitored for compliance within the appropriate Care Group dashboards

No changes have been made to the Quality, Workforce or Finance quadrants.

The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position though performance continues to be affected by the legacy of Covid, although there is now a clear plan of delivery as outlined in the trajectories in 2022/23 including the continued support to the system, insourcing will continue to support the capacity within the elective programme whilst the internal workforce gaps are addressed.

Safety & Quality

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

The latest HSMR value is currently reporting at 85.31 (March 2021 to February 2022), with the latest SHMI value is 95.43 (December 2020 to November 2021) which remains within the control limits.

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

The number of Stage 1 and Stage 2 complaints have decreased during April 2022, with Stages 3 seeing a slight increase. The number of complaints received this month is consistent with pre pandemic status.

The number of red risks has remained higher than the mean over last few months but remain within the expected variance, demonstrating a dynamic risk management process.

Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Workforce

Training on Attendance Management, Probationary Periods and People Practices Training continues to be delivered to all line managers.

With retention rates across the Trust being reviewed, all managers have been requested to notify workforce representatives upon receipt of a resignation to initiate retention discussions as early as possible.

Schwartz rounds recommenced with a team time session for paediatrics and safe guarding colleagues.

An additional four cultural ambassadors have been trained for the Trust.

The Trust continues to actively participate in the Growing Occupational Health and Wellbeing project, with engagement sessions with four Trusts taking place in May 22

An evaluation session on the last flu campaign took place in April, in preparation for the 22/23 campaign with a focus on learning from last year and ensuring as many staff as possible are vaccinated.

April saw the organisation attend the Better Health at Work awards virtually to receive recognition of maintaining excellence, the highest level of achievement, demonstrating our commitment to supporting staff health and well-being. Monthly sessions continue to focus on a range of topics, to ensure that all aspects of health and well-being are supported. Work continues on the H&W strategy ensuring this is a collaborative approach utilising the health and well-being advisory group. Monthly well-being sponsor meetings continue with key information and opportunities shared.

As at 29th April 2022, the number of active volunteers is 248, with only 6 new volunteers this month which is a small increase on the previous months figure, and this is largely as a result of students concentrating on their exams as they develop their careers. Interest in the Trust volunteer Service remains high and following a marketing campaign in March, the Trust shortlisted and interviewed 23 applicants and we are hopeful that they will start with us in the coming weeks. The Volunteer Service has 39 applications awaiting final pre-employment checks before commencing the programme with the Trust. Future recruitment will continue to accommodate a further 39 expressions of interest. We are aiming to advertise for specific roles to support the expansion of the Volunteer Drivers, our Home but not Alone programme and the Trust responder role in the near future.

Finance

The Trust submitted a financial plan for 2022/23, which is a deficit of £1.4m.

At month 1, the Trust is reporting an in-month surplus of £0.888m against a planned surplus position of £0.817m which is £0.071m ahead of plan.

Total Trust income in M1 is £30.457m (including donated asset income).

M1 pay expenditure totalled £20.265m of which £0.206m is additional spend related to the Covid-19 response (including testing costs).

M1 non-pay expenditure totalled £9.074m of which £0.150m is additional spend related to Covid-19.

The month 1 year to date net contribution from Optimus is £0.024m against a plan of £0.014m (£0.010m ahead of plan) and the year to date net contribution from the LLP is £0.057m against a plan of £0.153m (£0.096m behind plan).

The Board Assurance Framework for 2022/23 has been updated and will be presented to the Finance Committee for approval.

At Month 1, the emerging key risks relate to increasing run rates and identification and delivery of CIP.

System Oversight Framework 6

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	2 Year Trend
New Cancer Two Week Rule	✗	Mar-22	90.24%	93.00%	
Breast Symptomatic Two Week Rule	✗	Mar-22	90.83%	93.00%	
28-day Faster Diagnosis	✓	Mar-22	84.35%	75.00%	
New Cancer 31 Days	✓	Mar-22	97.86%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Mar-22	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	Mar-22	83.33%	94.00%	
New Cancer 62 Days	✗	Mar-22	68.89%	85.00%	
New Cancer 62 Days (Screening)	✓	Mar-22	93.62%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✓	Mar-22	93.33%	85.00%	

Narrative

Cancer

Challenges in delivering against cancer standards continues with similar issues experienced across the system. The position remains comparable to regional position, with the Trust achieving five out of the nine cancer standards, with a continued achievement above the standard for the 28 day faster diagnosis. An improving position against both the cancer 2 week rule and breast symptomatic standards can be seen. New cancer 62 day target is still a pressure although March is reflective of an improved compliance. There continues to be issues in breast, gynaecology, colorectal and urology which are the focus of the work of the South Cancer Cell and the boarder system.

The Trust remains committed to a collaborative approach through the South Cancer Cell initiative alongside South Tees NHS Foundation Trust, ensuring equitable access to treatment for all patients.

A deep dive into performance against this standard and its associated risks is currently underway.

The Trust awaits the outcome of the national consultation which is underway to review existing cancer standards.

System Oversight Framework 7

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*2 Year Trend*
Referral To Treatment Incomplete Pathways Wait (92%)	Apr-22	79.19%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	Apr-22	28.29	28.00	
Incomplete Pathways Wait (Median)	Apr-22	8.57	7.20	
Incomplete Pathways Wait (>52 Week Wait)	Apr-22	58	25	
Diagnostic Waiting Times and Activity	Apr-22	87.23%	99.00%	

Narrative

RTT

Trusts are expected to reduce their overall waiting list size by March 2023. In April the Trust has seen a slight increase to the overall waiting list reporting a 1.23% (n=214) increase in comparison to March.

The number of patients waiting longer than 52 weeks is 58 against a target in April of 25. From the most recent regional data (March 2022) the Trust has the third lowest number over 52 weeks in the region.

At the end of April 2022 the Trust had one patient waiting longer than 78 weeks and zero patients waiting longer than 104 weeks.

The waiting list policy is being reviewed to align with national policy and clinical prioritisation.

Diagnostics

Performance has been affected this month as a result of an increase in patients waiting longer than 6 weeks within Ultrasound (Non-Obstetric). Staffing resource is the main pressure within this modality. Other areas of pressure include Endoscopy, MRI, Cardiology & Audiology.

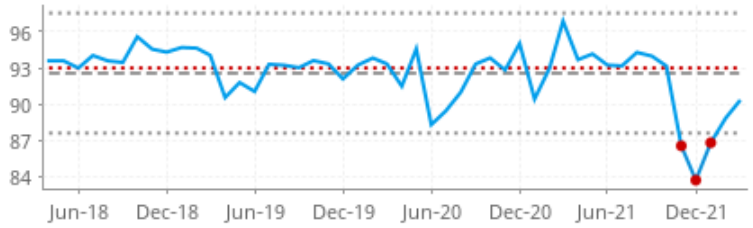
System Oversight Framework 8

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

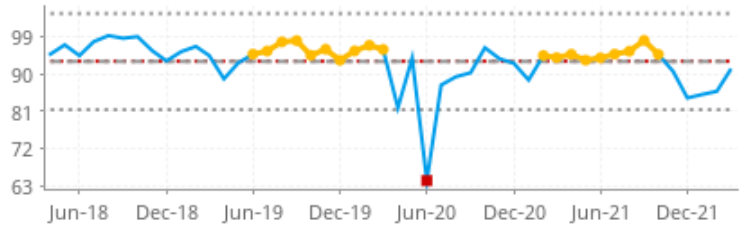
Cancer - 2 Week Rule

Month	Performance	Standard
Mar-22	90.24%	93.00%



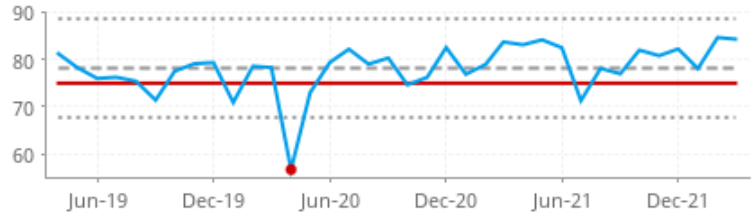
Cancer - Breast Symptomatic

Month	Performance	Standard
Mar-22	90.83%	93.00%



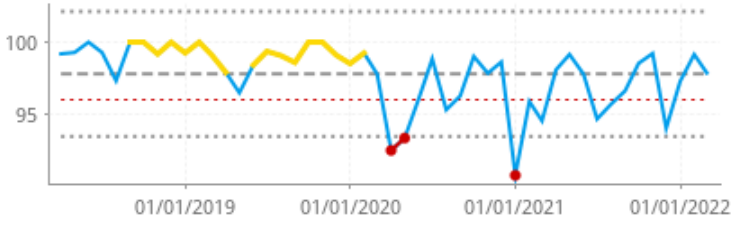
Cancer - 28 day Faster Diagnosis

Month	Performance	Standard
Mar-22	84.35%	75.00%



Cancer - 31 days

Month	Performance	Standard
Mar-22	97.86%	96.00%



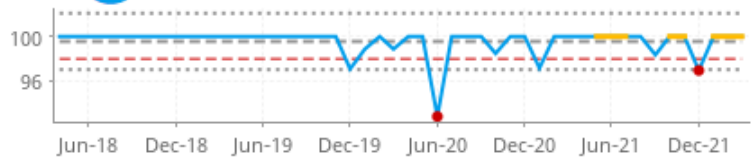
System Oversight Framework 9

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

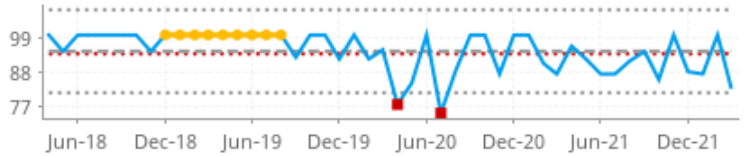
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
Mar-22	100.00%	98.00%



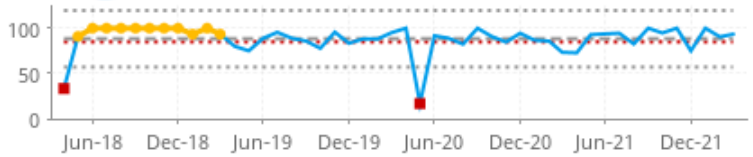
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
Mar-22	83.33%	94.00%



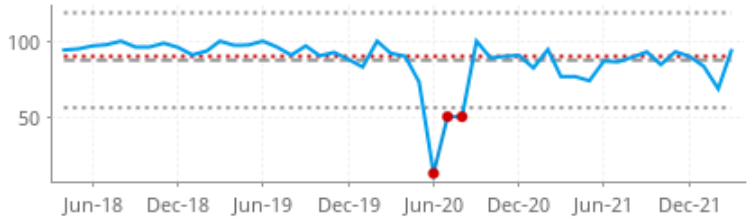
Cancer - 62 Consultant Upgrade

Month	Performance	Standard
Mar-22	93.33%	85.00%



Cancer - 62 Days Screening

Month	Performance	Standard
Mar-22	93.62%	90.00%



Cancer - 62 Days

Month	Performance	Standard
Mar-22	68.89%	85.00%

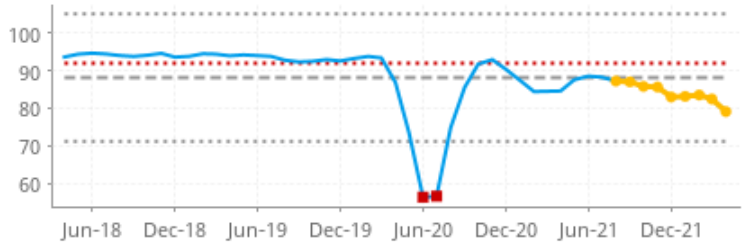
System Oversight Framework 10

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

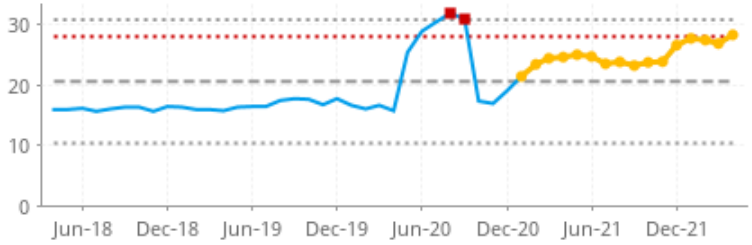
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Apr-22	79.19%	92.00%



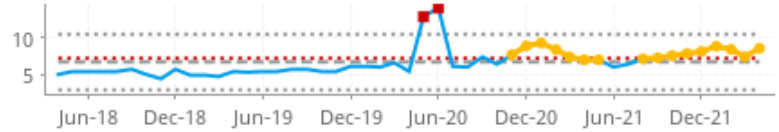
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Apr-22	28.29	28.00



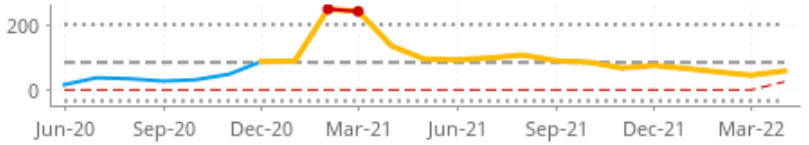
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Apr-22	8.57	7.20



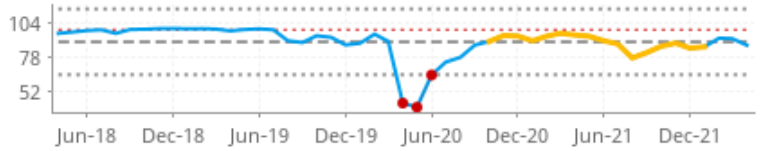
Referral To Treatment- Incomplete Pathways Wait (>52 Week Wait)

Month	Performance	Standard
Apr-22	58	25



Diagnostic Waiting Times and Activity

Month	Performance	Standard
Apr-22	87.23%	99.00%



Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	2 Year Trend
Decision To Admit (DTA) (over 12 hours)	Apr-22	5	0	
Time to Initial Assessment (mean) Type 1 & 3	Apr-22	11.06	15.00	
Number of Ambulance Handovers waiting more than 60 Mins	Apr-22	5	0	
65% of Ambulance Handovers completed within 15 Mins	Apr-22	31.42%	65.00%	
95% of Ambulance Handovers completed within 30 Mins	Apr-22	59.88%	95.00%	
2 hour Urgent Community Response	Mar-22	56.67%	70.00%	

Narrative

Ambulance Handover

Urgent & Emergency Care Standards have been reviewed and aligned to the requirements set out in the 2022/23 Priorities and Planning submission that focuses on compliance with handover times within 15 and 30 minutes Turnaround time is a key metric, reflecting the ability to support NEAS in capacity to respond with the Trust reporting at 56.7% ambulance turnaround times within 30 minutes, placing the Trust 2nd regionally.

The trust continues to respond to a number of requests for mutual aid and ambulance diverts and deflections from neighbouring trusts which adds to the pressures within the organisation

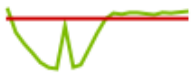
The Trust is committed to improving compliance with ambulance turnaround times and continues to work with NEAS as a priority. Quality initiatives are focused on improving ambulance turnaround times and NEAS was on site on the 20 April 2022 as part of the QI project team.

Urgent Community Response

The Tees Valley Urgent Community Response Service brings together a range of Health and Social Care professionals to respond quickly to support patients to remain in their own home. This national requirement forms part of the system work and promotes collaboration, as part of the Tees Valley Clinical Services Strategy through the Urgent & Emergency Care Managed Clinical Network.

Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*2 Year Trend*
Outpatient Did Not Attend (Combined)	Apr-22	9.32%	9.20%	
Reducing Reviews	Apr-22	89.06%	85.00%	
Patient Initiated Follow Up (PIFU)	Apr-22	0.20%	1.30%	
Advice and Guidance	Mar-22	11.06%	16.00%	
Diabetic Retinopathy Screening	Apr-22	98.97%	95.00%	

Narrative

Outpatients

A slight reduction in performance against DNA rates is noted in April (when compared to March) with an upward trend evident.

Within the Annual Operating Plan a new standard has been agreed for patients to be transferred into a Patient Initiated Follow-Up (PIFU) pathway. The standard has been set to incrementally increase to 5% by the end of 2022/23, with the following specialities asked to consider clinically appropriate pathways. Gynaecology, Rheumatology, Cardiology, Gastroenterology and Respiratory.

The outpatient transformation group will work to improve compliance with the national direction of travel including the reduction of review appointments to 75% of those delivered within 2019/20. The trust submitted a plan to achieve 85% through a transformational and innovation approach.

Efficiency & Productivity

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North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	2 Year Trend
Electronic Discharge Summaries	✗	Apr-22	87.66%	95.00%	
Super Stranded	✓	Apr-22	38	43	
Average Depth of Coding	✓	Mar-22	6.12	3.01	
Length of Stay - Elective	✓	Apr-22	2.05	3.14	
Length of Stay - Emergency	✓	Apr-22	2.81	3.35	
Day Case Rate	✓	Apr-22	87.62%	75.00%	
Pre-op Stays	✓	Apr-22	2.10%	4.50%	
Trust Occupancy	✗	Apr-22	90.62%	85.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	✗	Feb-22	9.01%	7.70%	
Not reappointed within 28 days	✗	Mar-22	3	0	

Narrative

Electronic Discharge Summary (EDS)

A downward trend is noted in terms of summaries being complete within 24 hours however completion is being undertaken but outside of the required 24 hours. Challenges have been noted in turnaround times because of staffing sickness due to increased covid rates.

As a result, actions are underway to standardise EDS reports to enable a more targeted view of the ward position and Care Groups have been asked to undertake detailed reviews to understand the position and establish improvement methodologies.

Trust Occupancy

The Trust operated at 90.63% (average) occupancy during April with surges in activity noted and an increase in Covid admissions.

A peak on 4 April 2022 saw occupancy rise to 98.06%, with 27 escalation beds opened. Escalation beds open throughout the month ranged from a minimum of 18, to a maximum of 42 (on the 6 April).

Trust Occupancy standard is currently set at 85% however, an acceptable level of 90% has been submitted within the 22/23 priorities and operational planning submission.

Work underway to review core bed base to ensure that the organisational operating model has the ability to respond to the post Covid population needs.

Readmissions

Readmissions saw a reduction in February (latest available data). Main reasons for readmission are non-malignant Gastrointestinal Tract disorders and respiratory issues. Data cleansing and capture continues to be a focus alongside a review of the patients to consider if alternative pathways could have been considered.

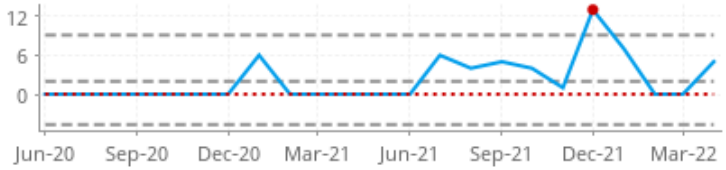
Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

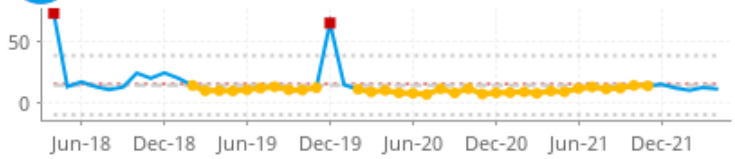
Decision to Admit (DTA) (Over 12 hours

Month	Performance	Standard
Apr-22	5	0



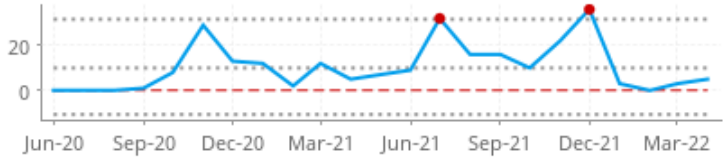
Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Apr-22	11.06	15.00



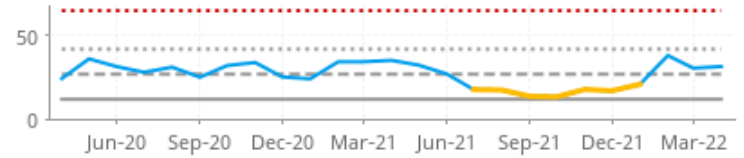
Number of Ambulance Handovers waiting more than 60 mins

Month	Performance	Standard
Apr-22	5	0



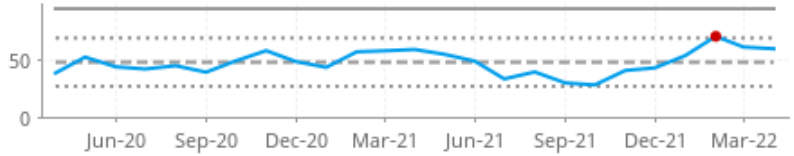
65% of Ambulance Handovers completed within 15 mins

Month	Performance	Standard
Apr-22	31.42%	65.00%



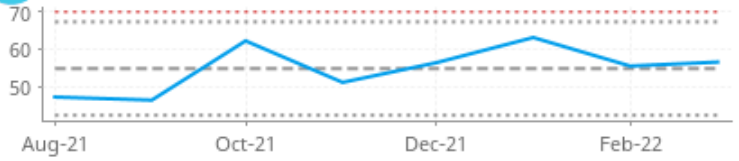
95% of Ambulance Handovers completed within 30 mins

Month	Performance	Standard
Apr-22	59.88%	95.00%



2 hour Urgent Community Response

Month	Performance	Standard
Mar-22	56.67%	70.00%



Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

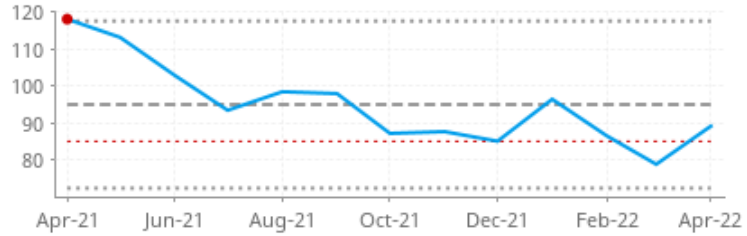
Statistical Process Control (SPC) Charts

Outpatient Did not Attend

Month	Performance	Standard
Apr-22	9.32%	9.20%

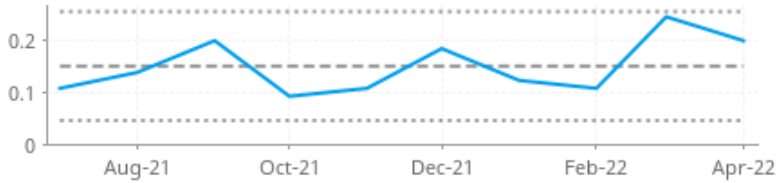
Reducing Reviews

Month	Performance	Standard
Apr-22	89.06%	85.00%



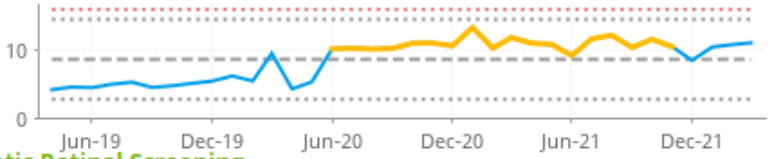
Patient Initiated Follow up

Month	Performance	Standard
Apr-22	0.20%	1.30%



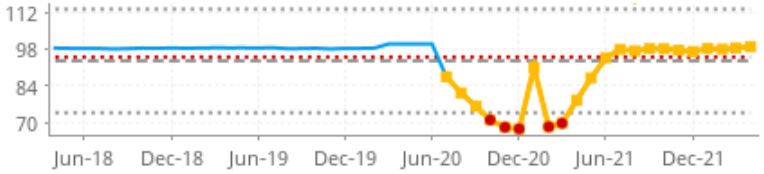
Advice and Guidance

Month	Performance	Standard
Mar-22	11.06%	16.00%



Diabetic Retinal Screening

Month	Performance	Standard
Apr-22	98.97%	95.00%



Efficiency & Productivity

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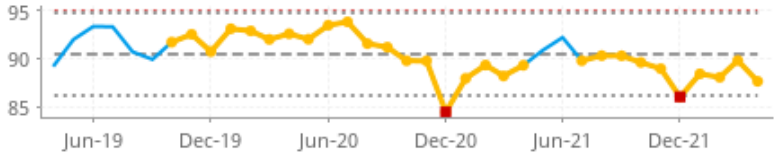
NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

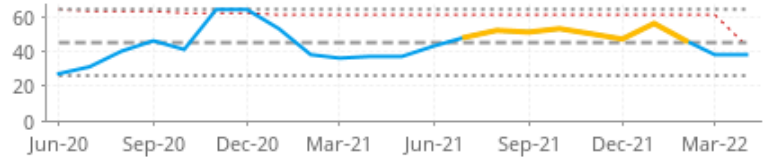
Electronic Discharge Summaries

Month	Performance	Standard
Apr-22	87.65%	95.00%



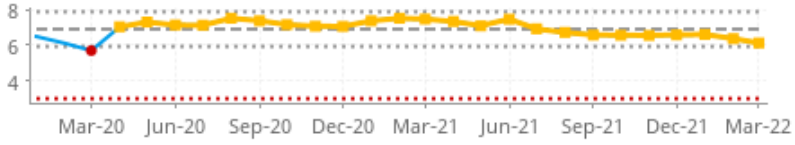
Super Stranded

Month	Performance	Standard
Apr-22	38	43



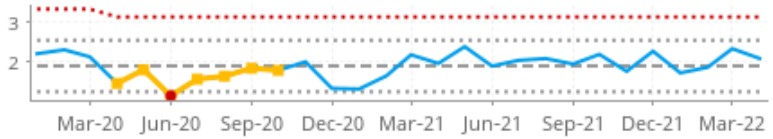
Average Depth of Coding

Month	Performance	Standard
Mar-22	6.12	3.01



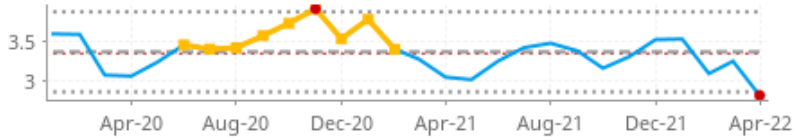
Length of Stay - Elective

Month	Performance	Standard
Apr-22	2.05	3.14



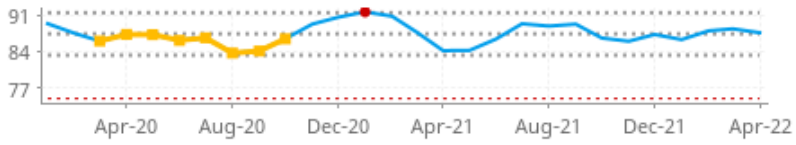
Length of Stay - Emergency

Month	Performance	Standard
Apr-22	2.81	3.35



Day Case Rate

Month	Performance	Standard
Apr-22	87.62%	75.00%



Efficiency & Productivity

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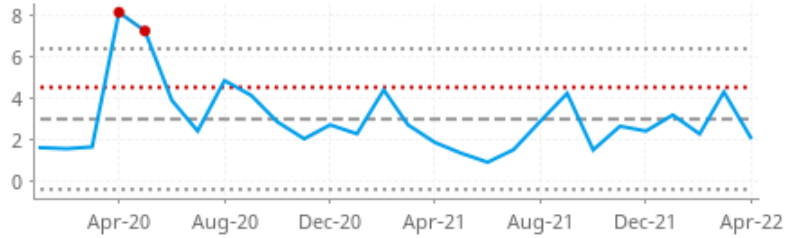
North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

Pre-op Stays

Month	Performance	Standard
Apr-22	2.10%	4.50%

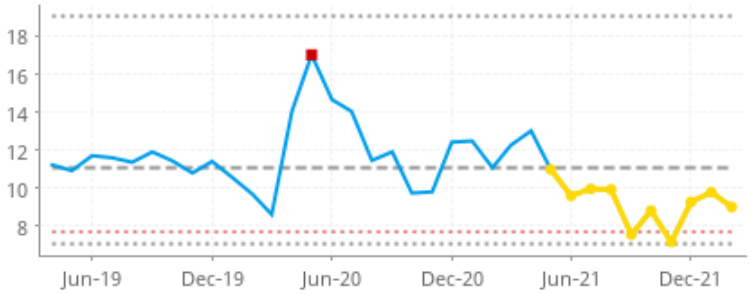


Trust Occupancy

Month	Performance	Standard
Apr-22	90.62%	85.00%

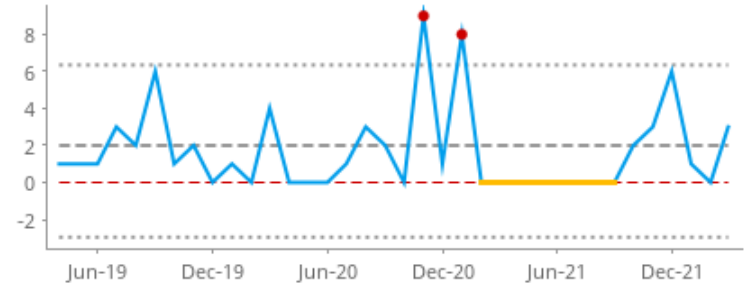
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Feb-22	9.01%	7.70%



Not Reappointed within 28 days

Month	Performance	Standard
Mar-22	3	0



Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Mar 21 - Feb 22	85.31	
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Dec 20 - Nov 21	95.43	

Standard	Standard Achieved	Month	Performance	Standard	Trend
Stage 1 Complaint	✗	Apr-22	105	98	
Stage 2 Complaint	✗	Apr-22	5	4	
Stage 3 Complaint	✗	Apr-22	10	9	
Compliments	✓	Apr-22	341	252	

Narrative

Mortality

The latest HSMR value is currently reporting at 85.31 (March 2021 to February 2022) which has increased from the previous rebased value of 84.87 (February 2021 to January 2021). The latest SHMI value is now 95.43 (December 2020 to November 2021) which has decreased from the previous rebased value of 95.82 (November 2020 to October 2021).

Complaints

The number of complaints has slightly decreased in April compared with the previous month, with a decrease in Stage 1 complaints. The number of Stage 2 complaints received is the same as the previous month. There has been a slight increase in Stage 3 complaints. The numbers received and themes continue to be closely monitored. The Trust continues with the drive for local and face to face resolution of concerns, virtual meetings have been developed to support this process.

Limited visiting continues on an appointment basis. However, families continue to be supported through John's Campaign and provisions for those patients at End of Life. During April 2022, communication was the highest reported main issue in concerns raised to the Trust, and increased slightly from the previous two months. Complaint trends are discussed during weekly Safety Panel meetings and Senior Clinical Professional Huddles, supporting timely identification of the themes.

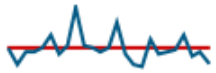
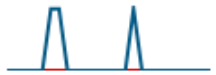
There has been a significant reduction in the number of relatives arranging virtual visits, this has reduced steadily during this year, with only one virtual visit arranged during April 2022. The number of parcels and letters delivered to the Patient Experience Team as part of the patient's property drop off service has also noted a steady decline, from 9 in March to 3 in April. Staff continue to promote virtual visiting as an alternative option to face to face visiting

Compliments

The Trust records the compliments received onto the Greatix platform. For April 2022 the number of compliments received is 341, which is higher than the mean of 247 compliments. Compliments consistently remain higher than the number of complaints the Trust receives.

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*Trend*	
Red Risks	✗	Apr-22	6	4		**Falls** During April, there has been a very slight increase in falls; however this continues to be a reduction following the rise during December 2021. The majority of falls result in no harm, the minor increase relates to falls with no harm. All falls incidents are reviewed and the level of harm confirmed following relevant investigations. The risks around in patient falls are multifactorial and the Falls Group have developed an assurance framework to provide details of the on-going work being undertaken trust wide to promote risk mitigation strategies and ensure appropriate education and support is available. The digital team continue to support the development of e-solutions around the falls documentation, bed rails assessment and also medicine reconciliation/review particularly for patient requiring multiple medications. Updates in relation to the content of risk assessments and record keeping are agreed by the Falls working group. Digital solutions are also supporting the improvement work of lying and standing blood pressures; the recent agreement to and inclusion of a mandated field for this should see the overall compliance with the requirement continue to improve.
Never Events	✓	Apr-22	0	0		
VTE %	✓	Apr-22	95.28%	95.00%		
Fall No Harm	✗	Apr-22	87	81		
Fall Low Harm	✓	Apr-22	9	16		
Fall Moderate Harm	✓	Apr-22	1	1		
Fall Severe Harm	✓	Apr-22	0	0		

Safety & Quality

NHS
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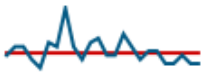
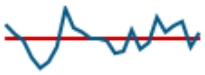
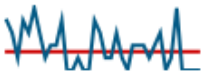
Standard		Month	Performance	Standard	Trend
Pressure Category 1 (inpatient)	✓	Mar-22	2	5	
Pressure Category 2 (inpatient)	✗	Mar-22	24	22	
Pressure Category 3 (inpatient)	✓	Mar-22	0	2	
Pressure Category 4 (inpatient)	✗	Mar-22	1	0	

Narrative

Pressure Ulcers

In the March 2022 reporting period, Category one pressure ulcers remain below the standard of five. An increase in Category two pressure ulcers, 24, is above the accepted standard of 22 cases, is reflective of the activity and acuity within the trust at the time. There were zero Category three pressure ulcers identified in March 2022. One Category four pressure ulcer was reported in March 2022 which exceeds the standard of one case. This was a deterioration of a known category 2 ulcer as the patient approached end of life.

Safety & Quality

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Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*Trend*	
Hand Hygiene	✓	Apr-22	98%	95%		**Infections** In April 2022, the Trust reported three Hospital-onset healthcare-associated case of Clostridioides difficile infection, which is below our projected trajectory for April 2022. A Period of Increased Incidence (PII) has been declared on Ward 42, with the infection control team providing increased support, education and monitoring. Our yearly objective for 2022-23 is 54 cases of Clostridioides Difficile. The Trust has reported nine E-coli bacteraemia in April 2022. Three cases were community-onset healthcare-associated, six cases were hospital-onset healthcare-associated. Our yearly objective for 2022-23 is 73 cases which is a significant reduction on the previous year. There were no trust attributable cases reported for Pseudomonas infections. Our 2022-23 objective is 12 cases. The trust reported five cases of hospital-onset healthcare-associated Klebsiella in April 2022, which is above our projected trajectory of one case for the month of April. Further surveillance has not identified any links between the cases, with different sources and clinical areas noted. Our yearly objective for Klebsiella species for 2022-23 is 21 cases. There have been three healthcare-associated cases of MSSA in the month of April, which is in line with our monthly projected trajectory of three cases. There is no set national objective set for MSSA, but by applying the same criteria that the national team have to the other targets, our own internal trust target for MSSA for 2022-23 is 30 cases. For the month of April, 17 CAUTI cases were reported for the trust. The trust continues to report 0 MRSA bacteraemias, with a zero tolerance target for 2022-23.
Clostridium difficile	✓	Apr-22	3	4		
MRSA	✓	Apr-22	0	0		
MSSA	✓	Apr-22	3	3		
Ecoli	✗	Apr-22	9	7		
Klebsiella	✗	Apr-22	5	1		
Pseudomonas	✓	Apr-22	0	1		
CAUTI	✓	Apr-22	17	18		

Safety & Quality

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NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Friends and Family Test (FFT) - Emergency	✓	Apr-22	86.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	✓	Apr-22	89.00%	75.00%	
Friends and Family Test (FFT) - Maternity	✓	Apr-22	93.00%	75.00%	
UNIFY - RN Day	✗	Apr-22	76.67%	>=80% and <=109.99%	
UNIFY - RN Night	✓	Apr-22	84.61%	>=80% and <=109.99%	
UNIFY - HCA Day	✓	Apr-22	85.16%	>=80% and <=109.99%	
UNIFY - HCA Night	✓	Apr-22	124.40%	>=110% and <=125.99%	

Narrative

Friends and Family

For April 2022 the Trust received 962 FFT returns, this has decreased on the previous month. The Very Good or Good responses returned for April 2022 is 92.20%.

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

UNIFY

Nursing fill rates remain challenging due a range of factors including continued vacancies and a higher sickness absence than planned. The daily challenges have been safely managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse. The nursing fill rates presented in April 2022 show that these pressures are still evident but continue with a positive forecast emerging from October 2022 following further recruitment plans and the deployment of planned international nurses.

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

Monthly recruitment centres are on-going for both Registered Nurses and Health Care Assistants with further recruitment centres planned for RNs, HCAs and Team Support Workers throughout May/June and approx. 35wte Pre-Reg Nurses being invited to interview in June 2022.

The international recruitment of up to 60wte registered nurses is currently underway which will further support increasing the shift fill rate and reducing the overarching nursing vacancy level.

Safety & Quality

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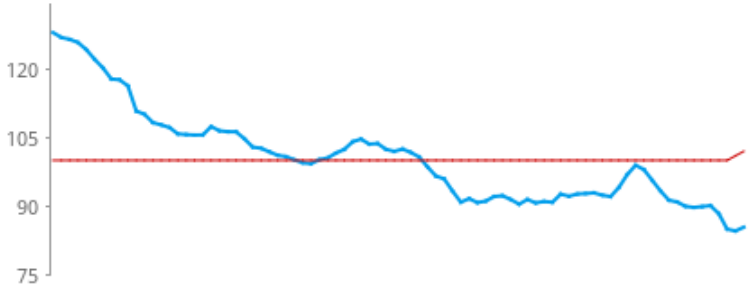
Additional Detail Charts

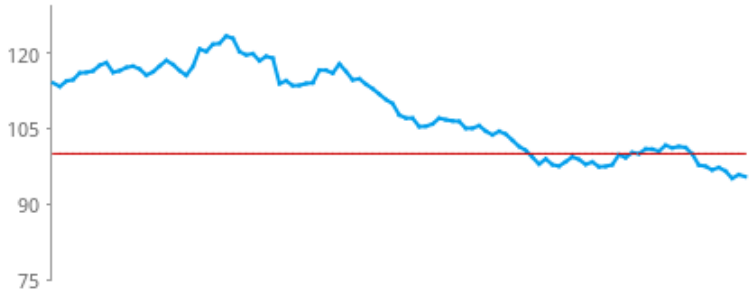
Hospital Standardised Mortality Ratio

Month	Performance
Mar 21 - Feb 22	85.31



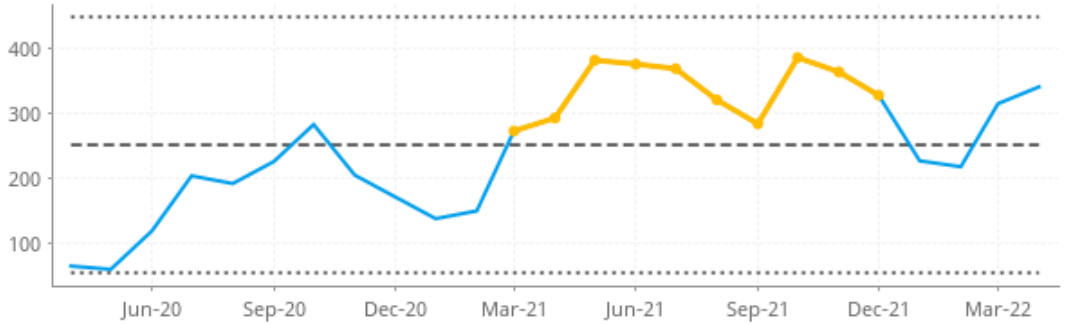
Summary Hospital-Level Mortality Indicator

Month	Performance
Dec 20 - Nov 21	95.43



Compliments

Month	Performance	Standard
Apr-22	341	252



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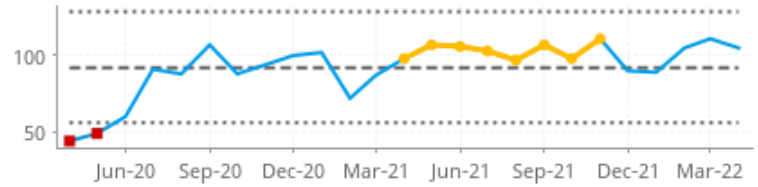
Statistical Process Control (SPC) Charts

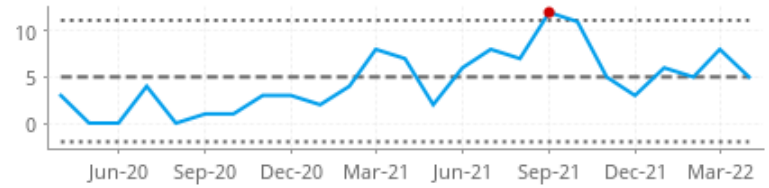
Stage 1 - Informal

Month	Performance	Standard
Apr-22	105	98



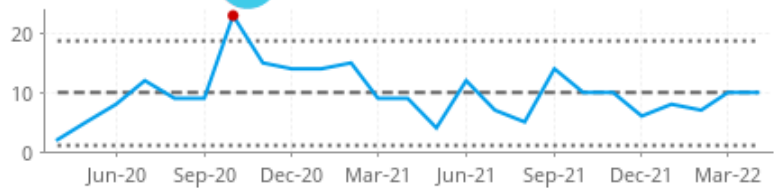
Stage 2 - Meeting

Month	Performance	Standard
Apr-22	5	4



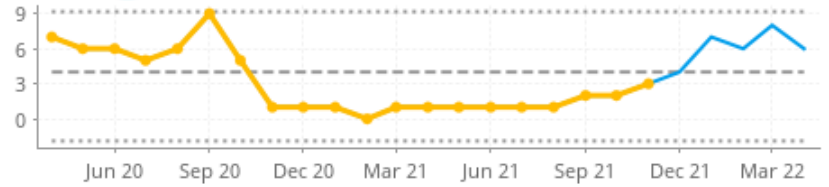
Stage 3 - Formal

Month	Performance	Standard
Apr-22	10	9



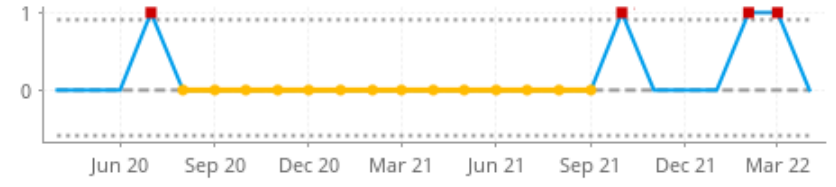
Red Risks

Month	Performance	Standard
Apr-22	6	4



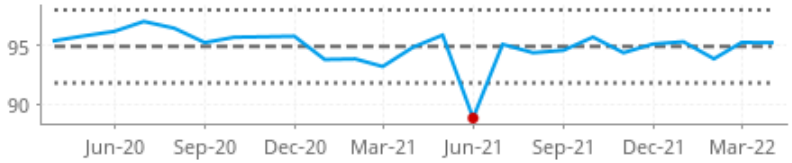
Never Events

Month	Performance	Standard
Apr-22	0	0



VTE %

Month	Performance	Standard
Apr-22	95.28%	95.00%



Safety & Quality

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North Tees and Hartlepool NHS Foundation Trust

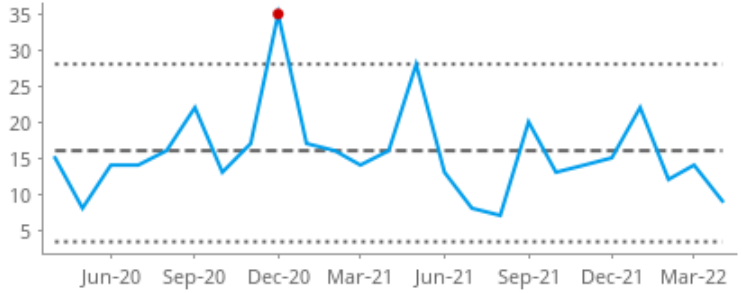
Statistical Process Control (SPC) Charts

Fall No Harm

Month	Performance	Standard
Apr-22	87	81

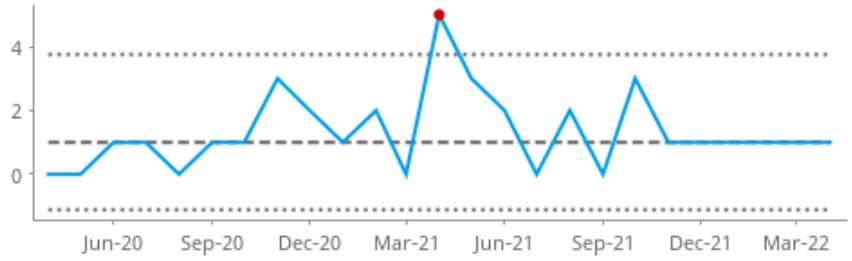
Fall Low Harm

Month	Performance	Standard
Apr-22	9	16



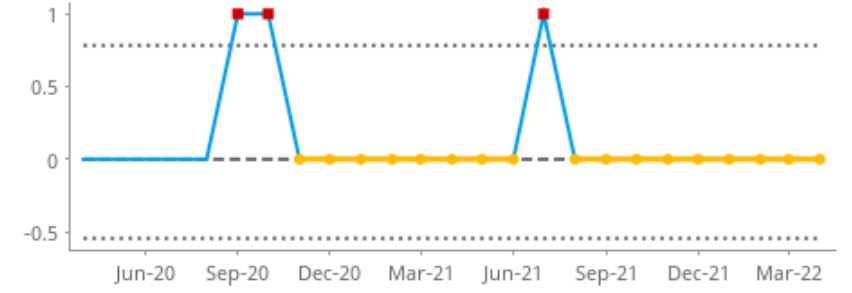
Fall Moderate Harm

Month	Performance	Standard
Apr-22	1	1



Fall Severe Harm

Month	Performance	Standard
Apr-22	0	0



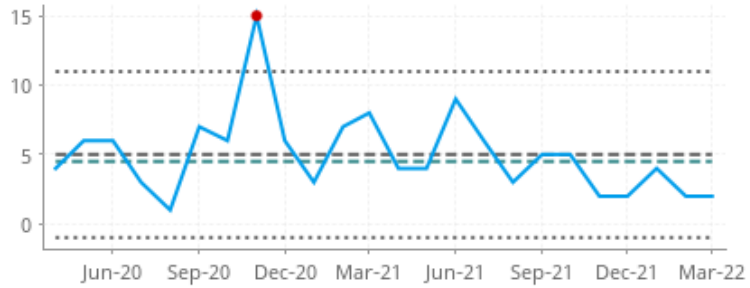
Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

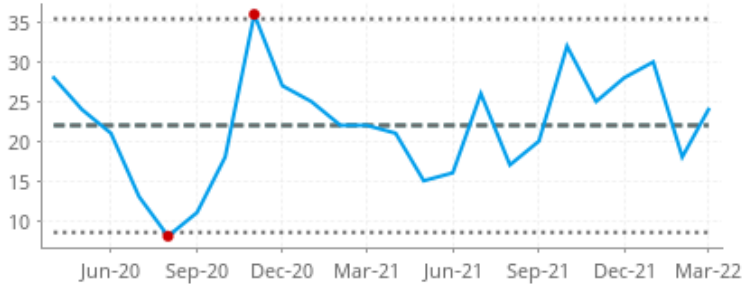
Pressure Ulcer Cat 1

Month	Performance	Standard
Mar-22	2	5



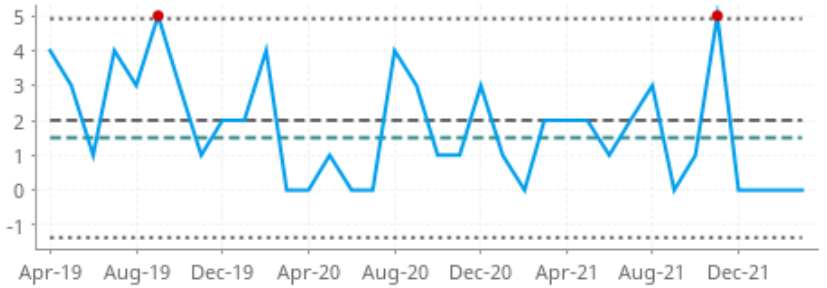
Pressure Ulcer Cat 2

Month	Performance	Standard
Mar-22	24	22



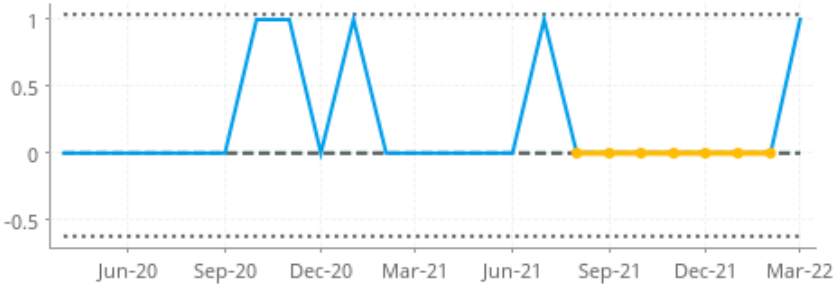
Pressure Ulcer Cat 3

Month	Performance	Standard
Mar-22	0	2



Pressure Ulcer Cat 4

Month	Performance	Standard
Mar-22	1	0



Safety & Quality

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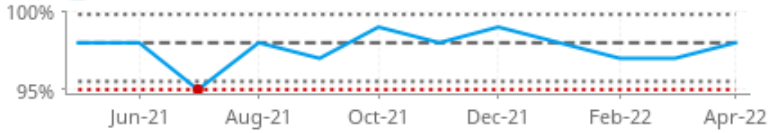
Statistical Process Control (SPC) Charts

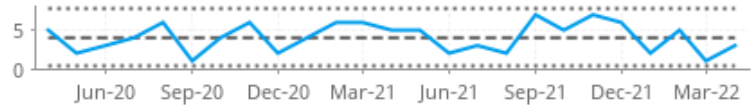
Hand Hygiene

Month	Performance	Standard
Apr-22	98%	95%



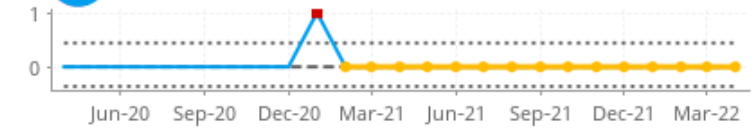
Cdiff

Month	Performance	Standard
Apr-22	3	4



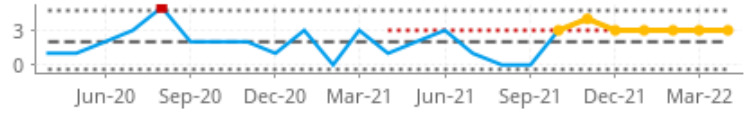
MRSA

Month	Performance	Standard
Apr-22	0	0



MSSA

Month	Performance	Standard
Apr-22	3	3

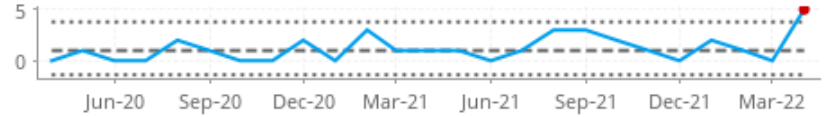


Ecoli

Month	Performance	Standard
Apr-22	9	7

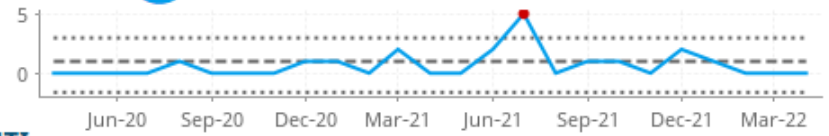
Klebsiella

Month	Performance	Standard
Apr-22	5	1



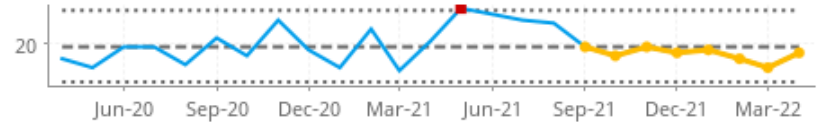
Pseudomonas

Month	Performance	Standard
Apr-22	0	1



CAUTI

Month	Performance	Standard
Apr-22	17	18



Safety & Quality

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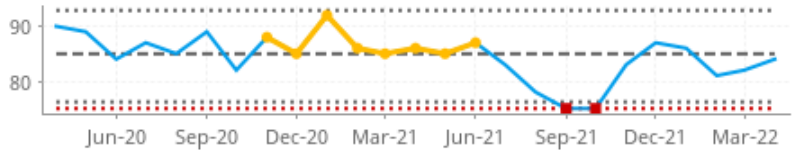
Statistical Process Control (SCP) Charts

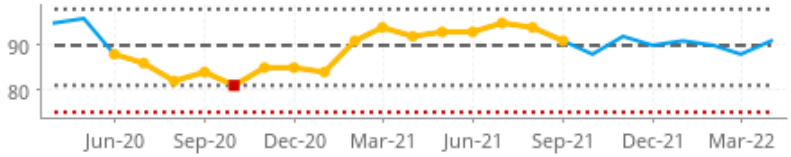
FFT Emergency Care

Month	Performance	Standard
Apr-22	84.00%	75.00%



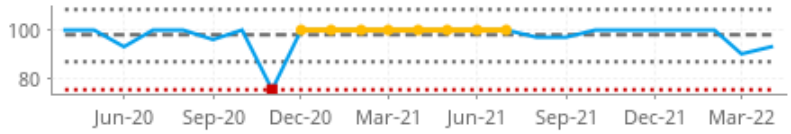
FFT Inpatient

Month	Performance	Standard
Apr-22	91.00%	75.00%



FFT Maternity

Month	Performance	Standard
Apr-22	93.00%	75.00%

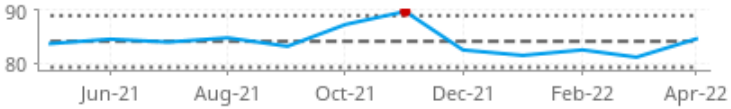


UNIFY RN Day

Month	Performance	Standard
Apr-22	76.67%	>=80% and <=109.99%

UNIFY RN Night

Month	Performance	Standard
Apr-22	84.61%	>=80% and <=109.99%

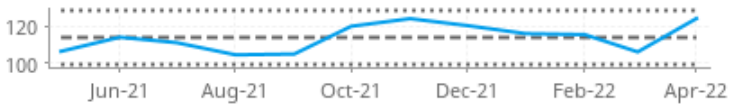


UNIFY HCA Day

Month	Performance	Standard
Apr-22	85.16%	>=80% and <=109.99%

UNIFY HCA Night

Month	Performance	Standard
Apr-22	124.40%	>=110% and <=125.99%



Workforce

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NHS
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Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*2 Year Trend*
Sickness	Mar-22	5.92%	4.00%	
Appraisals	Apr-22	84.17%	95.00%	
Turnover	Apr-22	12.02%	10.00%	
Mandatory Training	Apr-22	89.75%	80.00%	

Narrative

The sickness absence rate for March 2022 is reported at 5.92%, a decrease of 0.52% compared to the previous month (6.44%). This is broken down into 1.15% attributable to Covid-19 related sickness and 4.77% attributable to other sickness.

The cost of sickness absence in March 2022 is reported as £367,225, a decrease of £16,619 compared to February (£383,844).

'Anxiety/stress/depression' was the top sickness reason in March, accounting for 26% of all sickness absence during the month. The second highest reason was 'Chest & respiratory problems', which accounted for 21% of sickness absence.

There were 248 cases of Covid-19 related staff absence in April 2022, broken down into 241 cases of staff absent sick and 7 who isolated.

Other workforce metrics for April 2022 are:

- Appraisal compliance reported as 84%, a 1% increase on the previous month
- Mandatory Training compliance reported as 90%, a 1% increase on the previous month
- Staff Turnover reported as 12.02%, a 0.08% decrease from the previous month

Workforce

NHS
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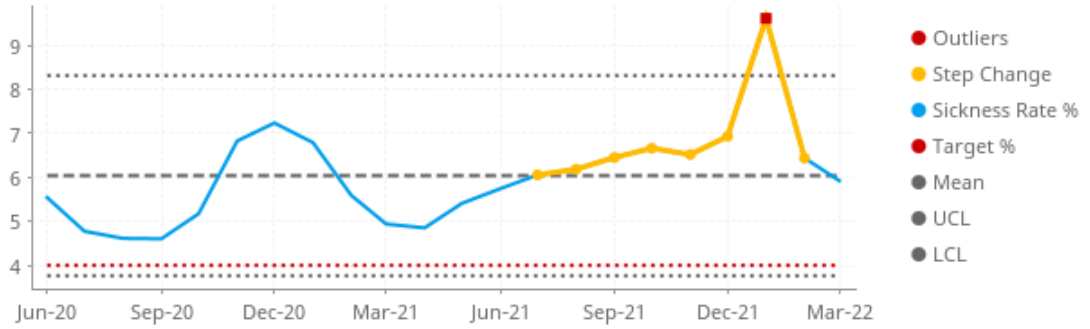
Statistical Process Control (SPC) Charts

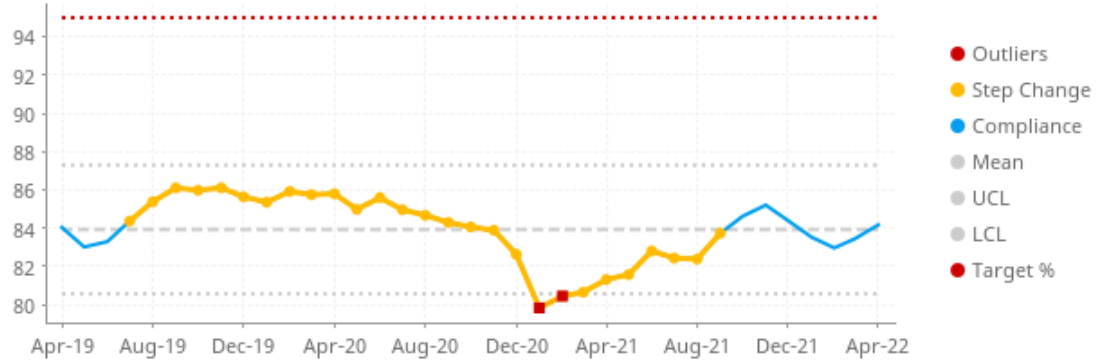
Sickness

Month	Performance	Standard
Mar-22	5.92%	4.00%



Appraisal

Month	Performance	Standard
Apr-22	84.17%	95.00%



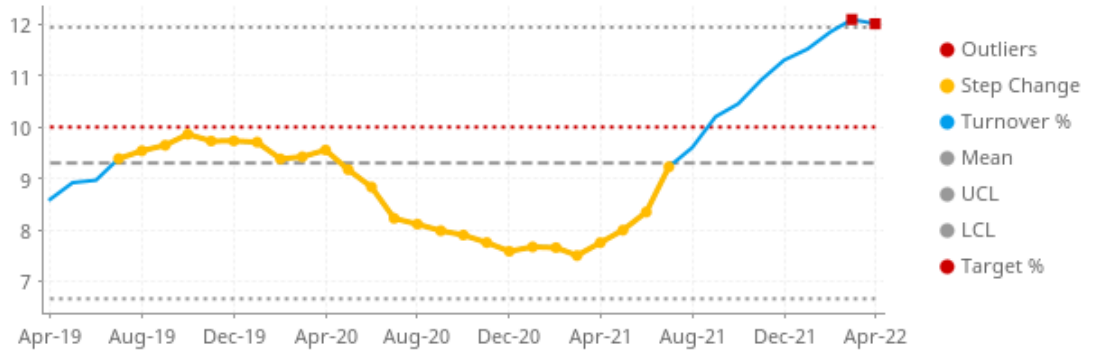
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Turnover

Month	Performance	Standard
Apr-22	12.02%	10.00%



Mandatory Training

Month	Performance	Standard
Apr-22	89.75%	80.00%

Finance

NHS
North Tees and Hartlepool
NHS Foundation Trust

Finance Overview - Month 1

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	817	888	☺
Year to Date	817	888	☺

Balance Sheet

£m

Cash Actual	68.5
Cash Plan*	55.5

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

Capital

	Plan (£m)	Actual (£m)	
In Month	0.0	0.1	☺
Year to Date	0.0	0.1	☺

Use of Resources*

Capital Service Cover Rating	1	I & E Margin Distance from Plan	1
Liquidity Rating**	4	Agency Rating	1
I & E Margin Rating	1	Risk Rating After Overrides	3

*UOR suspended in 2021-2022 - manual calculations
** Rating will only improve with increased cash reserves

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Appendix 1

RTT and Cancer

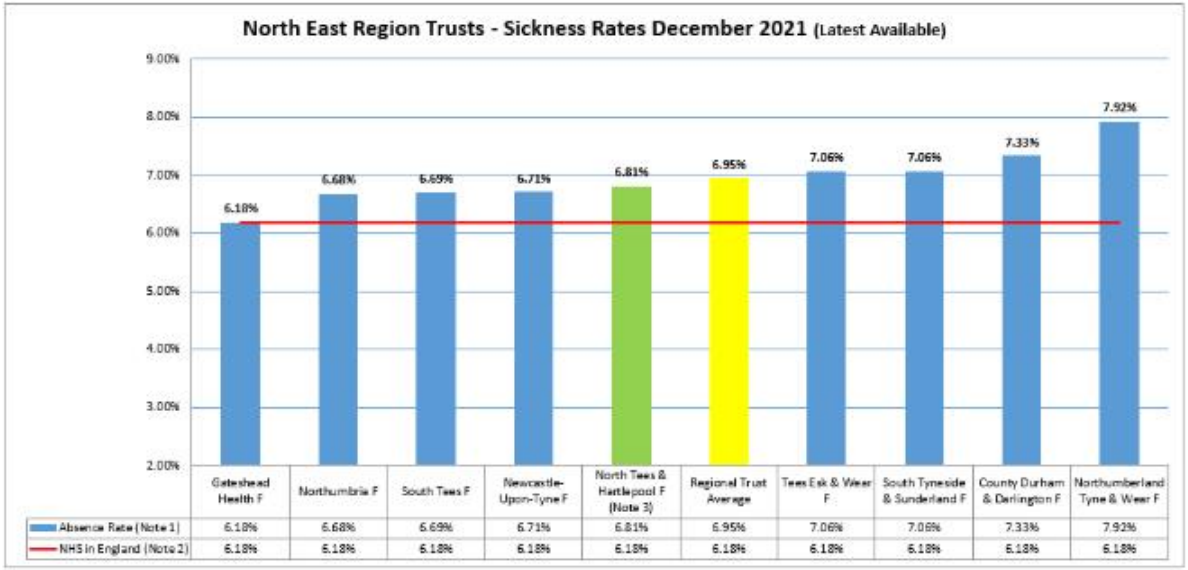
Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - March 22										
Incomplete Pathways waiting <18 weeks	62.4%		82.5%	82.6%	62.3%	74.7%	70.1%	86.1%	65.3%	72.9%
Half of incomplete patients wait less than	12		7	7	13	9	10	8	11	9
Half of admitted patients wait less than	12		8	17	28	15	10	11	7	8
19 out of 20 admitted patients wait less than	70		40	41	81	49	66	42	57	57
Half of Non admitted Pathways waited less than	7		4	6	9	3	6	6	5	5
19 out of 20 non admitted patients wait less than	46		27	28	50	33	40	31	34	24
Incomplete Pathways waiting >52 weeks	306286		44	67	946	41	3527	30	1161	788

Cancer Waiting times Summary		S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals		92.89 (1450/1561)	80.05 (955/1193)	88.59 (1095/1236)	84.1 (2021/2403)	96.98 (1799/1855)	79.75 (1508/1891)	90.24 (1347/1271)	79.88 (1830/2291)	86.16 (11805/13701)
Breast Symptomatic Referrals		0 (0/0)	87.27 (48/55)	100 (36/36)	37.95 (63/166)	94.96 (132/139)	72.73 (8/11)	90.83 (218/240)	81.98 (182/222)	79.06 (687/869)
31Day First Treatments		99.08 (215/217)	91.15 (103/113)	97.39 (149/153)	86.88 (470/541)	98.79 (163/165)	93.7 (223/238)	97.86 (137/140)	93.47 (186/199)	93.2 (1646/1766)
31Day Subsequent Treatments - Drugs		99.15 (117/118)	100 (1/1)	100 (63/63)	96.38 (266/276)	100 (21/21)	97.8 (89/91)	100 (78/78)	100 (7/7)	98.02 (642/655)
31Day Subsequent Treatments - Radiotherapy		0 (0/0)	0 (0/0)	0 (0/0)	99.51 (404/406)	0 (0/0)	99.94 (217/231)	0 (0/0)	0 (0/0)	97.49 (621/637)
31Day Subsequent Treatments - Surgery		88.24 (15/17)	90 (9/10)	97.14 (34/35)	66.67 (94/141)	92.31 (12/13)	57.14 (4/7)	83.33 (10/12)	69.57 (16/23)	75.19 (194/258)
62 Day Target - 2WW		81.5 (92.5/113.5)	53.18 (46/86.5)	59.54 (51.5/86.5)	60.23 (129.5/215)	84.23 (101.5/120.5)	72.01 (114.5/159)	68.89 (46.5/67.5)	78.62 (108.5/138)	69.99 (690.5/986.5)
62 Day Target - Screening		85.71 (3/3.5)	100 (4/4)	83.64 (23/27.5)	80.95 (25.5/31.5)	100 (5.5/5.5)	55.56 (2.5/4.5)	93.62 (44/47)	33.33 (2/6)	84.56 (109.5/129.5)
62 Day Target - Upgrade		75 (16.5/22)	100 (10.5/10.5)	33.33 (0.5/1.5)	67.24 (19.5/29)	90.48 (9.5/10.5)	80.85 (19/23.5)	93.33 (14/15)	84 (10.5/12.5)	80.32 (100/124.5)
28 Day Target - 2WW		71.78 (982/1368)	60.3 (609/1000)	79.78 (947/1187)	83.38 (1726/2070)	73.47 (1260/1715)	72.08 (1092/1515)	82.75 (878/1061)	83.28 (1783/1397)	77.87 (9277/11913)
28 Day Target - Breast Symptomatic		0 (0/0)	86.79 (46/53)	100 (36/36)	75.16 (118/157)	66.92 (89/133)	100 (10/10)	98.25 (225/229)	93.3 (209/224)	87.05 (733/842)
28 Day Target - Screening		62.5 (5/8)	44.44 (4/9)	68 (85/125)	82.14 (115/140)	77.19 (44/57)	100 (7/7)	76.34 (142/186)	50 (31/62)	72.9 (433/594)
28 Day Target - Overall		71.73 (987/1376)	62.05 (659/1062)	79.23 (1068/1348)	82.76 (1959/2367)	73.12 (1393/1905)	72.39 (1109/1532)	84.35 (1245/1476)	88.61 (2023/2283)	78.23 (10443/13349)

North Tees and Hartlepool NHS Foundation Trust

Appendix 2

Workforce



North East Region Trusts - Sickness Rates December 2021 (*latest available)

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

North Tees and Hartlepool NHS Foundation Trust is represented by the green column (6.81%). The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column (6.95%).

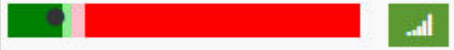
The red line is the average rate for the whole of the NHS in England (6.18%).

The sickness rate for North Tees and Hartlepool is 6.81%, slightly below the regional average of 6.95%.

Gateshead Health NHS Foundation Trust report the lowest sickness absence rate for December 2021 at 6.18%.

Northumberland, Tyne and Wear NHS Foundation Trust report the highest rate at 7.92%.

Standard Indicator Set: Operational Efficiency	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2022)	9.39% (Feb 2021 - Jan 2022)	9.48% (Jan 2021 - Dec 2021)	-0.09 ↓	7.68%	7.66%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2022)	2.27% (Feb 2021 - Jan 2022)	2.35% (Jan 2021 - Dec 2021)	-0.08 ↓	2.33%	2.03%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2022)	5.04% (Feb 2021 - Jan 2022)	5.20% (Jan 2021 - Dec 2021)	-0.16 ↓	4.99%	4.34%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2022)	7.54% (Feb 2021 - Jan 2022)	7.68% (Jan 2021 - Dec 2021)	-0.14 ↓	7.16%	6.17%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2022)	10.53% (Feb 2021 - Jan 2022)	10.70% (Jan 2021 - Dec 2021)	-0.17 ↓	9.79%	8.39%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Apr 2022)	7.59% (Mar 2021 - Feb 2022)	7.45% (Feb 2021 - Jan 2022)	0.14 ↑	8.07%	7.52%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Apr 2022)	2.55 (Mar 2021 - Feb 2022)	2.56 (Feb 2021 - Jan 2022)	-0.01 ↓	2.34	2.19	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Apr 2022)	0.00% (Mar 2021 - Feb 2022)	0.00% (Feb 2021 - Jan 2022)	No Change	9.22%	9.43%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Mar 2022)	91.99% (Feb 2021 - Jan 2022)	92.22% (Jan 2021 - Dec 2021)	-0.23 ↓	79.04%	82.80%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Mar 2022)	96.81% (Feb 2021 - Jan 2022)	96.30% (Jan 2021 - Dec 2021)	0.51 ↑	93.56%	93.66%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Mar 2022)	71.32% (Feb 2021 - Jan 2022)	72.29% (Jan 2021 - Dec 2021)	-0.97 ↓	70.33%	70.00%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Mar 2022)	74.41% (Feb 2021 - Jan 2022)	74.49% (Jan 2021 - Dec 2021)	-0.08 ↓	68.68%	63.10%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Mar 2022)	87.40% (Feb 2021 - Jan 2022)	87.51% (Jan 2021 - Dec 2021)	-0.11 ↓	85.54%	77.74%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Mar 2022)	85.86% (Feb 2021 - Jan 2022)	86.23% (Jan 2021 - Dec 2021)	-0.37 ↓	72.92%	60.12%	
Day case realisation rate (12 mth rolling) HES Inpatients (Apr 2022)	96.71% (Mar 2021 - Feb 2022)	96.70% (Feb 2021 - Jan 2022)	0.01 ↑	96.45%	96.63%	
Day case rate (12 mth rolling) HES Inpatients (Apr 2022)	86.56% (Mar 2021 - Feb 2022)	86.68% (Feb 2021 - Jan 2022)	-0.12 ↓	84.93%	72.88%	

Average excess length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.14 (Mar 2021 - Feb 2022)	0.08 (Feb 2021 - Jan 2022)	0.06 ↑	0.35	0.45	
Average length of stay (12 mth rolling) HES Inpatients (Apr 2022)	3.18 (Mar 2021 - Feb 2022)	3.19 (Feb 2021 - Jan 2022)	-0.01 ↓	3.83	4.50	
Average elective length of stay (12 mth rolling) HES Inpatients (Apr 2022)	1.94 (Mar 2021 - Feb 2022)	1.93 (Feb 2021 - Jan 2022)	0.01 ↑	3.37	4.50	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Apr 2022)	3.30 (Mar 2021 - Feb 2022)	3.31 (Feb 2021 - Jan 2022)	-0.01 ↓	3.89	4.49	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.20 (Mar 2021 - Feb 2022)	0.21 (Feb 2021 - Jan 2022)	-0.01 ↓	0.23	0.24	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.01 (Mar 2021 - Feb 2022)	0.01 (Feb 2021 - Jan 2022)	No Change	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.34 (Mar 2021 - Feb 2022)	0.35 (Feb 2021 - Jan 2022)	-0.01 ↓	0.43	0.47	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.79 (Mar 2021 - Feb 2022)	0.82 (Feb 2021 - Jan 2022)	-0.03 ↓	0.97	0.93	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	0.20 (Mar 2021 - Feb 2022)	0.20 (Feb 2021 - Jan 2022)	No Change	0.31	0.26	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2022)	1.22 (Mar 2021 - Feb 2022)	1.27 (Feb 2021 - Jan 2022)	-0.05 ↓	1.60	1.68	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Apr 2022)	36.56% (Mar 2021 - Feb 2022)	36.52% (Feb 2021 - Jan 2022)	0.04 ↑	39.31%	34.53%	
Elective stranded rate (12 mth rolling) HES Inpatients (Apr 2022)	5.15% (Mar 2021 - Feb 2022)	5.23% (Feb 2021 - Jan 2022)	-0.08 ↓	11.38%	12.34%	
Emergency stranded rate (12 mth rolling) HES Inpatients (Apr 2022)	16.37% (Mar 2021 - Feb 2022)	16.55% (Feb 2021 - Jan 2022)	-0.18 ↓	17.64%	20.76%	
Elective super-stranded rate (12 mth rolling) HES Inpatients (Apr 2022)	0.54% (Mar 2021 - Feb 2022)	0.54% (Feb 2021 - Jan 2022)	No Change	2.13%	3.12%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Apr 2022)	90.66% (Mar 2021 - Feb 2022)	92.15% (Feb 2021 - Jan 2022)	-1.49 ↓	74.33%	78.29%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Apr 2022)	0.17% (Mar 2021 - Feb 2022)	0.18% (Feb 2021 - Jan 2022)	-0.01 ↓	0.81%	0.93%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Apr 2022)	78.95 (Mar 2021 - Feb 2022)	78.27 (Feb 2021 - Jan 2022)	0.68 ↑	99.09	99.83	

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Meeting of the Board of Directors

Date:	8 June 2022								
Prepared by:	Hilton Heslop, Associate Director of Corporate Affairs & Strategy								
Executive Sponsor:	Julie Gillon, Chief Executive								
Purpose of the report	The purpose of the report is to provide the Board of Directors with an overview of the Annual Reporting process for 2021/22.								
Action required:	Approve	X	Assurance	X	Discuss	X	Information	X	
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X	
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

The process for the completion and submission of the Trust's Annual Report for 2021/22 was discussed and presented to the Board of Directors at the Board seminar on 12 May 2022.

The attached draft Annual Report has been subject to contributions from across the organisation and incorporates the Annual Accounts to the rear of the report at section 6.

The draft report has been reviewed by the Trust's external auditors (Deloitte) and the comments received are in the process of being actioned and will culminate in a final audit opinion and sign-off from external auditors via the Audit Committee.

All statutory elements and sections to the Annual Report are now complete with only some non-statutory content still to update.

The attached draft report will be subject to further updates and presentational styling during the first two weeks of June prior to the final submission to NHS Improvement on 22 June.

The Annual Report, Audited Accounts and Financial Performance must be uploaded to the NHS Improvement portal by 22 June 2022 before a full and finalised annual report and full statutory audited accounts is submitted to Parliament in July 2022 (date TBC).

How this report impacts on current risks or highlights new risks:
There are no risks associated with the recommendation in this report

Committees/groups where this item has been discussed	None at this stage

Recommendation	The Board of Directors is asked to note the content of the report (acknowledging that changes will continue to be made to content that is non-statutory(and approve the document for submission to NHSE Imprrovement pending external and internal Audit approval;

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

	Nursing and Midwifery Workforce Report										
Date:	8 June 2022										
Prepared by:	Emma Roberts, Interim Head of Professional Workforce										
Executive sponsor:	Lindsey Robertson, Chief Nurse/Director of Nursing, Patient Safety and Quality										
Purpose of the report	This report provides the Trust Board with an overview of the Nursing and Maternity staffing status and linked quality metrics for the period March and April 2022. The report is set out in line with the National Quality Board (2016) safe staffing guidance and expectations to provide assurance that arrangements are in place to safely staff our services with the right number of nurses and midwives with the right skills at the right time and provides an explanation about how this was achieved.										
Action required:	Approve		Assurance	x	Discuss	x	Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing our People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

This report provides a position and overview of RN, RM and Care workforce during February and March 2022.

The information within the report provides assurance that arrangements are in place to ensure safe staffing across services; staff who have the right skills deployed at the right time safely across the organisation and provides and explanation about how this was achieved. Where concerns are identified, processes are in place to ensure appropriate escalation.

Three areas have been included as requiring revised establishments which are being addressed through business planning with robust mitigation in place in the interim.

Maternity workforce reviews are now in place and included in daily process with escalation to ensure safe maternity services. Three yearly Birthrate plus review has commenced with a three month data collection to ensure establishment meet demand.

The CHPPD required versus actual for February and March 22 identifies a reducing deficit however, the associated processes and quality metrics demonstrate safe care provided. During Covid workforce pressures the Trust has supported innovative roles such as the Team Support Worker, now a rolling six-month recruitment as part of widening access supporting RN and RM's to release time to care.

However, it is recognised that maintaining safe staffing and safe care is not achieved easily; redeployment of workforce out with their substantive areas is not a position that the Trust wants to sustain. The strategy outlined supports a decreasing vacancy position over the next nine months

with the recruitment of sixty international nurses in addition to domestic recruitment from both apprenticeship pipelines and students due to graduate this year.

Workforce reviews completed bi-annually include all professional groups across the organisation with a focus on skill mix across multidisciplinary professions and advancing practice roles to ensure that the workforce evolves, as patient needs change.

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

- 1A – Patient Safety – moderate – no change
- 1B – Patient Experience – low – review or risk rating
- 2A – Valuing our people – moderate – no change

Committees/groups where this item has been discussed	Patient Safety & Quality Standard Committee
Recommendation	The Trust Board are asked to note the significant work to ensure safe staffing during February and March 2022 and the ongoing work to reduce vacancies across RN's and RM's and the care workforce.

North Tees & Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

Nursing and Midwifery Workforce Report

8 June 2022

1. Introduction

1.1 This report provides the Trust Board with an overview of the Nursing and Maternity staffing status and linked quality metrics for the period March and April 2022. The report is set out in line with the National Quality Board (2016) safe staffing guidance and expectations to provide assurance that arrangements are in place to safely staff our services with the right number of nurses and midwives with the right skills at the right time and provides an explanation about how this was achieved.

2. Background

2.1 North Tees and Hartlepool NHS Trust has a duty to ensure staffing levels are adequate so that our patients are cared for by appropriately registered and experienced staff in safe environments. This right is enshrined within the NHS constitution (2015) and Health Act (2009) which make explicit the Board's corporate accountability for quality. Demonstrating sufficient staffing is one of the quality and safety standards as set out in 'Hard Truths' (2014) a publication from the Care Quality Commission (CQC).

2.2 In its guidance the NQB (2016), sets out a series of expectations and a framework within which organisations and staff should make decisions about safe staffing and emphasises the requirement for NHS provider Boards to be accountable for ensuring that their organisation has the right skills in place for safe, sustainable and productive staffing. The key expectations are set out below:

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.3 This report covers period February and March 2022 following the professional bi-annual review presented at Board in Public Committee in January 2022, with in-patient data published via an upload to Unify each month and now includes Care Hours Per Day (CHPPD) data.

2.5 In line with the most recent NQB guidance in relation to CHPPD, the Trust has not identified any clinical inpatient teams where Allied Health Professionals should be included in the planned staffing levels, the criteria being that they are permanently part of the ward roster. This position is reviewed at the safe staffing meetings and will be amended should models of service delivery change.

3. Trust Safe Staffing - Strengthening the escalation and reporting of safety and quality concerns

3.1 Safe Staffing meetings have continued throughout the pandemic as a core function to ensure safe staffing. They have been a critical component of our continued response to the Covid-19 pandemic. The safe staffing meetings enable our Ward, Service Leaders and Matrons to escalate their successes and challenges to the Chief Nurse or Deputy Chief Nurse and Chief Operating Officer.

3.2 In this reporting period the Trust wide safe staffing escalation plans have been refreshed collaboratively with the Heads of Nursing and a specific escalation plan for the Emergency Assessment Unit and the Emergency Department has also been developed to further support clear decision making associated with these areas in the event of safe staffing not being achieved.

3.3 Safe Staffing meetings are held twice daily, seven days per week (Monday-Sunday, 9am and 3:30pm). The chair of each meeting is a Senior Clinical Matron (SCM). The focus of the meeting includes:

- Review of the planned and actual Nursing and Maternity staffing levels across all adult and Paediatric in-patient areas, Maternity and the Emergency Department / Urgent Care Centres.
- Review of the acuity and dependency levels of patients across all areas
- Review of highlighted staff/skills gaps and associated over-utilisation of staffing hours
- Overlay of professional judgement to clearly balance data and patient and staff safety
- Identification of redeployment opportunities of staff with appropriate skills to mitigate risk where highlighted

3.4 Within the reporting period, particular attention focused on the recovery of services and to the well-being of our teams. Executive Team agreed a business case, which supported the immediate pressures presenting in the Theatre workforce to ensure compliance with elective recovery trajectories in the short term; a full Theatre workforce strategy developed, supported by both domestic and international recruitment.

4. Registered nurse (RN), registered midwife (RM) & Health Care Support Worker recruitment trajectory

4.1 Vacancy Position

4.2 The Trust wide registered nurse (RN) vacancy position for March 2022 is **84.9wte (6.24%)** a **reduction** from **87.9wte (6.46%)** in February 2022.

4.3 The Trust wide forecasted registered nurse vacancy position for April 2022 is **76.65wte (5.56%)**. This includes all vacancies across Community services and Theatres registered nursing; this forecast includes recent RN recruitment in March 2022.

4.4 Additional registered nurse recruitment of 2wte took place in April 2022 with a further 6wte registered nurses planned for interview 31 May 2022.

4.5 Registered maternity vacancy remains static at 12.10wte with planned recruitment of 5wte student midwives later this year. A bespoke advert for midwifery has been refreshed and advertised externally to attract registered midwives (RMs) from outside the Trust in addition to pre-registered Midwives. Senior Midwives also attend the safe staffing meetings and present their acuity levels and safe staffing plans.

4.6 The unregistered nurse vacancy continues to **reduce month on month.** Monthly recruitment centres are in place across the year. The vacancy has reduced from 11.83wte (1.88%) in Feb22 to 1.83wte (0.29%). A further twenty-four applicants have been invited to the next centre and if the majority of these applicants are appointable, the Trust will be in position to recruit to turnover in multiple areas in all identified areas.

5. Absence due to sickness and paternity leave

5.1 In March 2022, non-Covid sickness absence increased to 5.60% (5.15% in February 2022), there has been an increase in Covid sickness to 1.29% (1.15% in February 2022) with a decrease in Covid isolation from 0.18% in February 2022 (0.16% in March 2022).

5.2 Total maternity leave for March 2022 was 2.88% across registered and unregistered nursing and midwifery staff (N&M). This is a decrease from 3.02% in February 2022. Currently the agreed and set headroom for N&M roles does not allow absence cover for maternity/paternity leave.

6. Turnover

6.1 Registered nurse turnover for March 2022 was 1.24% (16.8wte); an increase from 0.54% (7.3wte) in February 2022, all N&M turnover is presented in table 1 below.

March 2022	Staff Monthly WTE Turnover % of budgeted establishment	
Registered Nursing	1.24% (16.8wte)	(Feb22 - 0.54%, 7.3wte)
Unregistered Nursing Support	1.24% (7.78wte)	(Feb22 - 0.62%, 3.89wte)
Registered Midwives	0.89% (1.12wte)	(Feb22 - 0.56%, 0.7wte)
Unregistered Maternity Nursing Support	0.00% (0.0wte)	(Feb22 - 1.35%, 0.14wte)

7. Fill rates

7.1 Registered nurse fill rate remains a challenge however does show an increase from 46.1wte in February 22 to 58.5wte in March 2022. Unregistered nurse fill rate has also increased slightly from 120.4wte in February 22 to 132.2wte in March 2022

7.2 A core part of the professional workforce strategy is the recruitment process for registered nurses; which has been revised to replace generic advertising with bespoke adverts for all specialties. Applicants are shortlisted and interviewed by specialty leads and applicants who are not successful at interview for a specific specialty but are appointable move to a 'successful candidate pool' and offered an alternative vacancy of their choice. In partnership with our Communications team, a recruitment communication strategy is now in place ensuring that adverts are available across all social media platforms for the public to view. A successful open day and careers fair was held at North Tees on the 19 May 2022 to engage our community and to show case the different opportunities and routes into care.

7.3 Initiatives for 'on boarding' are in line with the workforce strategy and more recently, the 'postcard' initiative launched by the Chief Nurse to engage and welcome our expected workforce throughout the recruitment and the pre-employment checking period.

7.4 Registered Nurse and Midwife recruitment is a national issue and recognised that domestic recruitment alone will not, in the short term, resolve the gap in nursing vacancies. In support, in January this year the Trust committed to international recruitment for the first time in four years. So far, 43 nurses from India and the Philippines have been offered positions following successful interview; with further interviews planned. The plan is to over recruit to nursing vacancies of up to 60wte nurses to be deployed to the UK as part of three cohorts. The first cohort of 20 nurses are planned to arrive into the UK on the 8 June 2022 and their education programme is being finalised in preparation for their OSCE scheduled for August 2022.

7.5 To support their learning and preparation for OSCE, a comprehensive programme of education has been developed which includes attendance at a structured OSCE 'boot camp' for five days in Milton Keynes. The programme will provide the nurses with the necessary clinical skills and education to successfully pass their OSCE and subsequently gain their Nursing Midwifery Council registration, allowing them to safely practice in the UK as a registered nurse.

7.6 The Trust is fully engaged in the development of evidence based alternative workforce models and in support has continued to fund an Allied Health Professional Workforce Lead. This role is supporting a collaborative approach to skills development aligned to care needs and an initial scoping session took place in February 2022 where significant collaborative work between Nursing, Therapy and Education teams produced the first draft of a road map, identifying all possible routes into care within the trust. Further work has been identified to formally present the road map and outline the associated next steps. In addition, an evaluation of Ward 40 and Ward 42 model is currently underway whereby previous skills matrix work is being refreshed with Ward Matrons, Heads of Nursing, Therapy Leads and Care Group Managers. A pilot is taking place on Ward 24 which supports the introduction of respiratory physiotherapists and extended scope such as medication rounds and being integrated into the management structure of the ward. The physiotherapist is not included in the care hours available until the completion of the pilot.

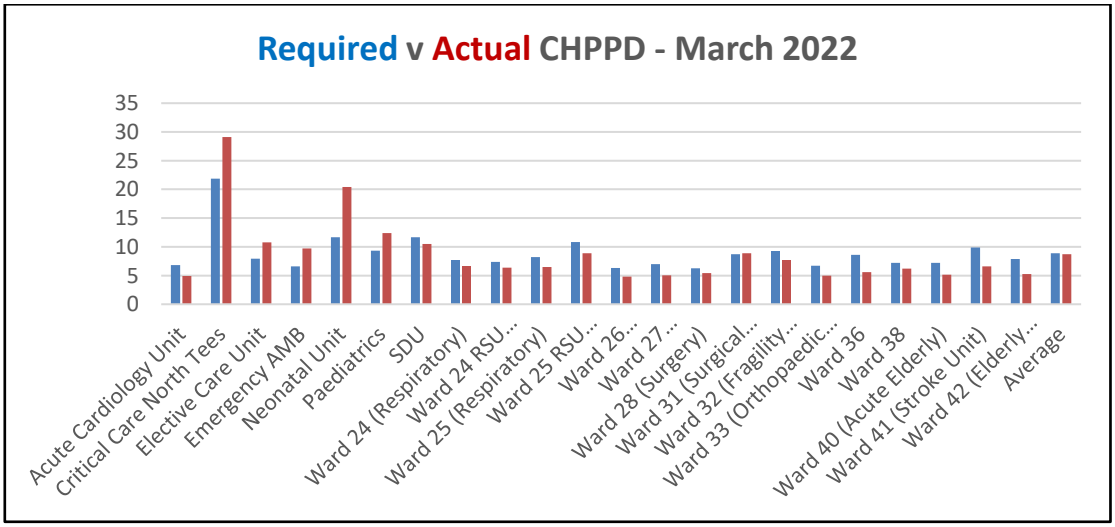
8. Care hours per patient day (CHPPD)

8.1 Safe nurse staffing is based on patient acuity and dependency data and the required decision making process is managed via the trust wide staffing meetings as outlined in section (). The senior nursing and midwifery team assure safe and efficient staffing levels are in place by triangulating acuity and dependency, staffing levels and professional judgement. The required vs. actual CHPPD in all inpatient areas including variance for March 2022 presented in Table 2**.**

Table 2

Required CHPPD – Mar22	Actual CHPPD – Mar22	CHPPD Variance – Mar22
8.85	8.71	-0.14 (reduction from -0.52 in Feb22)

8.2 Overall, the aggregated position of required care hours per patient per day was more than was available in March 2022 at -0.14 although a significant reduction from February at -0.52. The chart below depicts the Ward or department required and actual CHPPD for March 2022:



9. Assuring safe services

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

9.2 Red Flags, in addition to shortfalls in workforce, include quality indicators:

- Delay in Pain relief (n=1)
- Missed intentional rounding (n=3)
- Vital signs not assessed or recorded (n=1)

9.3 For the last quarter of 2021/22 there were 4 out of 59 flags where staff were concerned about care delivery. All areas of concern were reviewed and confirmed no harm had occurred despite the pressures on the team.

9.4 However, it is recognised that this is a retrospective process and therefore in this reporting period, we have introduced **RESET**, an approach to assure quality and safety standards are maintained when nurse-staffing levels drop below the required hours based on patient acuity and dependency.

9.5 This information is included as part of the twice daily staffing meetings. Where agreed compliance is not achieved, the Senior Clinical Matron will undertake a professional discussion with the relevant Matron or Nurse in charge and if there are concerns, regarding the gap in nurse staffing then a RESET visit will take place within 60 minutes. This will provide an independent assessment of quality and safety metrics across the fundamental domains including:

- **Response:** 15 Steps; first impressions (environment, phones ringing, staff visibility, review of occupancy, acuity, dependency and staff morale; including enhanced care;
- **Establishment:** safe care hours, % reduction in required establishment, redeployment already, skill mix/temporary staff, alternative workforce; red flags;
- **Safe:** Medication delays, patient buzzer response times, intentional rounding, N&H, staff breaks, Infection Prevention Control, falls and appropriate response to escalation of deteriorating patients; Datix submission; complaints;
- **Effectiveness:** Risk assessment and Documentation; timeliness of escalation in rota gaps; agency escalation;
- **Team:** Team agreement, a discussion (SCM/Nurse in charge) and agreed actions (escalation, redeployment) and outcome of decisions to be documented in safe care as part of professional judgement and within staffing escalation meeting notes, timescale for review (if required)

9.6 The outcome of all initiated RESET interventions are escalated to the Chief Nurse. Significantly, there have not been any escalations since the pilot commenced at the beginning of May 2022. This initiative is in its infancy and will be fully evaluated in time for the next Annual professional workforce review

9.7 <u>Areas of focus risk and mitigation</u>

In the last professional workforce reviews submitted to the Board in January 2022, three areas were identified as having an establishment below expected workforce based upon acuity and dependency. Those areas identified as part of Responsive Care. The table below identifies the establishment shortfall and the immediate to longer term plan to ensure safe staffing which the Chief Nurse oversees.

Area	Risk	Mitigation
Ward 36	Validated staffing under-establishment (13wte total workforce) 4wte existing RN vacancies based on current establishment	Immediate mitigation includes: • Daily safe staffing meetings to ensure that staff are deployed to this area with the right skills when required to maintain safe staffing levels in line with patient acuity and dependency levels; • Additional roles supporting clinical needs of patients including specialist nurses, static Nurse Practitioner, and critical care outreach team; • Recruitment to turnover of HCA • Ward specialty/patient criteria review • Business case development within Care Group Business Planning cycle.
EAU	19wte RN vacancies March 2022	• Daily safe staffing meetings ensure that staff are deployed to this area with the right skills when required to maintain safe staffing levels in line with patient acuity and dependency levels. • Additional Band 7 redeployed to support leadership; • Recruitment to turnover of HCA; • Block booking (3) agency nurses continues; • Communications strategy in place to support bespoke recruitment process; • Planned allocation of a cohort of 8wte international nurses to be deployed into this area with dedicated practice teacher support.
Ward 26	9.2wte RN vacancies at the end Feb22	• Daily safe staffing meetings ensure that staff are deployed to this area with the right skills when required to maintain safe staffing levels in line with patient acuity and dependency levels. • Review of Transfer window – timescales; • Communications strategy in place to support bespoke recruitment process

10. Nursing and Midwifery Establishment Setting

10.1 The Safer Nursing Care Tool (SNCT) 21 day data collection was completed in October 21. Data analysis and associated recommendations for the uplift of establishments have been presented in the bi-annual workforce review and agreed actions relating to this are being progressed.

10.2 The Emergency Department SNCT has now been received into the Trust and the first cycle of data collection has taken place. Formal training with NHSEI and senior leader within ED took place on 5 May 2022 with further study dates planned.

10.3 The Community Nursing Safe Staffing Tool (CNSST) was received in December 21 and beta testing of the tool was completed. Outputs from have now been returned to NHSEI for analysis.

10.4 Maternity are scheduled to have their three-year establishment review using the Birthrate plus (nationally recommended) tool in June 2022. Data collection is planned for the next 3 months.

10.5 The next bi- annual workforce establishment review (Nursing and Midwifery) is planned between June – September 2022 with initial SNCT data collection scheduled for the first three weeks of June 2022.

11. Conclusion

11.1 This report provides a position and overview of RN, RM and Care workforce during February and March 2022.

11.2 The information within the report provides assurance that arrangements are in place to ensure safe staffing across services; staff who have the right skills deployed at the right time safely across the organisation and provides and explanation about how this was achieved. Where concerns are identified, processes are in place to ensure appropriate escalation.

11.3 Three areas have been included as requiring revised establishments which are being addressed though business planning with robust mitigation in place in the interim.

11.4 Maternity workforce reviews are now in place and included in daily process with escalation to ensure safe maternity services. Three yearly Birthrate plus review has commenced with a three month data collection to ensure establishment meet demand.

11.5 The CHPPD required versus actual for February and March 22 identifies a reducing deficit however, the associated processes and quality metrics demonstrate safe care provided. During Covid workforce pressures the Trust has supported innovative roles such as the Team Support Worker, now a rolling six-month recruitment as part of widening access supporting RN and RM's to release time to care.

11.6 However, it is recognised that maintaining safe staffing and safe care is not achieved easily; redeployment of workforce out with their substantive areas is not a position that the Trust wants to sustain. The strategy outlined supports a decreasing vacancy position over the next nine months with the recruitment of sixty international nurses in addition to domestic recruitment from both apprenticeship pipelines and students due to graduate this year.

11.7 Workforce reviews completed bi-annually include all professional groups across the organisation with a focus on skill mix across multidisciplinary professions and advancing practice roles to ensure that the workforce evolves, as patient needs change.

12. Key Priorities and next steps

- Overlay patient safety and quality metrics into the dashboard to present potential correlations between vacancy levels and patient outcomes and allow appropriate and timely intervention
- Maintain trajectory of domestic and international recruitment as planned
- Prioritise the advertising and recruitment strategy across all areas
- Recruitment of a third cohort of Team Support Workers.
- Continue to prioritise advertising and associated recruitment strategy for four key areas based on current vacancies – EAU, Ward 26, Ward 36 and Maternity.
- Review the establishments in areas where there are validated under establishments >5wte with the initial priority being ward 36.
- Continue collaborative work with Wards 40 and 42, these are areas with higher dependency rather than clinical acuity. Current workforce models are being reviewed within the alternative workforce strategic action group.

13. Assurance and Recommendations

The Trust Board are asked to note the significant work to ensure safe staffing during February and March 2022 and the ongoing work to reduce vacancies across RN's and RM's.

Author
Emma Roberts, Interim Head of Professional Workforce

Sponsor
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	NHS Improvement Annual Self Certifications										
Date:	8 June 2022										
Prepared by:	Neil Atkinson, Director of Finance Linda Hunter, Interim Director of Planning and Performance Hilton Heslop, Associate Director of Corporate Affairs and Strategy										
Executive Sponsor:	Linda Hunter, Interim Director of Planning and Performance										
Purpose of the report	In line with NHS Improvement Annual Planning requirements and Licence conditions, NHS Foundation Trusts and NHS Trusts are required to complete annual self-certifications of compliance against a number of governance requirements. This summary report provides an overview of the requirements and the Trust's position against each declaration.										
Action required:	Approve	x	Assurance	x	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	x	

NHS Foundation Trusts are required to make the following declarations to NHS Improvement;

- Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence requires the Board to review and declare that, in the financial year most recently ended, the Trust (Licensee) took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution (Appendix 1, section 1&2)
- Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence requires that the Board have a reasonable expectation that the Trust (Licensee) will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to within the declaration, 2021/22 (Appendix 1, section 3)
- Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act requires the Board to review and declare compliance that it is satisfied that during the financial year most recently ended, 2021/22, that the Trust (Licensee) has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role (Appendix 2)
- Corporate Governance Statement requires the Board to review and declare that it is satisfied that the Trust (Licensee) applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Corporate Governance Statement requires evidence of compliance against a number of key criteria, to support assurance of self-certification (Appendix 3 FT4 declaration)

The Board received an overview of the Trust's Annual Priorities and Planning Programme at the April Board of Directors meeting, outlining the key requirements within the NHSE/I '2022/23 Priorities and Operational Planning guidance', the Trust's position against these requirements and future plans to meet any outstanding gaps. The 2022/23 planning requirements include:

- Investing in the workforce and strengthening a compassionate and inclusive culture
- Delivering the NHS COVID-19 - vaccination programme and meeting the needs of patients with COVID-19
- Tackling the elective backlog, reduce long waits, improve performance (Referral to Treatment (RTT), cancer, diagnostics)
- Improving the responsiveness of urgent and emergency care and community care capacity (including creasing additional beds, virtual ward models), eliminate 12-hour waits in ED, minimise ambulance handover delays
- Improving timely access to primary care
- Improving mental health services and services for people with a learning disability and/or autistic people
- Developing approach to population health management, prevent ill-health, and address health inequalities
- Exploiting the potential of digital technologies
- Moving back to and beyond pre-pandemic levels of productivity
- Establishing ICBs and enabling collaborative system working

The Trust Final Annual Operating Plan was submitted on 14 April 2022 and included further iterations beyond this date.

Due consideration has been given against each of the Self-Certifications, based on the 2021/22 performance and the forecast pressures for 2022/23, taking into account the on-going operational pressures, however alongside the mitigating actions that have been put in place to improve the position in 2021/22.

The individual Self Certifications have been completed, providing evidence of assurance where necessary, with the aim to declare compliance against each of the declarations for the periods of 2021/22 and 2022/23, as applicable.

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

One of the key areas highlighted at risk within the Annual Operating Plan for 2022/23 includes the consistent delivery of the Cancer 62-day referral to treatment access standard, due to the impact of COVID-19 and the continuous impact of increased referrals, patient choice, complexity of pathways and system pressures including onward pathway referral for specialist care and tertiary centre capacity which are outside the organisation's control, however recognising the robust governance structure the Trust has in place to monitor and manage pathways.

The impact of the COVID-19 pandemic continued into 2021/22 and is recognised as a key risk to on-going delivery of both non-elective and elective pathway delivery. The Trust has developed detailed plans to mitigate the risks and deliver recovery in line with the Annual Operating Planning requirements, to ensure sustainable delivery of the Trust's services. However, the significant impact of Covid-19 has affected the continued performance against key access standards in 2021/22 with a major effort in improvement in systems and processes, culture, ownership and collaboration.

The Trust commenced work across the Integrated Care Partnership (ICP)/Integrated Care System (ICS) to address both recovery and overall performance delivery as a system, working collaboratively to address the capacity issues compounded by the backlog associated with the Covid pressure. For 2021/22 the Trust was successful in achieving against its elective recovery trajectories; one of only two Trusts in the NENC region with no patients exceeding 78 weeks.

Interim financial management arrangements were implemented during 2020/21, these arrangements (system envelopes) continued for the first six months (H1) of 2021/22 following which distribution of H2 allocations were agreed for the Tees Valley system. The Trust delivered over and above requirements reporting a surplus position for 2021/22 and as a consequence, made a significant contribution to the financial position across both the ICP and ICS. The system

financial envelope has been set at an ICS level for 2022/23 and allocated to the four organisations within the ICP with the Trust planning a deficit position for 2022/23 with the main drivers being utility spend and inflation costs/cost of living increase. Good control and mitigation in operational financial management and good grip in corporate financial management is therefore essential.

Governance, mitigatory actions and assurance processes have been appropriately escalated within the Board Assurance Framework.

The Trust faced a number of challenges in the latter quarter of 2021/22 due to the resignation of a number of Non-Executive Directors. The Trust proactively met the statutory duties to transact business, and the Board Committee structure was adequately chaired with due diligence and oversight in relation to Non-Executive Director representation. In responding in a fast paced manner, to ensure appropriate interim appointments with proposals to appoint permanently to be implemented in 2022/23.

The Trust remains in segment 2 of the Provider SOF, during 2021/22 it was not subject to any enforcement undertakings or action. In February 2022 NHS England / NHS Improvement advised the Trust that it would be undertaking an independent review on two licence conditions in relation to governance and leadership with specific reference to the unitary Board position. The investigation was concluded in two weeks the Trust is awaiting the outcome, following which any recommendations/areas of learning will be addressed accordingly.

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is asked to note: • due diligence has been paid by the Board of Directors in assessing on-going compliance with governance requirements, specifically those illustrated in regular seminars and committee discussion, in line with the NHS Provider Licence Conditions; and • the requirement for the Board of Directors to delegate responsibility to the Chair and Chief Executive to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board.

Appendix 1

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2021-22

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Board of Directors has identified key risks to financial, clinical and operational sustainability. The Board has declared concerns with regards to the consistent delivery of the 62 day cancer referral to treatment access standard, due to the impact of Covid-19, continuous impact of patient choice, complexity of pathways and system wide pressures and challenges outwith its influence and control.

The Covid-19 pandemic is recognised as a key risk to on-going delivery of both non elective and elective pathway delivery. The Trust has developed and implemented detailed plans to mitigate the risks and deliver recovery in line with the Annual Operating Planning requirements, to ensure sustainable delivery of the Trust's services. However, the significant impact of Covid-19 has affected the continued performance against key access standards in 2021/22.

The Trust commenced work across the Integrated Care Partnership (ICP)/Integrated Care System (ICS) to address both recovery and overall performance delivery as a system, working collaboratively to address the capacity issues compounded by the backlog associated with the Covid pressure. For 2021/22 the Trust was successful in achieving against its elective recovery trajectories.

Interim financial management arrangements were implemented during 2020/21, these arrangements which comprised system envelopes, continued throughout 2021/22. During 2021/22, the Trust set a breakeven plan and delivered an operating surplus of £12.5m and as a consequence, made a significant contribution to the financial position across both the ICP and ICS.

The system financial envelope has been set at an ICB level over the full 12 month period for 2022/23 (circa £5.8bn). The expectation from NHSE/I is delivery of financial balance at an ICB level over the 12 month period. The ICB financial allocation has largely been disaggregated to ICPs using the same methodology as the ICB allocation was calculated.

Each ICP baseline is based on allocations for the last six months of the 2021/22 financial year and then in effect doubled to reflect a full year allocation. Added to these are the set amounts of generic growth for the NE&NC ICB which varies across the country depending on a national allocation formula and then evenly shared across the respective ICBs. The 2022/23 South ICP system envelope funding is £1.24bn (excluding funding for Health Inequalities, SDF and ERF).

As per the process in 2021/22, by mutual agreement and on a net neutral basis, organisations are able to amend their positions, to reflect an alternative distribution of current resources and the impact of new resources, pressures and policy priorities.

Given that the majority of the system funding has been identified at an individual organisational level, this has become the default position for the allocation of funding.

Like most health economies, significant financial challenges are faced by the local NHS. The Commissioner and Trusts within the ICP have agreed to work closely to identify system solutions that will enable both provider and commissioner to meet their financial obligations for 2022/23. The Trust is confident that it can support the system in this manner and continue to subscribe to its financial plan for 2022/23.

The plan for 2022/23 requires the Trust to deliver a deficit plan of £1.4m, which requires the Trust to deliver a CIP requirement of £9.3m (approx. 2.5% of turnover).

Strategic financial risks have been reported to the Finance Committee on a monthly basis during 2021/22 along with the associated mitigating actions.

The five strategic risks are identified below and will be reconsidered as part of a refreshed BAF for 2022/23.
• Wider Health Economy Issues (ICP/ICS);
• Contract Performance (operating under block arrangements);
• Cost containment (control total);
• Delivery of savings (CIP), and;
• Trust subsidiaries (operation and separate legal entities)

Key areas to be reflected in the refreshed BAF relate to system funding arrangements and the significant risk associated with delivery of CIP. In summary,
governance, mitigatory actions and assurance processes have been appropriately escalated within the Board Assurance Framework.

The Board of Directors is aware of internal and external risks which pose a threat to quality, service performance and financial balance, within the agreed NHS Improvement plan, and whilst mitigation is in place supported by enhanced accountability and governance frameworks, will continue to assess service delivery options and radical efficiency gains to mitigate and maintain assurance.

The Trust remains in segment 2 of the Provider SOF, during 2021/22 it was not subject to any enforcement undertakings or action. However, in February 2022 NHS England / NHS Improvement advised the Trust that it would be undertaking an independent review on two licence conditions which had potentially been breached in relation to governance and leadership. This review has been concluded and the Trust is awaiting the outcome, following which any recommendations/areas of learning will be addressed accordingly.

Signature		**Signature**	
Name	Derek Bell	**Name**	Julie Gillon
Capacity	Joint Chair	**Capacity**	Chief Executive
Date	08 June 2022	**Date**	08 June 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Appendix 2

Worksheet "Training of governors"

Financial Year to which self-certification relates 2021-22 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		Signature	
Name	Derek Bell	Name	Julie Gillon
Capacity	Joint Chair	Capacity	Chief Executive
Date	08 June 2022	Date	08 June 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Appendix 3

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2021-22**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board of Directors certifies on-going compliance with the governance condition, via the Corporate Governance Statement, using performance against governance indicators, financial performance, exception reports and third party information to test the certification. The Board of Directors effectively planned and assessed risks with the continued risk of underachievement against the 62 day referral to treatment cancer standard, linked to the on-going impact of the Covid Pandemic. The Trust has recognised the consistent delivery of cancer standards continues to present a risk and as such has declared this within the Annual Plan for 2022/23. The Trust is focussed on the recovery of activity across both elective and non-elective pathways, post the impact of the Covid pandemic and is working to reduce and eliminate long waiters. In the planning submission for 2021/22 forecasting a position of no patient waiting over 52 weeks by the end of March, and although significant work was undertaken this was not achieved. The determination continues with the plan for 2022/23 to achieve this position by September 2022. The Trust is fully engaged in system working, with significant input into the development and delivery of the ICS Annual Operating Plan for 2021/22 and 2022/23. Post the Covid pandemic, the Trust has developed robust recovery plans to ensure both elective and non elective pathways are delivered, taking into account the wider system pressures and the need to support equitable access to services for the local population, recognising the impact of the high levels of deprivation across the locality. The Trust continues to work closely with partners across the ICP and ICS (as well as, representatives from NHSE/I), to ensure continued delivery of robust financial plans and was successful in achieving a surplus position at the end of 2021/22. Delivery of financial plans will continue to be given appropriate scrutiny and oversight by the Board. The plan currently contains risk associated with the delivery of CIP, and the plan is aligned with system envelope assumptions.. In order to address the system risk, the Trust, and its partners have agreed to work collaboratively to address these financial pressures and will work closely to identify system solutions that will enable both provider and commissioner to meet their financial obligations for 2022/23. This demonstrates the commitment of the Trust to work collaboratively within the Integrated Care Partnership and support the wider system returning to financial balance.
			The Board of Directors gains assurance from a number of sources and assurance mechanisms as follows: Internal and external audit plans which cover a full range of audits; Annual Governance Statement; Head of Internal Audit Opinion; Integrated performance report to the Board of Directors covering quality, performance, workforce and finance; Board Assurance Framework reported quarterly to the Board of Directors' Risk Management Strategy.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust remains in segment 2 of the Provider SOF, during 2021/22 it was not subject to any enforcement undertakings or action. In February 2022 NHS England / NHS Improvement advised the Trust that it would be undertaking an independent review on two licence conditions in relation to governance and leadership with specific reference to the unitary Board position. The investigation was concluded in two weeks the Trust is awaiting the outcome, following which any recommendations/areas of learning will be addressed accordingly
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a robust governance structure with a locally agreed committee structure under the Board of Directors which are over and above those required in statute. This ensures that members of the Board are more closely involved in the governance of the organisation and are closer to assurance on the quality of services (clinical and non-clinical). Each committee has terms of reference which clearly articulate the purpose, responsibilities, accountabilities, reporting lines and delegated authority they have been given by the Board to carry out work on its behalf. Minutes of the individual sub-committees are reviewed within the Board of Directors meeting. The Board agenda focuses on the key areas of quality, strategy, performance and governance; reports, along with minutes of committee meetings are presented on a regular basis. The terms of reference are reviewed on a regular basis to ensure effectiveness and this will continue in 2022/23. Significant work has been undertaken during 2021/22, which will continue in 2022/23, in order to create the capacity, capability and leadership required to fulfil the future ambitions of the organisation through the Care Group Operating Model, with robust support from corporate services and functions. This will make the Trust sustainable and an enabler to drive the vision, deliver the strategy and the Long Term Plan. A number of documents outline the accountabilities, responsibilities and reporting lines including: Well led external review with on-going internal self-assessment CQC Inspection reports The Trust's Constitution Standing Financial Instructions Scheme of Delegation Sub-Committee terms of reference Accountability structures Third Party/Regulatory visits Patient and staff feedback Complaints and Incident Analysis
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Although COVID-19 has continued to impact during the year the Trust has continued to ensure robust governance in respect to financial decision-making in order to support the management, grip and control of expenditure, this will continue in 2022/23. The Trust was placed into segment 3 within the Single Oversight Framework risk assessment in 2018, with enforcement actions in place aligned to the Trust's financial deficit position and strategy. The Trust has remained in segment 2 during 2021/22 demonstrating a sustained position. In 2021/22 the Trust reported a £12.5m surplus which was significantly ahead of plan for the year end, as well as making a significant contribution to the ICP/ICS . The delivery of the continued improved financial position is due in part to the robust Financial Management Performance Framework and Capital Performance Framework, that has operated during 2021/22 which has maintained 'grip and control' over the financial position. The Trust has engaged effectively with NHS Improvement during 2021/22. The Board has timely and effective oversight receiving monthly/quarterly reports via the Integrated Performance Report which was reviewed and redesigned in 2021/22 to adopt an integrated approach across Compliance, Quality, Workforce and Finance, reflecting the NHSI Single Oversight Framework, Lord Carter Model Hospital review, contract metrics, and internal reporting requirements, together with key objectives. Due consideration is given to both positive and negative variances and progress against monthly, annual and in year improvement targets. The revised report has been developed in Yellowfin and provides detailed trend analysis, presented in SPC format, with additional commentary provided within the report outlining supporting underlying narrative of the Trust's position. The Board is also provided with sufficient information in respect to the Single Oversight Framework and the Trust position in relation to segmentation and use of resources. The Trust has a robust Risk Management process in place, which is supported through a standardised Board Assurance Framework, with each Corporate risk monitored through the individual Board sub committees and the overall Trust governance structure. The Board and its sub-committees receive timely information in accordance with its scheduled cycle of business and will scrutinise performance. Performance is also reported to the Council of Governors and Governors are provided with an opportunity of holding the Non-Executive directors to account for the performance of the Board. The Trust received an overall rating of 'Good' across all elements (previously rated as 'Requires Improvement) in 2018 and has ambitions to progress to an 'Outstanding' rating with a strong focus on continuous learning and quality improvement at all levels throughout the organisation. Internally the focus is on 'Excellence as our Standard'. The trust proactively supports a culture of innovation and improvement with a number of initiatives being driven from the frontline staff. The Care Quality Commission (CQC) have recently undertaken a Well Led inspection during 24-26 May and we await the final report in July.
			A review by the Good Governance Institute in 2018 concluded that the organisation is a well-led Trust, with effective governance arrangements and a satisfactory system of internal control in place, both of which are fit for purpose and operating effectively. The Trust has a positive and patient centred culture, which is well embedded throughout the organisation and at Board level, with a clear vision and values demonstrated across the Trust. A Board Development Programme building on the expertise, experiences and essential requirements of a new cohort of interim Non-Executive Directors is in the planning stage and will be delivered once the permanent appointment of NEDs is underway in June/July. During 2021/22, a review has been undertaken against well led statements by considering each key line of enquiry (KLOE) in order to provide self-assessment and an overarching trust level response. The collection and collation of qualitative information linked to underpinning evidence will support the identification of further improvements and the development of action plans that will feed into to the trust response for an external review planned n 2022/23. The Trust has a robust Business Planning cycle in place, which supports the development and delivery of Care Group specialty Business Plans, and in year service delivery. The Business Planning process has been reviewed by internal audit and received 'Good Assurance'. Operational delivery of business plans is monitored through the Care Group Director's meetings in-year, with appropriate oversight and scrutiny by the Chief Operating Officer and the Director of Planning and Performance. Trust financial performance delivery is monitored though the Executive Team and from an ICP perspective, system performance is monitored through the ICP and Leadership (Executive) Group, ICP DoFs / CFOs fortnightly meeting. Governance of compliance with Licence conditions is managed through the Board of Directors and Council of Governors, with assurance provided through the reporting structure outlined above. Evidence to support this statement include: Well led external review Constitutional documents Internal Audit plans, reports and opinion Risk Management Processes Board and Sub-Committee meetings cycle Safer staffing reports Financial performance reports to the Board and Sub-Committees Performance monitoring process and review by the Care Groups Annual Report, Quality Report, Annual Accounts and Annual Governance Statement Leadership Walkarounds

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed within the Annual Report and the statements contained therein. The Board of Directors both directly and through its committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set having regard to feedback from patients, carers, Governors and other key stakeholders with regular reporting of delivery against these priorities provided to the Board, Council of Governors and Commissioners. The effectiveness of these processes is considered as part of the Annual Governance Statement which in turn is subject to consideration by the Audit Committee and the Auditors prior to inclusion in the Annual Report. The Trust has continued to review and focus its attention on the management of strategic risks, which is supported by the Risk Management Strategy and Board Assurance Framework, which drives the Board's agenda. Board sub-committees and other high-level groups who have defined responsibilities and accountabilities for risk management are in place for the escalation of risks from the front line, through governance channels, to the Board of Directors. Overall decisions in relation to prioritisation of corporate risk issues and resource allocation are taken by the Board of Directors, with delegation of decisions relating to specific risks to sub-committees or the Executive Team as appropriate. This features highly in the planning round to deliver the Annual Operating Plan and the Board of Directors ability to self-certify. In 2021/22 the Board of Directors further reviewed the strategic direction in line with the North East and North Cumbria Integrated Care System objectives and the alignment of operational delivery. This included a refresh, reframe and development of the Corporate Strategy to ensure it is fit for the future and incorporates system wide integration and financial delivery, reflecting all external influences accordingly. In April 2019 a new operating model was introduced, with Care Groups replacing the traditional acute services model providing a new and innovative approach to pathway delivery outside the historical specialty level management. This model is now firmly embedded in the organisation and provides the Board with the operational assurity around quality and safety of care, and provides the opportunity to review how services are delivered through collaborative working both internally and across the community with local authority partners. This is supported by three executive team members taking on the role of 'Locality Director' for the local authority areas served by the Trust, with a focus on delivering the strategic objectives, partnership opportunities and place based planning. As detailed below, challenges were experienced in 2021/22 due to the loss of a number of Non-Executive Directors, however, immediate action was implemented to ensure any risks were mitigated and interim arrangements were successfully put in place.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board of Directors has a range of skills, experience maturity and expertise to deliver the key objectives. Where capacity is a risk an infrastructure of support has been considered and agreed. The Board of Directors has a track record of making intelligent decisions and tackling risks to clinical, operational and financial stability in a proactive and timely manner. The Well Led principles have been reassessed throughout the Trust and key areas of development supported to fit the strategic agenda. The Trust faced a number of challenges in the latter quarter of 2021/22 due to the resignation of a number of Non-Executive Directors. The Trust was still able to meet its statutory duties and transact business, and the Board Committee structure was adequately covered in relation to Non-Executive Director representation. In response, interim arrangements were agreed by the Council of Governors to ensure any gaps were covered with proposals to appoint permanently to be implemented in 2022/23. The Trust has an established process that ensures that all Board members are 'fit and proper' persons. This process is applied on appointment and thereafter on an annual basis it undertakes assessment of continued fitness for the role by completion of the fit and proper person test and declaration. This applies to Non-Executive and Executive Directors, as well as other senior staff. In addition, for senior staff that require registration with a professional body, this information is checked on an annual basis to ensure on-going validation. This information is presented to the Board of Directors annually in January each year. The Board and its Committees through receipt of workforce reports has been assured over the actions being taken to manage the workforce risks in relation to recruitment and retention and the review of people BAF risks. There remains a challenge to the organisation with the recruitment of staff to some specialities, however recruitment plans continue to be developed in order to address any gaps and discussions are continuing are taking place across the Integrated Care System and Integrated Care Partnership in looking at collaboration and network approaches. Regular reports is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce impact, through this process the Board is assured that the Trust retains and appropriately qualified workforce to deliver its services.

Signature **Signature**

Name Derek Bell **Name** Julie Gillon

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Overall rating for North Tees and Hartlepool NHS Foundation Trust GOOD

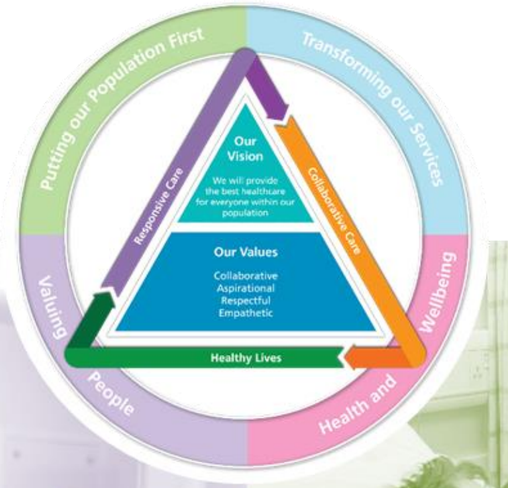
North Tees and Hartlepool
NHS Foundation Trust

MATERNITY SERVICES

Board of Directors Meeting

Lindsey Robertson, Chief Nurse

8 June 2022



Excellence as our Standard

Collaborative | Aspirational | Respectful | Empathetic

NATIONAL - MATERNITY SERVICES

Independent Investigation into East Kent Maternity Services

NORTH TEES MATERNITY SERVICES

North Tees and Hartlepool NHS Foundation Trust

- **2500** births/year
- Community and hospital based service delivery model
- Full range of birth choices for women with provision of antenatal, intrapartum and postnatal (including transitional care) services

Community

Antenatal care

Intrapartum care

Postnatal care

Obstetric Unit (North Tees site)

Freestanding Midwifery Unit (Rowan Suite, Hartlepool site)

Home birth

BETTER BIRTHS

MATERNITY TRANSFORMATION

AIMS / PRIMARY OUTCOME

To transform maternity services in line with the Better Births strategy and long term plan to reduce stillbirths, maternal mortality, neonatal mortality and serious brain injury by 50% by 2025

MEASURES

Aim Measure:
Maternal and perinatal mortality and serious brain injury.
Primary Driver—Outcome Measure (s):
Completion of regional and national submissions
Annual Improvement in staff survey & Service user feedback
Improved population health measures – smoking, PA, breast feeding
Improved scores on annual digital maturity assessment

SECONDARY DRIVERS

Exceed the requirements set out in safety schemes and national reports

- Achieve CNST MIS requirements yearly
- Embed changes recommended from both the interim (7 IEAs) and final (15 IEAs) Ockenden report.
- Embed improvements from MatNeoSIP
- Embed learning from Perinatal mortality review
- Engage proactively with HSIB
- Engage and collaborate with the LMNS
- Provide ward to board assurance
- Embed personalised care and co-production

Strengthen the leadership and culture within Maternity

- Review workforce (capacity and capability)
- Roll out psychological safety training
- Increase staff engagement
- Reduce staff turnover

Focus on population health and prevention

- Embed the LMNS/ICS public health in maternity programme
- Roll out continuity of carer
- Embed saving babies lives care bundle
- Strengthen postnatal and perinatal mental health support

Improve the digital capability

- Procure a maternity EPR
- Ensure handheld notes capability for pregnant people
- Improve information availability on Trust website
- Maximise digital opportunities to support service users

7-OCKENDEN IEAs

7 OCKENDEN IEAS INC OUR 12 CLINICAL PRIORITIES

NHS North Tees and Hartlepool NHS Foundation Trust

	COMPLIANT?	PARTIALLY COMPLIANT?
1 ENHANCED SAFETY		
A plan to implement the Perinatal Clinical Quality Surveillance Model		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	✓	
2 LISTENING TO WOMEN AND FAMILIES		
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		✓
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion. Further MVP development planned	✓	
3 STAFF TRAINING AND WORKING TOGETHER		
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place	✓	
Confirmation that funding allocated for maternity staff is ringfenced		

7-OCKENDEN IEAs

	COMPLIANT?	PARTIALLY COMPLIANT?
4 MANAGING COMPLEX PREGNANCY All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	✓	
5 RISK ASSESSMENT THROUGHOUT PREGNANCY A risk assessment must be completed and recorded at 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	✓	
6 MONITORING FETAL WELLBEING 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 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.	✓	
7 INFORMED CONSENT 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. We currently have a website redesign planned. An example of good practice is available on the Chelsea website.		✓

ASSURANCE

- Maternity Safety Champions Board and Executive Directors
- Ockenden support visit
- Revised Governance Structure
- Dashboard – alignment
- Leadership review

FEEDBACK FROM VISIT

- Envious of culture; improvement culture – potential to be great…
- Good relationships – floor to board
- Stop smoking work exemplary
- Staff can visualise a brighter future
- Exemplary preconseptual care
- Risk assessment strengthened with digital
- Fetal wellbeing in pace – good compliance

OPPORTUNITIES TO IMPROVE...

- Leadership
- Specialist midwives
- Audit cycle – close the loop
- Strengthen governance team
- Move forward with MVP – coproduction at every level
- Consultant expansion – alignment to key leadership roles
- LMNS direction

MATERNITY SERVICES

15-OCKENDEN IEAS

NHS
North Tees and Hartlepool
NHS Foundation Trust

15-OCKENDEN IEAS INC 80 CLINICAL PRIORITIES	COMPLIANT	PARTIALLY COMPLIANT
1A FINANCING A SAFE MATERNITY WORKFORCE 1B TRAINING BUDGETS RING FENCED		
MAINTAIN A CLEAR ESCALATION AND MITIGATION POLICY WHERE MATERNITY STAFFING FALLS BELOW THE MINIMUM STAFFING LEVELS FOR ALL HEALTH PROFESSIONALS		
STAFF MUST BE ABLE TO ESCALATE CONCERNS IF NECESSARY CLEAR PROCESSES FOR ENSURING THAT OBSTETRIC UNITS ARE STAFFED BY APPROPRIATELY TRAINED STAFF AT ALL TIMES IF NOT RESIDENT THERE MUST BE CLEAR GUIDELINES FOR WHEN A CONSULTANT OBSTETRICIAN SHOULD ATTEND		

15-OCKENDEN IEAS

NHS
North Tees and Hartlepool
NHS Foundation Trust

15-OCKENDEN IEAS INC 80 CLINICAL PRIORITIES

	COMPLIANT	PARTIALLY COMPLIANT
TRUST BOARDS MUST HAVE OVERSIGHT OF THE QUALITY AND PERFORMANCE OF THEIR MATERNITY SERVICES IN ALL MATERNITY SERVICES THE DIRECTOR OF MIDWIFERY AND CLINICAL DIRECTOR FOR OBSTETRICS MUST BE JOINTLY OPERATIONALLY RESPONSIBLE AND ACCOUNTABLE FOR THE MATERNITY GOVERNANCE SYSTEMS.		

5 CLINICAL GOVERNANCE INCIDENT INVESTIGATION AND COMPLAINTS

INCIDENT INVESTIGATIONS MUST BE MEANINGFUL FOR FAMILIES AND STAFF AND LESSONS MUST BE LEARNED AND IMPLEMENTED IN PRACTICE IN A TIMELY MANNER		

6 LEARNING FROM MATERNAL DEATH

NATIONALLY ALL MATERNAL POST-MORTEM EXAMINATIONS MUST BE CONDUCTED BY A PATHOLOGIST WHO IS AN EXPERT IN MATERNAL PHYSIOLOGY AND PREGNANCY RELATED PATHOLOGIES. IN THE CASE OF A MATERNAL DEATH A JOINT REVIEW PANEL/INVESTIGATION OF ALL SERVICES INVOLVED IN THE CARE MUST INCLUDE REPRESENTATION FROM ALL APPLICABLE HOSPITALS/CLINICAL SETTINGS		

15-OCKENDEN IEAS

NHS
North Tees and Hartlepool
NHS Foundation Trust

15-OCKENDEN IEAS INC 80 CLINICAL PRIORITIES

	COMPLIANT	PARTIALLY COMPLIANT
• STAFF WHO WORK TOGETHER MUST TRAIN TOGETHER • STAFF SHOULD ATTEND REGULAR MANDATORY TRAINING AND ROTAS • JOB PLANNING NEEDS TO ENSURE ALL STAFF CAN ATTEND • CLINICIANS MUST NOT WORK ON LABOUR WARD WITHOUT APPROPRIATE REGULAR CTG TRAINING AND EMERGENCY SKILLS TRAINING		
• LOCAL MATERNITY SYSTEMS, MATERNAL MEDICINE NETWORKS AND TRUSTS MUST ENSURE THAT WOMEN HAVE ACCESS TO PRE-CONCEPTION CARE • TRUSTS MUST PROVIDE SERVICES FOR WOMEN WITH MULTIPLE PREGNANCY IN LINE WITH NATIONAL GUIDANCE • TRUSTS MUST FOLLOW NATIONAL GUIDANCE FOR MANAGING WOMEN WITH DIABETES AND HYPERTENSION IN PREGNANCY		
• THE LMNS, COMMISSIONERS AND TRUSTS MUST WORK COLLABORATIVELY TO ENSURE SYSTEMS ARE IN PLACE FOR THE MANAGEMENT OF WOMEN AT HIGH RISK OF PRETERM BIRTH. • TRUSTS MUST IMPLEMENT NHS SAVING BABIES LIVES VERSION 2 (2019)		

15-OCKENDEN IEAS

NHS
North Tees and Hartlepool
NHS Foundation Trust

15-OCKENDEN IEAS INC 80 CLINICAL PRIORITIES

	COMPLIANT	PARTIALLY COMPLIANT
• TRUSTS MUST ENSURE THAT WOMEN WHO HAVE SUFFERED PREGNANCY LOSS HAVE APPROPRIATE BEREAVEMENT CARE SERVICES.		
• THERE MUST BE CLEAR PATHWAYS OF CARE FOR PROVISION OF NEONATAL CARE • THIS REVIEW ENDORSES THE RECOMMENDATIONS FROM THE NEONATAL CRITICAL CARE REVIEW (DECEMBER 2019) TO EXPAND NEONATAL CRITICAL CARE, INCREASE NEONATAL COT NUMBERS, DEVELOP THE WORKFORCE AND ENHANCE THE EXPERIENCE OF FAMILIES. THIS WORK MUST NOW PROGRESS AT PACE		
• CARE AND CONSIDERATION OF THE MENTAL HEALTH AND WELLBEING OF MOTHERS, THEIR PARTNERS AND THE FAMILY AS A WHOLE MUST BE INTEGRAL TO ALL ASPECTS OF MATERNITY SERVICE PROVISION • MATERNITY CARE PROVIDERS MUST ACTIVELY ENGAGE WITH THE LOCAL COMMUNITY AND THOSE WITH LIVED EXPERIENCE, TO DELIVER SERVICES THAT ARE INFORMED BY WHAT WOMEN AND THEIR FAMILIES SAY THEY NEED FROM THEIR CARE		

15-OCKENDEN IEAS

NHS
North Tees and Hartlepool
NHS Foundation Trust

15-OCKENDEN IEAS INC 80 CLINICAL PRIORITIES

	COMPLIANT	PARTIALLY COMPLIANT
• WOMEN WHO CHOOSE BIRTH OUTSIDE A HOSPITAL SETTING MUST RECEIVE ACCURATE ADVICE WITH REGARDS TO TRANSFER TIMES TO AN OBSTETRIC UNIT SHOULD THIS BE NECESSARY • CENTRALISED CTG MONITORING SYSTEMS SHOULD BE MANDATORY IN OBSTETRIC UNITS		
• IN ADDITION TO ROUTINE INPATIENT OBSTETRIC ANAESTHESIA FOLLOW-UP, A PATHWAY FOR OUTPATIENT POSTNATAL ANAESTHETIC FOLLOW-UP MUST BE AVAILABLE IN EVERY TRUST TO ADDRESS INCIDENCES OF PHYSICAL AND PSYCHOLOGICAL HARM • DOCUMENTATION OF PATIENT ASSESSMENTS AND INTERACTIONS BY OBSTETRIC ANAESTHETISTS MUST IMPROVE. THE DETERMINATION OF CORE DATASETS THAT MUST BE RECORDED DURING EVERY OBSTETRIC ANAESTHETIC INTERVENTION WOULD RESULT IN RECORD-KEEPING THAT MORE ACCURATELY REFLECTS EVENTS • STAFFING SHORTAGES IN OBSTETRIC ANAESTHESIA MUST BE HIGHLIGHTED AND UPDATED GUIDANCE FOR THE PLANNING AND PROVISION OF SAFE OBSTETRIC ANAESTHESIA SERVICES THROUGHOUT ENGLAND MUST BE DEVELOPED		
• TRUSTS MUST ENSURE THAT WOMEN READMITTED TO A POSTNATAL WARD AND ALL UNWELL POSTNATAL WOMEN HAVE TIMELY CONSULTANT REVIEW. • POSTNATAL WARDS MUST BE ADEQUATELY STAFFED AT ALL TIMES		

SUMMARY

- CQC core service review
- Positive feedback Ockenden support
- Governance
- Leadership capacity and capability – future state
- 15 Ockenden IEAs Assurance September 22 in line with East Kent

THANKYOU...QUESTIONS?

Board of Directors

Title of report:	Freedom to Speak Up Annual Report								
Date:	8 June 2022								
Prepared by:	Fiona Gray, Freedom to Speak Up Guardian								
Executive sponsor:	Lindsey Robertson, Chief Nurse/Director of Patient Safety & Quality								
Purpose of the report	Annual report of the Freedom to Speak Up Guardian 2021 – 2022 including progress to date, training, national and local data and staff feedback.								
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	x	Caring	x	Effective	x	Responsive	x	Well Led	x

Executive Summary and the key issues for consideration/ decision:

This is the annual report of the Freedom to Speak up Guardian (FTSUG)which provides an update in relation to progress over the last 12 months including themes, number of cases and ongoing work required promoting and continuing to embed the FTSU ethos across North Tees and Hartlepool NHS Foundation Trust and NTH Solutions

The Freedom to Speak up Guardian role (FTSUG) has been in place at the Trust since 2016; appointed full time since August 2021 in line recommendations from the National Guardian Office

The Trust promotes an open and honest culture and encourages staff to have the chance, choice and confidence to speak up via number of routes including line management, workforce or staff side representative. There are also 10 Freedom to Speak Up Champions across the Trust and NTH Solutions. The FTSUG supports the champions to promote the role and to signpost staff to appropriate speaking up routes.

National data 2020/2021 demonstrates an increase in cases reported via the FTSU route. North Tees has reported 50 cases reported during the period April 2021 – March 2022 in line with the national increasing trend.

An improvement plan is in place including incorporating Speak Up training as a core requirement, development of technical resources to support the FTSU process, recruitment of additional champions and identifying further communication and opportunities to promote the service to staff.

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

1a Patient Experience addition to control but no change to impact
2b Valuing our People addition to control but no change to impact

Committees/groups where this item has been discussed	Executive Team
Recommendation	The Board of Directors are asked to note the content of the report and the progress to date in embedding and developing the FTSUG role further

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

May 2022

Freedom to Speak Up Guardian

Annual Report

1. Introduction

The Freedom to Speak up Guardian role (FTSUG) has been in place at the Trust since 2016; appointed full time since August 2021 in line last year's recommendation from the National Guardian Office.

The FTSU role continues to evolve as does the National Guardian Office (NGO) who supports the FTSUG role. The NGO have recently appointed a new National Guardian for the NHS, replacing Henrietta Hughes. Dr Jayne Chidgey-Clark, a previous FTSUG, was recruited early 2022.

The FTSUG role continue to expand into other areas of healthcare including Ambulance Services, GP practices, Dental practices, Parliamentary and Health Service Ombudsman and NHS Blood and Transplant as well as NHSE/I.

There are currently 818 Guardians in 514 organisations

This report will provide an update in relation to progress over the last 12 months, themes, number of cases and ongoing work required promoting and continuing to embed the FTSU ethos across North Tees and Hartlepool NHS Foundation Trust and NTH Solutions.

This report also seeks to provide an update on the service and on-going developments as a means of enhancing the service provision over the next year and beyond.

The FTSUG is supported in the role by the Chief Executive Officer (CEO), the Executive Sponsor for FTSU (Chief Nurse and Director of Patient Safety and Quality), the senior leadership team, Non-Executive Director, the National Guardians Office, Regional Guardians in the North East, Chaplaincy and Trust's Psychology Team.

1.1 Progress to date

- A new Freedom to Speak up Guardian appointed in August 2022, increased the role from part to fulltime. Formal NGO training was completed in September 2022 with registration on the NGO database thereafter.

- One of the first priorities of the FTSUG was to gauge awareness of the role and to further introduce the role across wards and services. To enable staff easy access to contact details the FTSUG has distributed posters, pens, key rings and business cards across the organisation at Trust inductions, team meetings, clinical directorate meetings, floor walking and through promotions such as Speak Up Month in October 2021. The FTSUG also attends

staff networking groups to share the ethos and progress with the aim of communicating with harder to reach areas.

- The FTSU role is promoted as an additional and alternative channel for speaking up about work related concerns and is available for all staff as well as NHS Professionals, students and volunteers. An easy to read staff leaflet has been produced which explains the service and how to get in touch. This is available for all new joiners as well as existing staff via the staff intranet as well as in handout format.

- "Keep in Touch" Meetings have been established with all the Executive, Deputy Executive and Care Group Directors. The purpose of these meetings is to create a proactive and relational approach to speaking up. The FTSUG also prepares a monthly report for the Executive Team and is invited to join the team meeting for a verbal update every 2-3 months. Because of the keep in touch meetings, the FTSUG has been invited to a wider range of meetings including directorate meetings, team meetings, Patient Safety Committee, Schwartz Round and has received an invitation to speak at regional professional development events such as Health Education England Train the Trainer for trainee consultants.

- Staff are encouraged to speak up via a number of routes including their line manager, workforce or staff side representative. There are also 10 Freedom to Speak Up Champions across the Trust and NTH Solutions. The FTSUG supports the champions to promote the role and to signpost staff to appropriate speaking up routes. We want staff to have the chance, choice and confidence to speak up.

- The FTSUG presents monthly at the Corporate Trust Induction, Student Nurse Induction, Preceptorship Programme, and has also presented at volunteer inductions. The FTSUG also works closely with the Psychology Team in relation to mutual signposting and reflective supervision.

- The FTSUG attends monthly regional Guardian meetings which is a supportive forum. A good alliance has been established with neighbouring Guardians at South Tees NHS Foundation Trust and Tees Esk and Wear Valley NHS Foundation Trust. The FTSUG has also established a "buddy" alliance with the Guardian at North Lincolnshire and Goole NHS Foundation Trust. The aim of these alliances is to work collaboratively, seek support and share ideas to evolve service provision.

- As highlighted in last year's report, resilience for the role was raised as an area of improvement. A deputy Guardian (a current champion) completed NGO training in January 2022 and contingency arrangements are progressing.

2. Freedom to Speak Up Training Resources

The NGO e-learning modules have been developed in association with Health Education England and are for everyone wherever they work in the health service. They explain in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

- The first module **"Speak Up"** is core training for everybody. This module covers what speaking up is and why it matters. It will help staff understand how you can speak up and what to expect.

- The second module **"Listen Up"** is specifically for managers or aspiring managers. It builds upon the first and focuses on listening and understanding the barriers to speaking up.

- A third module **"Follow Up"** for senior leaders, was launched in April 2022 to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems.

Speak Up and Listen Up training is available for staff to access and staff are encouraged to complete this training. Speak Up core training has been requested to be included as mandatory training for staff.

The latest NGO Training "Follow Up" is now available for registration and access via the National e-Learning for Healthcare website. All Exec, Deputy Exec and Care Group Directors at North Tees and Hartlepool NHS Foundation Trust (including NTH Solutions) have been sent the link to access the training. An upload of the module to ESR has been requested via the next scheduled planned maintenance.

The National Guardians Office will also be releasing a new online training package for all Guardians, expected June 2022. The current FTSUG will be required to undertake refresher training and this will be required for the deputy guardian also. Any new Guardians will be expected to complete this new training package also.

3. National Guardian Office Survey Results

In March 2022, the NGO published the annual Guardian survey results.

- The NGO invited 745 Freedom to Speak Up Guardians to participate in the survey, which was open from 13 September to 31 October 2021. In total, there were 333 responses - a response rate of 44.7%. The FTSUG for North Tees and Hartlepool contributed to this national survey.

- While the majority of Guardians who responded to the annual survey were positive about the speaking up culture in their organisation, there are warning signs that more action is needed.

- The proportion of guardians who reported a positive culture of speaking up in their organisation has dropped by five percentage points on last year, to 62.8%.

- This drop correlates with the findings of the 2021 NHS Staff Survey, published 30th March 2022, where the proportion of staff who say they feel safe to speak up about anything which concerns them in their organisation has also fallen by more than three percentage points to 62%.

- The proportion of Freedom to Speak Up Guardians who say that speaking up culture in the healthcare sector has improved has also dropped – from 80% in 2020 to 72% in 2021.

- Detriment after speaking up is an area requiring significant consideration and all leadership teams have been asked by the National Guardian to consider proactive solutions for tackling this.

- The Freedom to Speak Up Index Report can also help build a picture of what speaking up culture feels like for workers which is drawn from questions in the NHS Annual Staff survey. The 2022 Freedom to Speak Up Index has not yet been published.

4. National Data

The table below summarises the cases, themes and 'who' is speaking up nationally. It is noted that there was an increase in cases reported via the FTSUG route during 2020/21

Cases Raised	Themes 2020/2021	Who is speaking up (Top 4 Groups)
2020/21**: 20,388** 2019/20: **16,199** 2018/19: **12,244**	Bullying and Harassment 30.1 % **(↓ 5.9%)** Patient Safety and Quality 18% **(↓ 5%)** Detriment as a result of speaking up indicated 3.1% **(↑ 0.1%)** Anonymous reporting 12% **(↓ 1%)**	Nurses and midwives Administration and clerical Allied Health Professionals Healthcare Assistants

5. Local Data 2021/2022

The same picture as national is noted across the Trust in relation to the increasing numbers and also 'who' is speaking up. Fifty concerns or contacts were made via the Freedom to Speak Up route during the period April 2021 – March 2022. Two contacts were suggestions for improvement.

Cases Raised	Main Themes 2021/2022	Who is speaking up (Top 4 Groups)
Q1 Apr 21 – Jun 21 **0 Cases** Q2 Jul 21 – Sep 21 **2 Cases** Q3 Oct 21 – Dec 21 **34 Cases** Q4 – Jan 22 – Mar 22 **14 Cases**	Senior Management / Culture Patient Safety and Quality Working Environment Staffing	Other Nurses and midwives Administration and clerical Healthcare Assistants

Outcomes:

- Twenty-seven cases have been closed and twenty-three were carried forward to 2022/2023 data.
- Nine new concerns were raised in April 2022.
- Thirty-two cases are open / ongoing as of May 2022. These are either in progress or commencing follow up actions.

6. Staff Feedback

For quality assurance purposes, staff are invited to provide feedback at the end of the FTSU process. Staff also to continue to offer feedback on an ad hoc and voluntary basis during the FTSU process as well as in general.

Staff feedback provides invaluable insight into the Speak Up, Listen Up, Follow Up process including what support staff need, whichever route they take to speak up as well as support for the listen up, follow up.

Feedback over the last 12 months shows that appropriate communication regarding next steps or follow up actions are appreciated and welcomed even when there is little to report. The FTSUG also explains next steps and where actions will be taken forward.

Whilst staff appreciate that communication updates are not always possible due to confidentiality, further improvements are required to ensure there is communication with staff involved in larger or more complex concerns for assurance.

Feedback also suggests that more complex concerns (e.g. those that require further fact-finding and / or investigations) can take time, which can have a significant effect on staff wellbeing. Timescales for resolution are monitored to ensure that areas for improvement are identified. Staff continue to be encouraged to report any detriment or disadvantageous responses to speaking up.

The Speak Up process and raising concerns may impact mental health which means offering support is essential. The FTSUG offers support to staff throughout the Freedom to Speak Up process, checks in with staff and also signposts to external psychological support if necessary or requested. The FTSUG has completed Mental Health First Aid training to enhance awareness of any emerging support requirements.

Direct quotes from staff involved in the FTSU process include:

"It was beneficial to air concerns and that we were listened to. I realise recruitment of staff will take time. I will continue to follow policy and escalate again if needed and ensure Datix is completed. Thanks again for your support"

"Thank you for taking the time to listen. It amazed me the positive effect it had on me to be listened to, sympathised with, and given details on what's happening next. Thank you"

"I'm okay overall but hoping the fact-finding process moves on now"

"I want my manager to listen but want them to feel supported too because I know how busy they are. They just do not have the time and it's really hard to get a response which is why I've come to you"

"It was a helpful discussion regarding the issues and actions going forward"

"The process of speaking up is an incredibly difficult one which I personally did not undertake without a huge amount of thought, considering all the potential outcomes if I did or did not come forward. I have and continue to lose sleep, worry and speculate if the eventual outcome will benefit the service enough to compensate for detrimental impact which this has had on my emotional wellbeing"

"I would speak up again without hesitation. I held back for a long time, found my confidence and it made a huge difference"

7. Case Study – Speak Up, Listen Up, Follow Up and Beyond

As part of Speak up month in October, the CEO encouraged all staff introducing the new Freedom Guardian and to encourage staff to speak up with any work related concerns. On the back of this campaign, the FTSUG visited Maternity Services and met a number of staff. The role was briefly explained with pens and contact cards left for staff.

Following this, several staff contacted the FTSUG to raise concerns. Staff were thanked for speaking up. They were assured that appropriate action would be taken to investigate their concerns further. The FTSUG maintained contact with the initial disclosees to stay connected and provided support at various stages of the process for any staff who requested FTSU support.

A number of decisions were made and follow up actions agreed. However, the Freedom to Speak up journey does not end there. The FTSUG has since been invited by staff to collaborate with Maternity Services including joining Team Leader meetings to talk about the FTSU ethos, wider staff

introductions on International Day of the Midwife and working with the clinical educator for Maternity Services to incorporate Speak Up and Listen Up modules within the maternity training programme. For our Maternity staff, this is hopefully the beginning rather than the end of the FTSU process. Support is now centred on embedding the ethos, working proactively and relationally with colleagues to evolve FTSU within the service as well giving staff the chance, choice and confidence to raise any new concerns.

8. Service provision

Review of the service is on-going and improvements identified include a request to incorporate Speak Up training as a core requirement, development of technical resources to support the FTSU process, recruitment of additional champions, ongoing communication and opportunities to promote the service to staff.

9. Next Steps

Key aims for 2022/23 include:

- Continuing to increase awareness across the organisation via walkabouts, joining staff meetings, visiting community settings.
- Develop staff Sharepoint site
- Follow Up Training to be completed by the leadership team including board members to set the tone of the speaking up culture
- Ongoing meetings with Champions for updates and supervision and to recruit more champions if needed.
- Maintain “Keep in Touch” Meetings with the leadership team
- Enhance collaborative working with team leaders, managers, staff side, Workforce, Education Organisational Development and Learning and the Workforce Independent Investigator.
- Confirm resilience for the Guardian role.
- Monitor process and timeframes.
- Attend Regional Team meetings to collaborate further.

10. Recommendations

The Board of Directors are asked to note:

- the content of the report and the progress to date;
- the positive increase in speaking up cases and outcomes
- key aims for 2022/23

Author
Fiona Gray
Freedom to Speak Up Guardian

On behalf of

Executive Sponsor
Lindsey Robertson
Chief Nurse/Director of Patient Safety & Quality

Board of Directors

Title of report:	Guardian of Safe Working Hours Report										
Date:	8 June 2022										
Prepared by:	Jamie Waters, Head of Business Support - NPSQ										
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 1 January 2022 to 31 March 2022.										
Action required:	Approve		Assurance	✓	Discuss	✓	Information	✓			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	✓	Transforming our Services	✓	Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well Led	✓	

Executive Summary and the key issues for consideration/ decision:

The Guardian of Safe Working Hours has increased the frequency of the doctors' forum to bi-monthly, in order to increase our level of support to our doctors, obtain feedback, and address or escalate concerns.

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.

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

- Impact of rota gaps and staff absence resulting in trainees working additional hours
- Possible breaches to safe working hours and rest requirements resulting in fines

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is asked to note the content and accept this report.

Guardian of Safe Working Report
1st January 2022 to 31st March 2022

Executive Summary

This report highlights the latest data from Exception Reporting system and forms part of the reporting requirements of the 2016 contract for doctors and dentists in training. The report highlights key topics reported and discussed through the Doctors in Training (DiT) Forums that occurred in the quarter.

The Medical Education Team have provided information to Junior Doctors relating to the “Too tired to drive” initiative, outlining the processes in place to secure temporary accommodation. This is a key scheme in supporting health and wellbeing of trainees during their time with the organisation.

The exception reports submitted during Q4 indicate that trainees working additional hours due to staffing levels is a consistent theme. This has been compounded by staff absence over the last 12-months as a result of the COVID pandemic. Trainees are encouraged and supported to continue to reporting using the exception reporting system to present an accurate reflection of staffing levels.

In recent forums it has been highlighted that escalating cannulation calls to anaesthetists inappropriately is a cause for concern. Although trainees are advised to escalate, the correct escalation process should be followed. Trainees were advised of increasing opportunities to undertake Ultrasound Guided Access programme, and that a plan around increasing number of trained trainees, trainers and equipment should reduce the need to escalate directly to anaesthetists. As planned, the training is now part of the scheduled F1 teaching programme from May 2022 and is open to other appropriate roles such as nurse practitioners and physician associates.

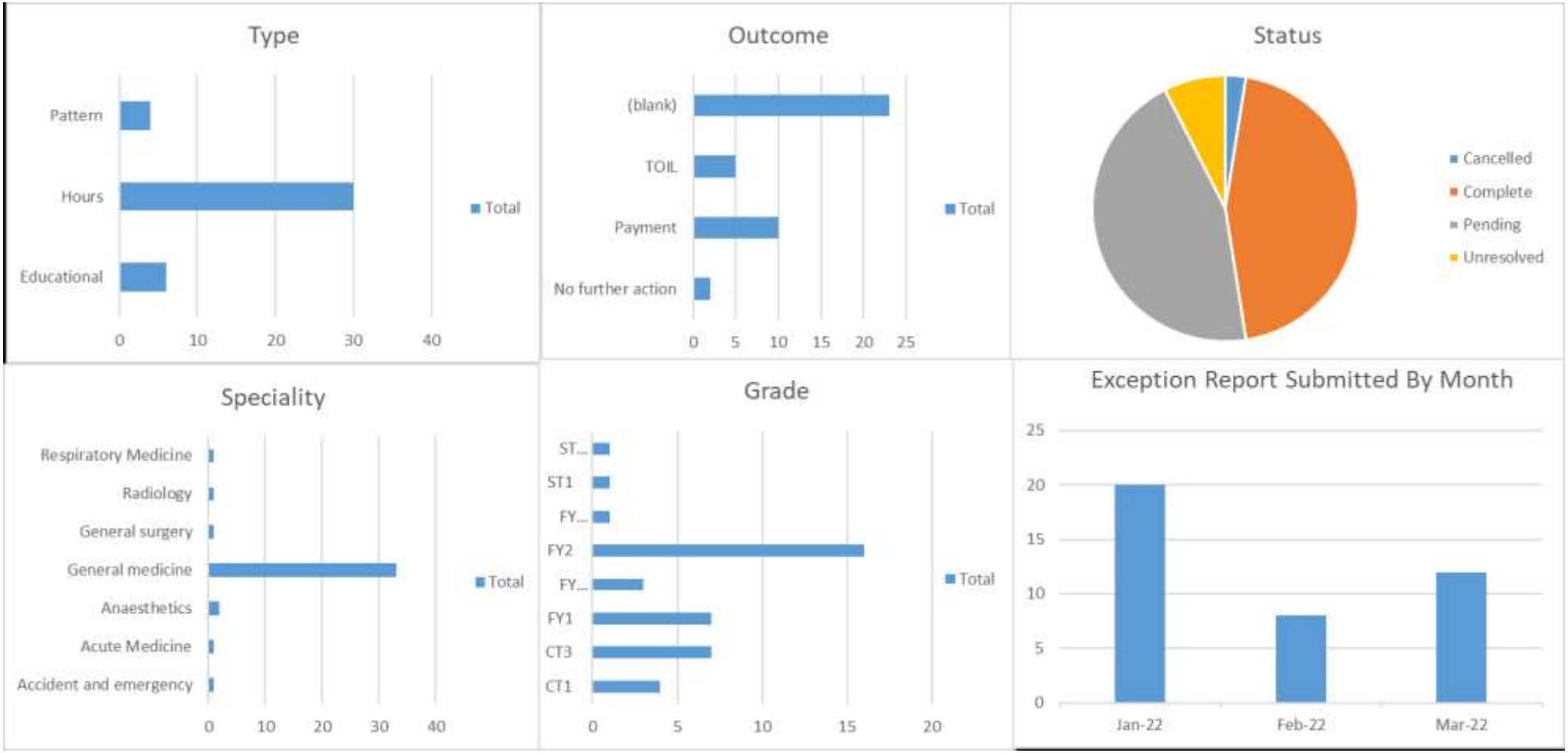
The disparity of locum pay rates across the region has been discussed in recent DiT Forums. Fluctuating rates over the last 12-24 months has led to significant variance across healthcare providers and it is recognised that organisations further collaborative work is required to prevent organisations competing for the same resource. It is acknowledged that the Trust has good practices in negotiating locum rates to minimise the financial impact on services.

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

Jamie Waters

Head of Business Support – Nursing, Patient Safety and Quality

Appendix One: Exception Reporting Dashboard Screenshot – 1st January 2022 to 31st March 2022



Overall rating for North Tees and Hartlepool NHS Foundation Trust GOOD

North Tees and Hartlepool NHS Foundation Trust

Transforming our services - Putting patients first - Valuing our people - Health and wellbeing

Annual Report

April 2021 - March 2022

of the

Vulnerability Unit

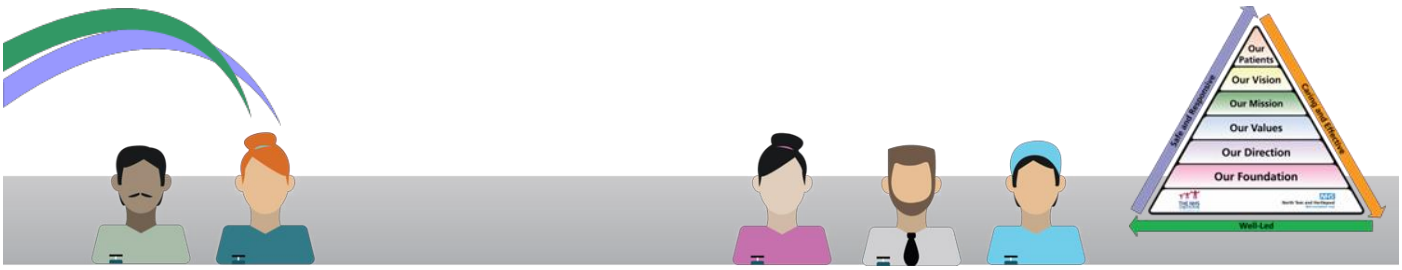
Safeguarding Adults,

Children and Young

People

Report of the Chief Nurse, Director of

Patient Safety and Quality



Safeguarding Adults

Children & Young People

Introduction

This report sets out the work carried out by North Tees and Hartlepool NHS Foundation Trust (NTHFT), Vulnerability Team, including Adults, Children & Young People in providing assurance that the Trust discharges its statutory responsibilities to those vulnerable patients who use Trust services. Whilst the team operates as one resource with common work streams identified it is important to note that the legal responsibilities in relation to adults and children are discrete in application. Therefore, specialists within each area have been maintained within the team; for the purpose of this report the governance arrangements have been reported for the Vulnerability Team and subsequently separated into the specialist areas.

Lindsey Robertson

CHIEF NURSE,

DIRECTOR OF PATIENT SAFETY AND QUALITY

Lorraine Mulvey

NAMED NURSE

Stuart Harper-Reynolds

NAMED NURSE

Adult Safeguarding 'protecting our adults in need'

ADULT SAFEGUARDING

Stephen Nicholson

SAFEGUARDING ADVISOR AND DEMENTIA SPECIALIST

Gemma Crooks

SAFEGUARDING ADVISOR AND LEARNING DISABILITIES SPECIALIST

Jenny Duthie

SENIOR NURSE ADULT SAFEGUARDING

Liam Gates

ADULT SAFEGUARDING ADMINISTRATOR

Children's Safeguarding 'giving a voice to the child'

Laura Holroyd
SENIOR NURSE
Safeguardng Children
SPECIALIST MIDWIFE

Terri Wells
SENIOR NURSE
Safeguarding
Children

Denise Hopkins
SENIOR NURSE
Safeguarding
Children

Catherine Flanagan
SENIOR NURSE
SPECIALIST MIDWIFE

Wendy Murdoch
SAFEGUARDING
Children's Trainer

Rachael Winthorpe
SENIOR NURSE
Safeguarding
Children / Trainer

1 Introduction

1.1 Safeguarding is a fundamental component of all care provided. The purpose of this Annual Report is to provide an overview of the work of the Vulnerability Team in relation to Safeguarding Children and Children's Health in Care ((CHiC) - (formerly Looked After Children)) activity across the Trust in the last 12 months ***(April 2021– March 2022).***

This Annual Report demonstrates the Trust's commitment to delivering its statutory responsibilities in respect of safeguarding vulnerable children and adults.

2 Governance

2.1 The Chief Nurse, Director of Patient Safety and Quality has responsibility for Adult, Children & Young Peoples Safeguarding including Children's Health in Care over this period with management of the operational team by the Associate Director of Risk, Patient Safety & Governance

2.2 The Adult Vulnerability Group includes safeguarding adults, learning disabilities and dementia. This group brings together key stakeholders who have responsibility for safeguarding adults with representation from Stockton and Hartlepool localities and maintains responsibility for the performance monitoring of the adult vulnerability work plan.

2. The Trust has maintained membership and actively contributes at a senior level within 2 Safeguarding Partnerships and 1 Adult Safeguarding Board:

- Hartlepool and Stockton Safeguarding Partnership (HSSCP)
- Durham Safeguarding Children's Partnership. (DCSP)
- Teesswide Safeguarding Adult Board (TSAB)

The Trust has maintained representation and in some cases chaired a number of partnership and board subgroups.

Safeguarding Committee

The Strategic Children's Steering Group and Adult Safeguarding Committee have been brought together to form the Safeguarding Committee to facilitate a 'think family' culture across the trust. Responsibilities include;

- Performance Monitoring of Children's and Adult Safeguarding Work Programme
- Sharing lessons learned to support dissemination across the trust.

Committee Members from Commissioners and Providers

- Tees Valley CCG
- Designated Doctor
- Designated Nurse Adult and Childrens Safeguarding
- Designated Nurse Looked After Children
- Designated Nurse Safeguarding and Looked After Children DURHAM, DARLINGTON, EASINGTON and

3 Adult Safeguarding Performance

3.1

536

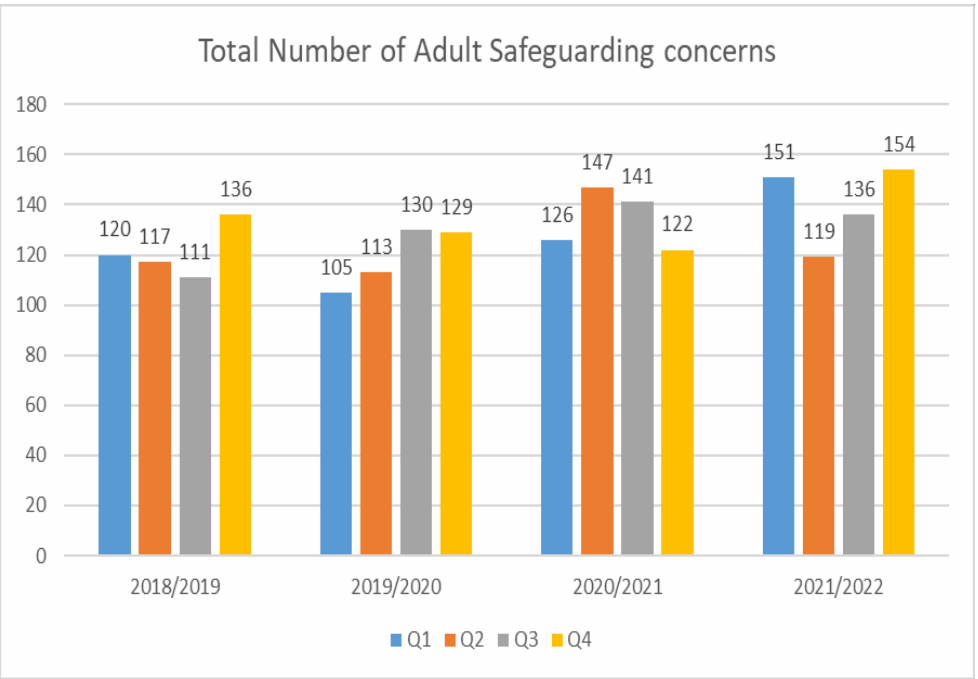
Safeguarding Concerns

Previous year

680

Trust involvement with Safeguarding Concerns

The increase is consistent with the activity seen across all local authorities. The concerns are raised through the safeguarding process, investigated in line with TSAB procedures and recorded within the Trust database.



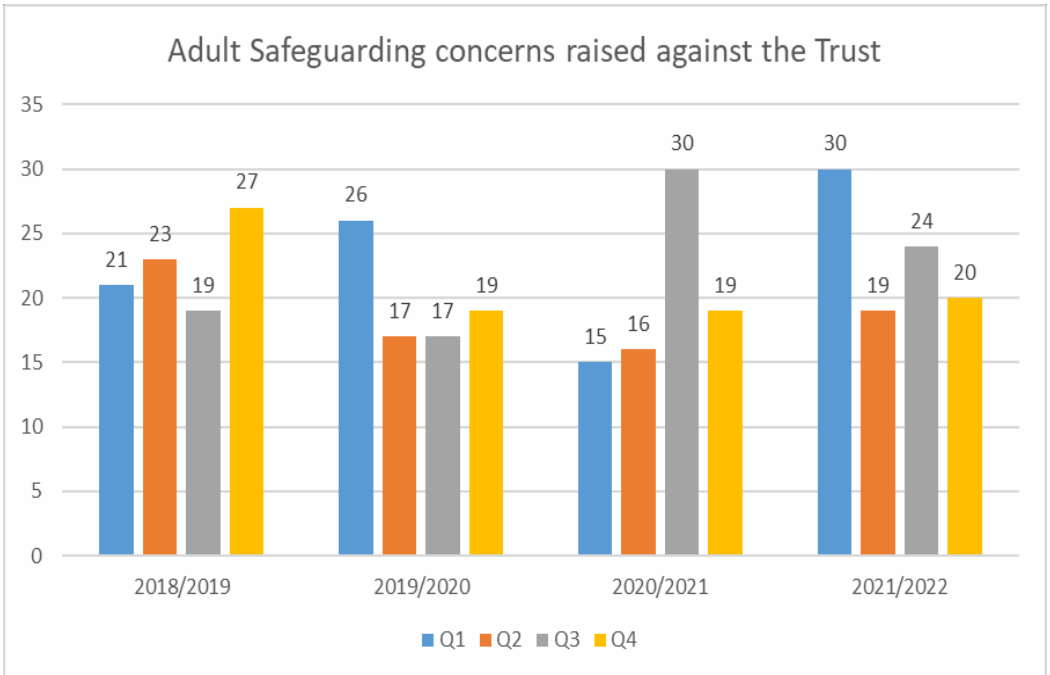
3.2 Increase in concerns against the Trust is consistent with the increase in numbers across Stockton and Hartlepool local authorities. The table below demonstrates the comparator data across 2018—2022

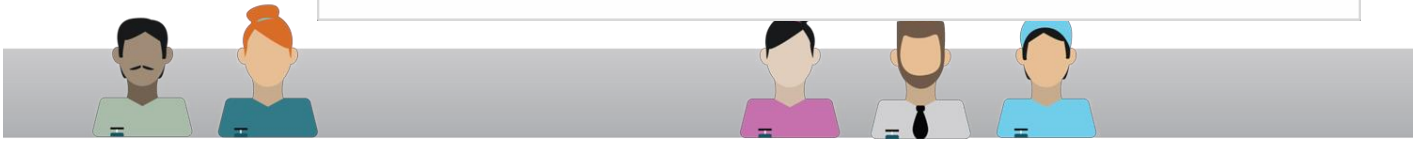
80

Concerns raised against the trust previous year

93

Concerns raised against the Trust this year investigated through safeguarding process

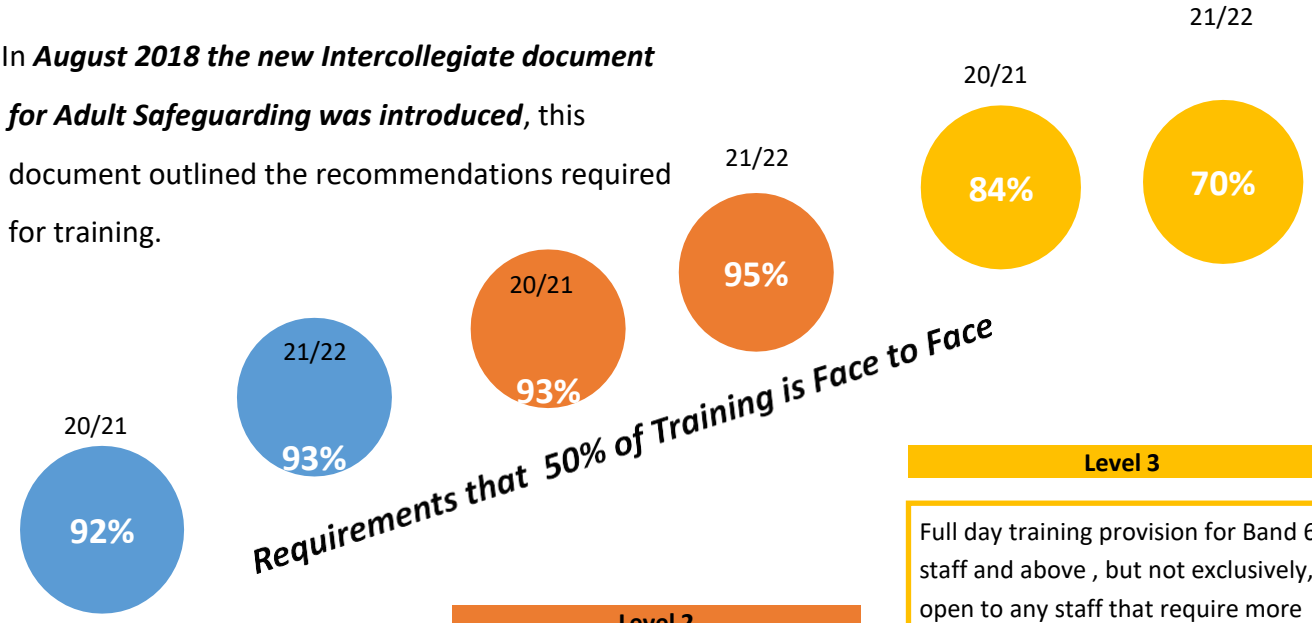




4 Adult Safeguarding - Training

4.1 The level one and level two adult safeguarding workbook has been incorporated into the Trust Corporate Induction Programme. The Trust has worked closely with Teeswide Adult Safeguarding Board training and education sub group to review the current training in place and alternative methodologies. E-learning at level 1 and 2 training is available. Face to face is carried out across Care Groups.

4.2 In ***August 2018 the new Intercollegiate document for Adult Safeguarding was introduced***, this document outlined the recommendations required for training.



4.3

Level 1

- Workbook provided at time of INDUCTION into the Trust
- E-Learning available through ESR.
- Face to Face included with MANDATORY training for each directorate.

Level 2

- Face to face level 2 training.
- 2 hour update on adult safeguarding practices as aligned to new intercollegiate document.
- E-Learning through ESR.

Level 3

Full day training provision for Band 6 staff and above , but not exclusively, open to any staff that require more detailed knowledge of adult safeguarding.

Compliance continues to be monitored through

- personal development plans
- appraisal processes

4.4 **Face to Face Training delivered to;**

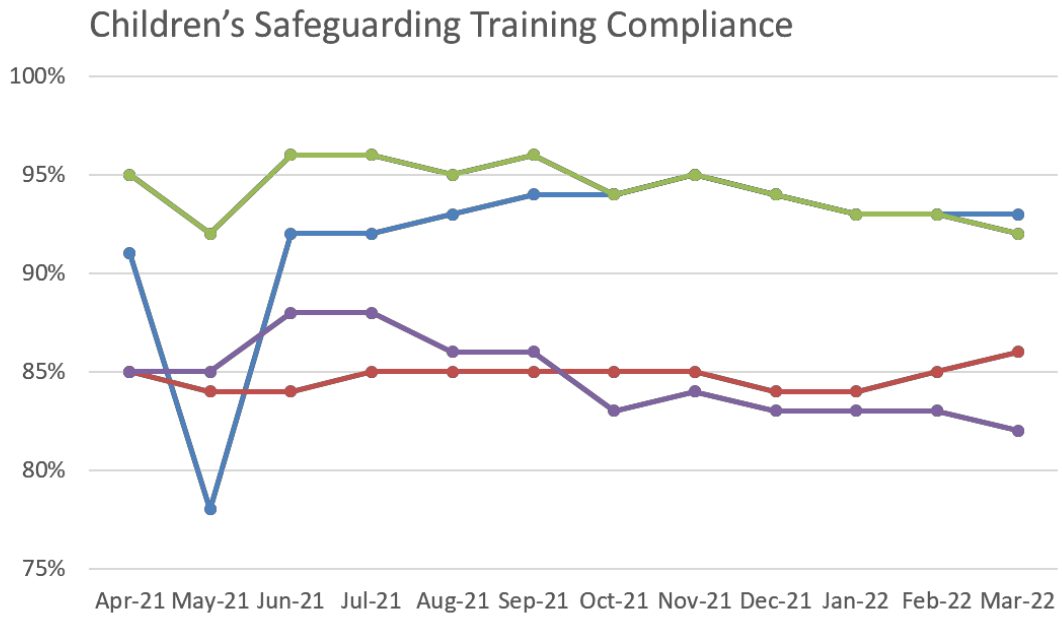
- Emergency Care
- Overseas Nurses
- Newly quality Staff
- Volunteers
- Mandatory Training Programme in a number of Care Groups

4.5 Focused work is being undertaken to improve Care Groups compliance with mandatory training and an improvement trajectory is in place. Face to face sessions have continued to be supported and delivered throughout the pandemic and additional courses have been provided to accommodate reduced class sizes to support social distancing.

Children's Safeguarding Training

4.6 The Trust's in-house Safeguarding Children Training Programme continues to provide training in line with the ***Safeguarding Children and Young people: roles and competences for health care staff; Intercollegiate Document (2019)*** and the Trust's Safeguarding Learning and Development Policy. The content of Safeguarding Children's Training is reviewed yearly or as required when informed by lessons learned from Local/ National Children Safeguarding reviews and Audits. Training methods include analysis based facilitated discussions of themed scenario's to promote a 'Think Family' approach in practice.

4.7 The table below demonstrates the training compliance monitored by the Safeguarding Committee through Care Group updates on their individual improvement plans where safeguarding training is outside of compliance. In addressing the challenges faced by staff and the Trust in response to the recover from the pandemic our Children's Safeguarding Trainers, continue to offer face to face training but continue to align any updates to face to face training with e-learning packages for both the Level 3 Children's Safeguarding Foundation Training and Updates. This has been a temporary measure to offer alternative methods of accessing training in light of additional stressors placed on staff.

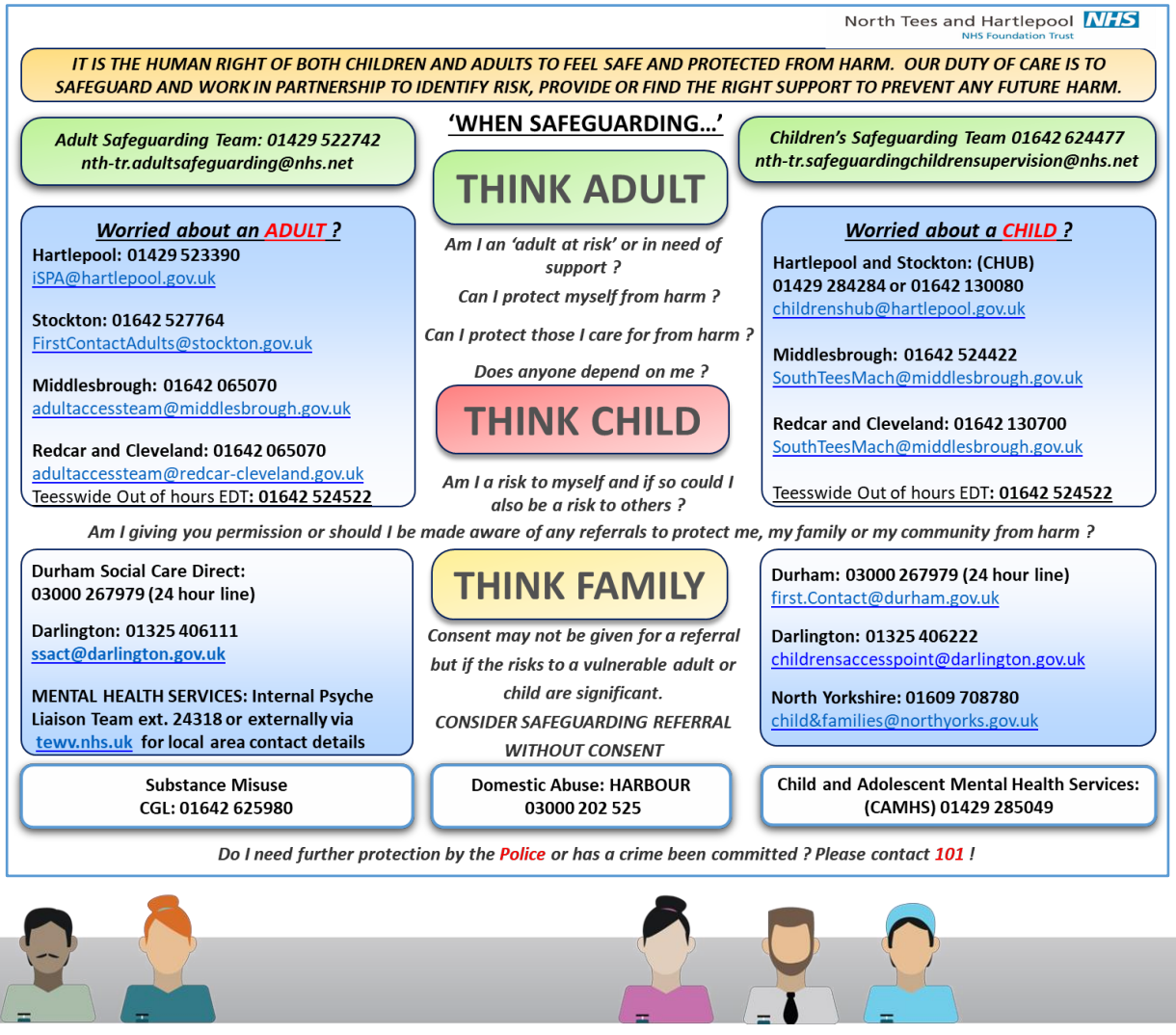


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Level 1	91%	78%	92%	92%	93%	94%	94%	95%	94%	93%	93%	93%
Level 2	85%	84%	84%	85%	85%	85%	85%	85%	84%	84%	85%	86%
Level 3 - Foundation	95%	92%	96%	96%	95%	96%	94%	95%	94%	93%	93%	92%
Level 3 Update	85%	85%	88%	88%	86%	86%	83%	84%	83%	83%	83%	82%

5 Domestic Abuse

5.1 In March 2013 the Government extended the definition of domestic violence and abuse to include young people aged 16 and 17 and has included wording to capture coercive control. There is representation from the Vulnerability Unit at the local Multi Agency Risk Assessment Conferences (MARAC) which are held fortnightly with representative from the Trust in attendance. The aim of MARAC is to ensure that high risk victims of domestic abuse are identified and their safety ensured as much as possible. The Domestic Abuse Bill (2021) has been embedded in training, the policy is being reviewed to reflect the changes.

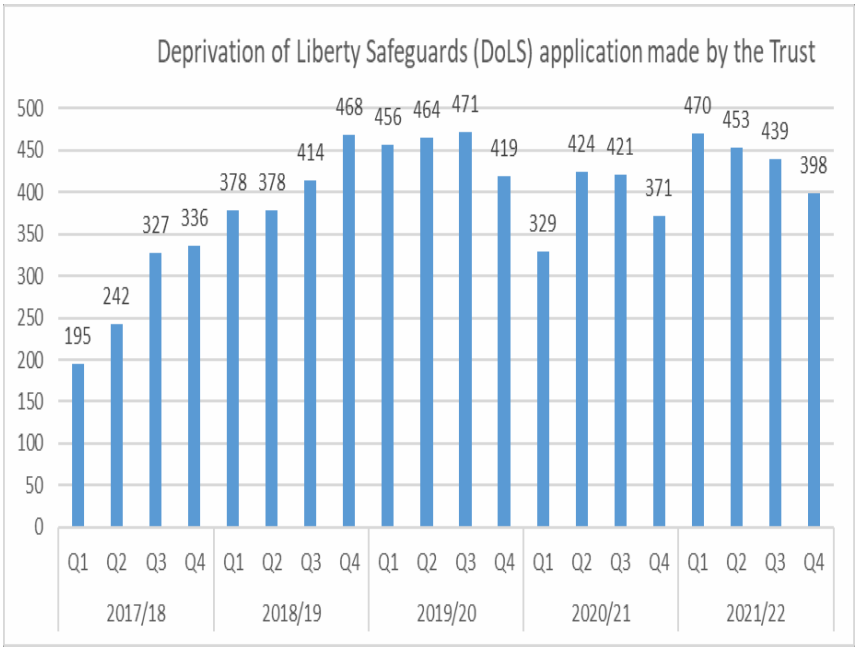
5.2 The Trust has been an active participant in Two Domestic Homicide Reviews for the period of this report, however there was no direct involvement by the Trust. Shared learning included raising awareness through teaching on Adult Risky Behaviours and continue to promote 'The Think Family Approach'. The development of the poster below continues to be distributed and promoted within clinical areas and the 'Ward Boards.' The Trust has contributed to Serious Safeguarding Adult Reviews (SARS) within other organisations to support external review process. Lessons learned from SARS are shared within the Safeguarding Committee.



6 Deprivation of Liberty Safeguards (DoLS)

6.1 In March 2014 the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council". The judgment is significant in deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty. The Supreme Court ruling now gives a new definition of what would constitute a deprivation of liberty, which is that if a person who lacks capacity is being kept in any setting under continuous supervision and control and they are not free to leave whenever they want, then they are being deprived of their liberty.

6.2 Over recent years the Trust has seen a significant increase in the number of DoLS applications. The new ruling has had a significant impact on the number of applications now being made as displayed in the graph below; the graph demonstrates a reduction in DoLS application in response to reduce admission rates in the initial phases of the COVID pandemic.



The DoLS database is now well established and applications of the DoLS are placed on Trakcare with expiry dates. Notifications of applications are sent to CQC, although due to the significant increase in activity, this is a challenge to achieve within the statutory 28 days function.

6.3 The DoLS policy has been updated to reflect Cheshire West and the changes in the DoLS process making it more user friendly. In March 2022, a 16 week consultation was commenced for the implementation of Liberty Protection Safeguards (LPS), this will replace DoLS,. The consultation period ends on 7th July, 2022. Following the consultation a review will take place and it is expected to be implemented in the Autumn of 2023, although the date has not been confirmed. The main change will be that NHS Trusts will be the Managing Authority and not the Local Authority, this will have a significant financial impact, as well as an impact on training and resources.

7 Safe Recruitment

7.1 Disclosure & Barring Scheme (DBS) checks are one aspect of safe recruitment and safeguarding and the check itself is only a snapshot of a point in time. To demonstrate this, in the past year there have been occasions where the Trust has been contacted by either the Police or the Local Authority Designated Officer (LADO) in relation to a significant safeguarding issues, despite the individuals concerned having a clear DBS check. Therefore other arrangements for safeguarding are equally as important including:

- Safe recruitment – identity checks, reference checks, interviews.
- Safe working practices – vigilant and on-going day-to-day management.
- Training and awareness – ensuring employees are appropriately trained and aware of safeguarding issues.
- Confidential reporting procedures – to ensure staff are able to express any concerns they may have.

7.2 It is also important to note that staff have a contractual and professional duty to disclose any instances which are likely to be the subject of a police inquiry during the course of their employment.

8 Mental Health including Learning Disabilities

North Tees and Hartlepool NHS Foundation Trust

8.1 The Adult Safeguarding team includes a Specialist Nurse for people with learning disabilities.

Gemma Crooks

SAFEGUARDING ADVISOR AND LEARNING

8.2 The Learning Disability Nurse proactively identifies appropriate patients within the acute setting via a virtual ward and provide specialist advice helping with reasonable adjustments and planning discharges, utilising Best Interest meetings The virtual ward system is linked to Trakcare, therefore when a person is admitted into our hospitals information regarding the admission can be viewed on Trakcare. This enables early identification and interventions for patients with learning disabilities who require reasonable adjustments towards effective individualised care.

8.3 During the last financial year, the Trust has worked with Stockton and Hartlepool Borough Council, who has provided relevant information to enable the Trust to flag people, accessing services, who have a learning disability. This has enabled the Trust identify 1930 patients with a learning disability. This has had an impact on the amount of referrals via the virtual ward system.

8.4

Learning Disabilities Mortality Review Programme (LeDeR)

LeDer is a national initiative to ensure lessons are learned from deaths where people with learning disabilities have received care and is undertaken as part of a multi-agency approach, which the Trust are actively involved in 10 reviews carried out in 21/22, this had been a decrease to the 27 carried out in 20/21. In most cases the care has been co-ordinated with other care services or persons involved and has identified evidence of reasonable adjustments when planning and delivering care. The Trusts process of co-ordinating the LeDeR reviews continues to receive national recognition.

8.5 **A Service Level Agreement** is in place with Tees Esk and Wear Valley NHS Foundation Trust who provide;

- Mental Health Act advice
- Training

for lead professionals on behalf of the Trust. During 21/22, 294 new patients were identified, the overall cohort is now 4776. In comparison to last year figures of 4482 this

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

9 Prevent Strategy and Channel

9.1 Three national objectives have been identified for the PREVENT strategy:

- **Objective 1**: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- **Objective 2**: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- **Objective 3**: work with sectors and institutions where there are risks of radicalisation which we need to address.

9.2 During 21/22, staff have been trained as Health WRAP 3 trainers (Workshop for raising awareness on Prevent), through monthly planned WRAP sessions. The Trust has developed an e-learning package on Prevent for staff.

9.3 Awareness of **Prevent** is included in all adult safeguarding training in addition to Trust wide adult safeguarding dedicated literature available in all clinical and public settings and dedicated boards for campaign materials.

9.4 The named nurse for adult safeguarding is an active member of the regional safeguarding networks and provides updates to the Trust Resilience Forum.

9.5 **Channel** referrals are raised where there is a concern around behaviour of an individual which may suggest radicalisation or extremist behaviour.

1

Number of Channel referrals from Trust 2021—2022

9.6 The Trust is required to submit Prevent data via Unify quarterly. This data measures compliance with regards to training for WRAP and Prevent awareness and compliance with policies and procedures.

The current trajectory is **85%** compliance Preventing Radicalisation – Levels 3, 4 & 5 (PREVENT Awareness); the Trust is currently at **92%**. The current target for Preventing Radicalisation – Levels 1 & 2 (Basic PREVENT Awareness) is **85%;** the Trust is currently at **90%.**

10 Adult Safeguarding - Key Achievements 2021 / 2022

- Embedding and sharing learning from LeDeR (Learning Disability Mortality Review).
- Domestic Abuse Bill (2022) embedded in training, policy has been reviewed and awaiting approval.
- Learning from Safeguarding Adult Reviews (SAR) disseminated within the Care Groups.
- Combined Adult and Childrens Safeguarding Committee, to generate shared learning and safeguarding of the family unit.
- Safeguarding team has remained fully operational through the pandemic.
- Achieved Green status for the Quality Assessment Framework (QAF) through Teeswide Safeguarding Adults Board (TSAB).
- Welcomed into Team the Independent Domestic Violence Advocate (IDVA) into the Trust, she has already supported 41 vulnerable people who she has identified as being subjected to domestic Abuse
- Introduced a new flagging system for autism and reasonable adjustments, to support clinical staff, this included attaching '***all about me'*** and '***hospital passport'*** to active clinical notes to increase personalised care.

10.1 Adult Safeguarding - Key Priorities 2022 / 2023

- Implement the Liberty Protection Safeguards and provide training within the Trust once the code of practice has been agreed.
- Continue to disseminate lessons learned from Safeguarding Incidents.
- Continue to provide clinical supervision for staff with regards to Safeguarding, also to provide supervision for clinical leads following safeguarding concerns raised against that area.
- Continue to audit and monitor performance and improve the quality of referrals.
- Further embed lessons learned from LeDer.
- Develop a Capacity Assessment and Best Interest Meeting audit
- Contribute to the Treat as One work to achieve parity between physical and mental health needs.
- Participation in the National Audit for Dementia and NHSI Learning Disability Standards.

11 Governance Assurance

The Children's Named Nurse and Children's Safeguarding Team work collaboratively with the Trust's Named Doctor in providing governance, leadership, education and support to all staff across the Trust. Escalation of any safeguarding practice issues and concerns are through the Associate Director of Risk, Patient Safety and Governance or directly to the Chief Nurse.

11.1 Safeguarding Committee

The Safeguarding Committee has oversight of all safeguarding audits with a high level summary provided by individual Care Groups responsible for departmental audits as part of the work plan.

11.2 Children's Safeguarding Work Programme

The Children's Safeguarding Work Programme monitors action plans from Children's Safeguarding Practice Reviews (CSPR); learning lesson reviews, Domestic Homicide Reviews and internal incidents. These inform the Trusts safeguarding children professionals' development work, the safeguarding children annual audits and assurance programmes. Key national drivers are also reviewed through the committee to explore the impact on Trust practices.

11.3 Audit

11.4 The safeguarding work program has a strong focus on quality and improving outcomes for children and young people. Audits include:

Adult Risky Behaviours A&E Audit	**Child Protection Medical Assessment Audit**
Section 11 Audit	**Safer Referral Audit**
NICE Guideline 89 Audit	**Looked After Children Review Health Assessment Audit**
Midwifery Quality Assurance Record Audit	**Immobile Baby Pathway Audit**
Paediatrics Quality Assurance Record Audit	**Children Not Brought for Appointments by Parents/ Carers Policy Audit**

11.5 Audit outcomes and monitoring of improvement plans are managed through the Safeguarding Operational Group with key safeguarding champions and leads from each care group responsible for supporting safeguarding improvements and dissemination of any identified learning through incidents and Learning Reviews.

12 Partnership Arrangements

12.1 The Trust continues to make active contributions at Senior level to the Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) and Durham Safeguarding Children Partnership (DSCP) and continues to maintain representation on a number of Safeguarding Partnership subgroups for;

- Tees Procedures Group
- Tees Strategic Engine room
- MACE - Multiagency Child Exploitation

- County Durham MASH Board
- Embedded Learning Group
- CEG - Child Exploitation Group

12.2 **HSSCP Partnership priorities for 2021-22**

The HSSCP Executive and Engine Room have undertaken development work to identify key priorities for the Partnership for 2021-22 as follows;

Business Priority:

1) Partnership Development
Governance, engagement

Thematic Priorities;

2) Contextual Safeguarding

3) Domestic Abuse Practice

Practice Themes;

4) Learning from reviews and good practice (to include active learning, audit, impacting upon frontline practice)

These key priorities have formed the basis for the HSSCP Business Plan for the coming year and work is already underway against each of these

12.3 **DSCP Partnership priorities for 2021-22**

The DSCP Board have undertaken development work to identify key priorities for the Partnership for 2021-22. These are;

Practice Improvement Themes

- Domestic Abuse Practice – Coercive controlling behaviour
- Cumulative Harm and Risk Assessment

The Board has facilitated initiatives that have bring together partner agencies to develop a range of tools, interventions and opportunities to support families where the about practice themes are a feature.

12.4 Our Trust is integral to supporting and understanding the development of these priorities and how key messages from these drivers inform our trusts safeguarding priorities.

Both partnerships continue to progress development work around Neglect and Contextual Safeguarding which our children continue to be at significant risk from and where the pandemic has impacted upon greatly.

13 Focus on Learning

13.1 Children's Safeguarding Practice Reviews

13.2 Local Learning

In 2021 - 22 HSSCP undertook six Rapid Reviews into serious safeguarding incidents of which the Safeguarding Named Nurse and team were active participants to support and understand any learning.

13.3 Four Rapid Reviews progressed to Local Safeguarding Practice Reviews (LSCPR). Three of these were completed during 2021 with final reports published early 2022 and learning disseminated throughout the trust on final recommendations made. The fourth is scheduled to be completed during 2022.

13.4 An example of themes from one of the reviews have centred around UNLOCKING FIXED THINKING promoting practice that requires practitioners

- To clarify and verify parental / carer self reporting.
- Adaptive and responsive thinking - Evidence Based Decision Making
- Creating Space - Opportunities for multi-agency reflection,
- Father inclusive practice

The Trust has been an active participant in many task and finish groups generated by work from all reviews to ensure practice continues to improved.

Learning Lesson's Reviews

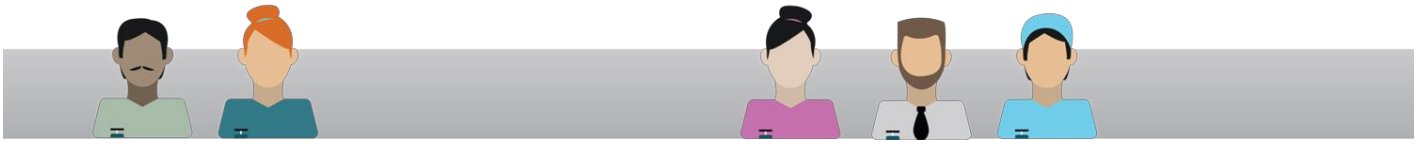
13.4 Although not all cases progress to LSPCR's this is usually in response to learning and actions evidenced from rapid review where conducting an LSPCR would not benefit any further learning.

13.5 Trust staff are supported during and after any LSCPR and learning reviews by the Safeguarding Team and their managers to support any areas for practice development where identified.

All reviews aim to consider how wider systems and processes in the Trust limit or support staff to effective safeguard. Learning informs our Children's Safeguarding learning and development policy for staff within the Trust and the focus of the Safeguarding Work Program operationally feeding into the Safeguarding Committee.

13.6 DATIX - Internal learning

13.7 The team continue to explore any concerns and any identified areas of safeguarding practice development through DATIX, the Trust's internal investigation systems. This also supports good governance structures, escalation and informs learning. Examples from incidents that have identified a need for learning include the Genital Injury Pathway and Fracture Path-



13.8 **Learning Events**

A joint 'learning from reviews' event has been facilitated and supported across both South and North Safeguarding Partnerships to share learning and themes across the Tees Valley footprint.

Yearly conferences have been produced by both safeguarding partnerships around the theme of Contextual Safeguarding - extra familial harm to support dissemination of learning further.

13.9 **National Learning**

The National Children's Safeguarding Practice Review Panel published their third National Review 'The Myth of Invisible Men' Safeguarding Children under 1 from non-accidental injury caused by main carers in September 2021 which provided important learning and recommendations regarding non-accidental injury of babies under 1 year old and reinforcing the importance of identifying and engaging fathers and promoted with our midwifery teams.

13.10 **National Inquiry**

The Government has launched a national inquiry in response to the death of Arthur Labinjo-Hughes. this will review the circumstances leading up to murder of Arthur Labinjo-Hughes to determine what improvements are needed by the agencies that came into contact with him in the months before he died.

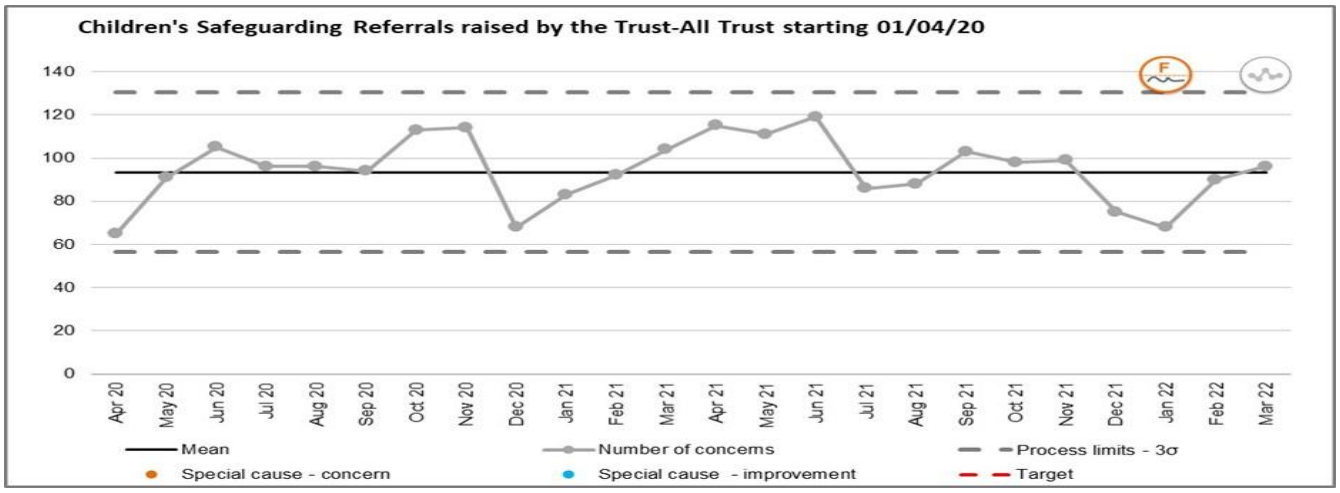
The government has separately commissioned 4 inspectorates, covering social care, health, police and probation to undertake an urgent inspection of the safeguarding agencies in Solihull to whom Arthur was known.

As part of this inspection, all the agencies tasked with protecting children at risk of abuse and neglect in Solihull will be subject to a Joint Targeted Area Inspection to consider their effectiveness and advise on where improvements must be made.

In addition to this, the independent, national review will identify the lessons that must be learnt from Arthur's case for the benefit of other children elsewhere in England, to be led by the National Child Safeguarding Practice Review Panel. Reports are awaited on this inquiry.

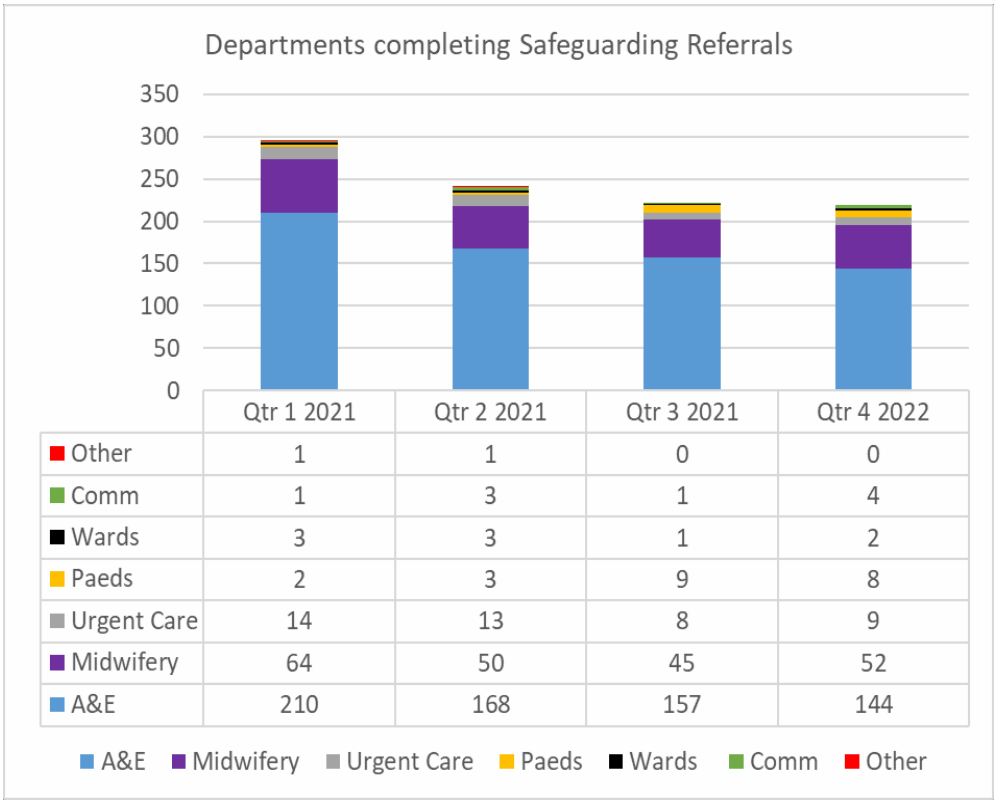
14 # SAFER REFERRALS

14.1



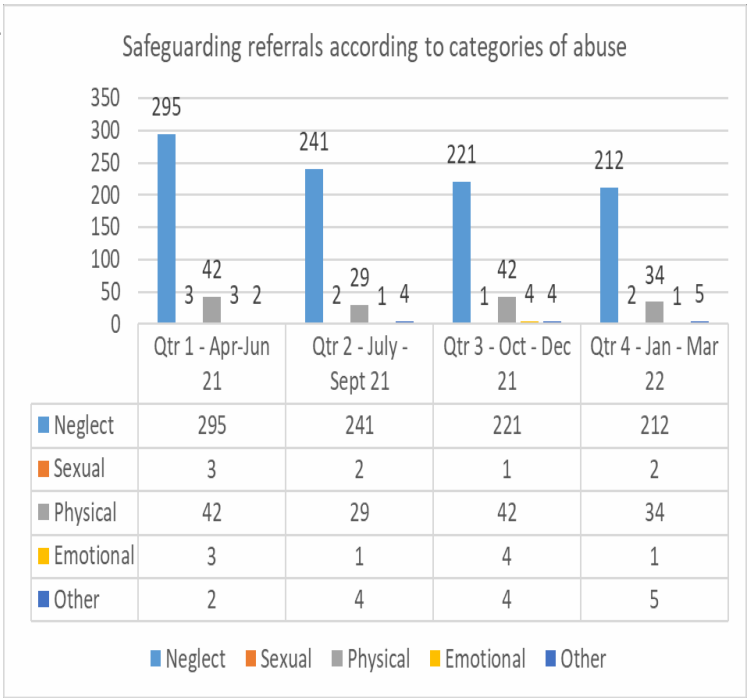
14.2 The Emergency department continues to generate most of the Trust's children's safeguarding referrals. As a result of this the safeguarding team provide daily liaison with our ED to support and advise if required. Our Trusts midwifery service also submits a significant amount of referrals and on the local authorities acceptance of a safeguarding referral, the teams specialist safeguarding midwives attend all multiagency strategy discussions, pre-birth meetings, and some pre-discharge meetings to support and formulate a risk assessment through 'antenatal alerts' and 'Birth Response Plans' to ensure the risk is managed throughout pregnancy, at birth and on discharge. As caseload holders all midwives are mandated to have safeguarding supervision.

14.3



	Qtr 1 2021	Qtr 2 2021	Qtr 3 2021	Qtr 4 2022
Other	1	1	0	0
Comm	1	3	1	4
Wards	3	3	1	2
Paeds	2	3	9	8
Urgent Care	14	13	8	9
Midwifery	64	50	45	52
A&E	210	168	157	144

14.4



	Qtr 1 - Apr-Jun 21	Qtr 2 - July - Sept 21	Qtr 3 - Oct - Dec 21	Qtr 4 - Jan - Mar 22
Neglect	295	241	221	212
Sexual	3	2	1	2
Physical	42	29	42	34
Emotional	3	1	4	1
Other	2	4	4	5

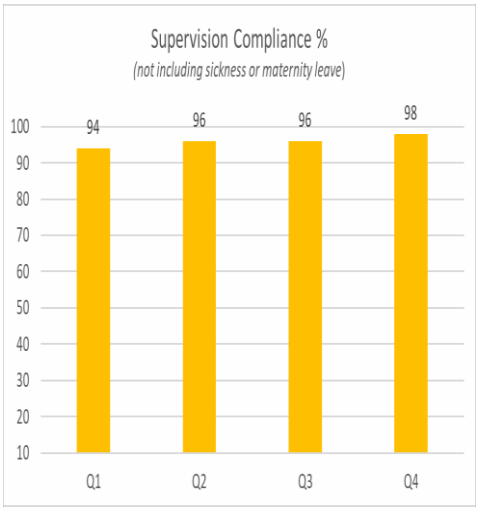
14.5 Neglect continues to feature in most of the Children's Safeguarding referrals, although emotional abuse and neglect often cannot be distinguishable in all aspects of abuse of children.

15 Safeguarding Children's Supervision

15.1 The Trust continues to recognise safeguarding supervision as fundamental to maintaining safe practice and supports 1:1 mandatory supervision by Senior Safeguarding Nurses on a three monthly basis for Midwives as primary caseload holders. This has been extended to our Community Staff who have prolonged involvement with children with complex needs. Group supervision is facilitated as a rolling programme primarily to the Trust's allied professionals who have a specialist role in families.

15.2 Safeguarding Supervision is accessed by all Safeguarding Senior Nurses with a Named Children's Safeguarding nurse outside of the Trust. Both the Named Nurse and Named Doctor seek supervision from Interim Designated Children's Safeguarding Nurses and Doctors outside of the Trust. However the vacant Designated Doctors role is yet to filled following retirement. These roles are essential to the Trust in helping to support, understand, develop and implement good practice across the Tees Valley footprint and sharing lessons learned from neighbouring Trusts.

15.3

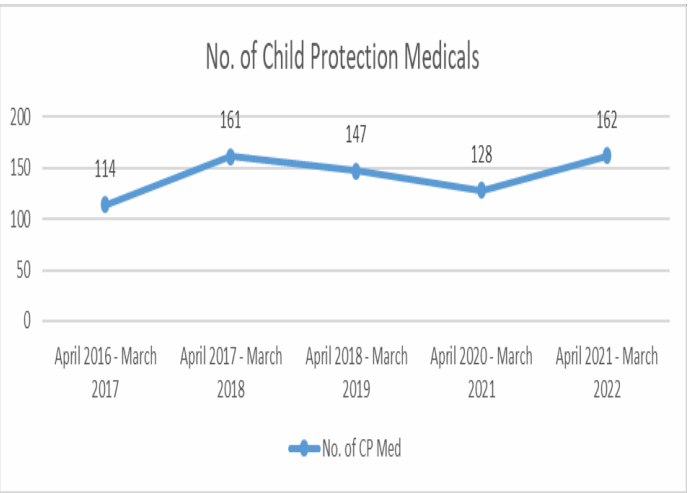


15.4 Staff compliance for safeguarding supervision continues to be monitored as a local quality and performance indicator, and consistent high compliance levels have been maintained through the year as demonstrated in the following graph, reported via the quarterly dashboard. This is despite significant challenges with practitioners sickness and isolation periods due to COVID.

16 Named Doctor Journey to Excellence

16.1 Child Protection Medicals

16.2



There is no significant increase in CP medicals as compared over a five year period.

16.6 **Dedicated Child Protection Suite**: Recent approval for a dedicated Child Protection Suite has now been authorised for development. This acknowledges and provides a compassionate response to the extremely stressful experience of a child protection medical for both the child and their family, improving confidentiality for families as part of learning from incidents. This area will also facilitate robust information sharing between multiagency practitioners surrounding this process as room for MDT meetings.

16.3 The development of identified time slots (x2 per day) for Child protection medical clinics is now well embedded Monday to Friday. This has supported a more formal timely response to children and families with positive feedback as sought from social care colleagues following every Child Protection medical.

16.4 **Compliance with the Royal College Paediatrics and Child Health (RCPCH) Service Standards**

The first-ever service standards for Child Protection Medicals were produced by the RCPCH in October 2020. There are Seventy-four standards, following cross trust collaboration a gap analysis and actions were formulated to address developmental areas to meet new standards. All of these standards have been achieved as a result of the significant amount collaborative working between Trust staff:

Dr Shashwat Saran
NAMED DOCTOR
CHILD PROTECTION

16.5

Fully revised child protection medical proforma	Child Protection Medical prospective audit
New Trust Child Protection Guidelines	Revised patient Information leaflets on 'Why a child protection medical examination.' to provide information on the role of chaperones.
Standard Operating Procedures	E-chaperone training which must be completed before chaperoning which the majority of Paediatric Staff are now trained. E-medical photography training course for Paediatricians.
Social Care Feedback form.	New Terms of Reference - Peer Review

16.7 **Single point of contact:** To address the challenges reported by our colleagues from Children's Social care & Police in accessing the Child Protection service a single point of contact was established. This was developed through the Trust undertaking deep-dive audits into administrative processes around child protection medicals and to monitor and address any breeches in compliance around reporting as identified through reported incidents. This supports more escalation points to address any breeches.

17 Ongoing developmental work

Mini-pupillage for our Paediatricians	New – emphasis on in house training by partners agencies (Social Workers, Police, Independent Reviewing Officers)
Formal learning and Case discussion through Peer Reviews	Proposed Safeguarding simulation drills / Safeguarding - key messages on a page

18 Fabricated and Induced Illness and Perplexing Presentation.

18.1 In March 2020 the RCPCH published new guidance for practitioners in managing cases where Fabricated or Induced Illness is suspected superseding previous guidance from 2009. A local policy has been developed by our Named Doctor which is awaiting approval. This aligns with further work on a Tees-wide FII procedure to ensure all agencies are given the guidance to support them in negotiating through, often extremely complex cases of perplexing presentation and fabricated and induced ill.

18.2 The Trust have supported the Named Doctor to establish a National Fabricated or Induced illness Special Interest group (FII-SIG). There are over seventy-five Named and Designated Doctors from all over the United Kingdom, who meet every other month (virtually) to peer review live potential FII/PP cases. This is the only network in the country to do so. This initiative is widely appreciated by the fraternity.

18.3 An Audit was also carried out to review FII cases within the Trust to assess whether Paediatricians are effectively responding to FII. Retrospective audit analysed investigation, documentation and management of all the patients with suspected FII/PP at our NHS Trust from March 2021 to September 2021. Although results were found to be positive and new guidance was supporting Paediatricians it was identified that a multi-agency audit would be beneficial and is still under exploration.

19 NETWORKING

19.1 An interface group (APS-IG) was initiated by our Named Doctor and is supported by Trust Safeguarding Senior Nurses, A&E and Paediatric staff, Police, Social care and CAMHS. This proactive group meets on a monthly basis to ensure that safeguarding concerns within the catchment area are dealt with appropriately. If not, concerns are promptly escalated to the decision makers. This group has proved to be successful in providing a forum to improve collaboration, understanding of each other challenges, break down barriers to sharing of information in a timely way and acts as a forum for respectful professional challenge and management of individual cases from all agencies.

20 Safeguarding CHAMPIONS

There are 25 Safeguarding Champions representing Paediatrics, Midwifery (Stockton, Hartlepool and Peterlee) and A&E who are offered a bi-monthly safeguarding champions meeting as facilitated by our Safeguarding Specialist Midwife to provide a forum for safeguarding practice issues to be raised and addressed in each of these areas.

21 Local Authority Designated Officer (LADO)

Monthly meetings continue between the Named Nurse and staff within the Workforce team to improve communication and referrals to LADO and to review whether any safeguarding considerations required around risks posed by or risks exposed to staff and their families. Additional safeguarding training has been delivered to Trust senior managers to increase their awareness of adult risky behaviors that may require safeguarding intervention when supporting staff are on sickness/absence or where there are capability issues.

23 Domestic Violence and Abuse

The Children's Safeguarding Senior Nurses continue to represent the Trust and share relevant information to the local Multi Agency Risk Assessment Conferences (MARAC) separately in Hartlepool and Stockton, where high risk victims of domestic abuse are identified and safety plans put in place with further contribution to the Multi Agency Tasking and Coordination (MATAC). The Trust Electronic Patient Record is used to flag concerns in support of people accessing our services.

23.1 The Domestic Abuse Policy has just been reviewed within the Trust to reflect outcomes from the Domestic Abuse Bill (2021) and changes will be promoted throughout the Trust to support the development of a domestic abuse-trauma informed approach and raise awareness of domestic abuse as an adverse childhood experience that impacts on the emotional and physical health into adulthood.

24 Child Exploitation (CSE / CCE)

24.1 As CSE and criminal exploitation continues to be a growing concern the Trust along with Safeguarding partners focus is on understanding and responding to extra-familial harm from exploitation, peer on peer abuse and resulting impact of Trauma on both the child and their families who are caught up with Organised Crime Groups (OCG's).

24.1 The Trust has representation at the Serious and Organised Crime Local Partnership Group to understand the changing landscape and challenges for children, the impact and how children may present to the Trust. Through collaborative work with HSSCP a Contextual Safeguarding Hub is presently under development. This is to acknowledge the very different approach required to respond to this form of harm. This new structure has the potential of affecting how the function of the local Vulnerable, Exploited, Missing Trafficked (VEMT) practitioners group at which the Trust is an active participant. VEMT identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk and the Trust is represented on both the Strategic and within Operational groups around VEMT.

24.2 A CSE risk assessment is completed on all LAC children over the age of 10 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk. This risk assessment has also been rolled out to the Paediatric areas.

Children's Safeguarding Key Achievements 2021 / 2022

- Strong working relationships have been maintained with HSSCP and DSCP children's safeguarding partnerships to continue to address the challenges of safeguarding service delivery.
- Compliance with all local safeguarding children quality requirements has been achieved monitored closely through quarterly Care Quality Review Group meetings with Teesswide CCG.
- Contribution to the new evolving Multi Agency Child Exploitation (MACE) as per new local authority arrangements supports a more robust and timely response to changes in practice required to protect children exposed to extra-familial harm, peer on peer abuse, criminal and sexual exploitation. This aligns to the newly formed CET (Child Exploitation Teams) developed by our Police colleagues in response to rising and increasing risks for our children and young adults. The Safeguarding Senior Nurses continue to provide information to support risk analysis within MACE and VEMT.
- Face to face foundation and update training continues to remain a priority as supported by the Trust wherever possible to ensure skills and knowledge are attained alongside the understanding the theory of children's safeguarding to support practitioners to 'think safeguarding,' and bridge the theory practice gap. To support compliance and ongoing challenges for staff in attending face to face there remains foundation and update e-learning packages as an additional tool to encourage and support staff in maintaining their safeguarding awareness.
- The Trusts Named Doctor has been supported in the development of new policies / audits and pathways in response to new standards as identified in pages .
- Introduction of Schwartz Round into the Peer Review annually which is prompted to for all trust staff and colleagues to attend to discuss the personal and professional impact of safeguarding on the practitioner. Contribution to this by practitioners has been excellent and evaluation very positive.
- Ongoing development and monitoring of action plans following recommendations from the Joint Targeted Area Inspections and Local Safeguarding Children Practice Reviews.

Children's Safeguarding Key Priorities 2022 / 2023

- Whole service review to be carried out to establish workforce priorities.
- Continued commitment to HSSCP and DSCP local children's safeguarding partnership and ongoing representation at Strategic Partnership Meetings / Subgroups and Task and Finish Groups.
- Continue to develop and monitor action plans following recommendations from both Local and National Children's Safeguarding Practice Reviews and Joint Targeted Area inspections to inform children's safeguarding training updates and facilitate dissemination of any targeted learning.
- To capture meaningful Safeguarding data across the trust to inform targeted response to quality improvements.
- Develop and review policy's and pathways informed by local and national learning and statutory safeguarding guidance and standards.
- Development of a Child Protection Medical Suite in recognition of the stress for children and their families and professionals in having to undergo and support Child Protection Medicals. Providing an increased level of confidentiality for families and facilitate robust information sharing.
- Continue to strengthen partnership working through expanding the Interface Group between front of house services from all agencies. This now includes the Trusts Emergency Department, Urgent Care and CYPED with Social Care's Emergency Duty Team, Social Care Children's Hub, CAMHS and Police representatives with Named Safeguarding Professionals for the Trust.
- Continue to collaborate with agencies in the development of the MACE contextual safeguarding hub to support how all agencies including the Trust understand how to respond and protect children appropriately against extra familial harm, peer on peer abuse, who are criminally and sexually exploitation.
- Continue to support and share information with appropriate consents to universal services and partners to support risk assessment of children who have had contact with the trust and appropriate support and response is considered at all levels of concern.
- Develop a Communication and engagement strategy to support sharing of key safeguarding messages to all trust members to increase awareness of adverse childhood experiences and the need to adopt a trauma informed care approach throughout the trust in response to recent lessons learned.
- Development of Dental Neglect Pathway to support access and feedback to practitioners for our vulnerable children (following child protection medical and our Children in Care)

27 Children in Our Care (CIOC) formerly (LAC)

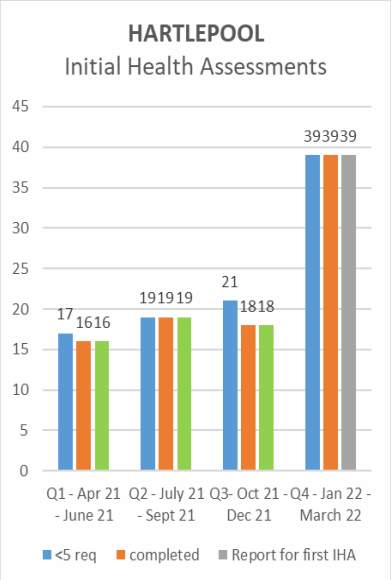
27.1 The services and responsibilities for CIOC are underpinned by legislation, statutory and good practice guidance including: "Statutory Guidance on Promoting the Health and Well-being of Looked After Children" (DH, 2015) and "Looked After Children and Young People" (NICE, Oct 2021). The importance of the health of children and young people in care cannot be overstated as many children in care are likely to have had their health needs neglected prior to coming into care. The health of looked after children is everyone's responsibility, so partnership working is essential to ensure optimum health for each individual child and young person.

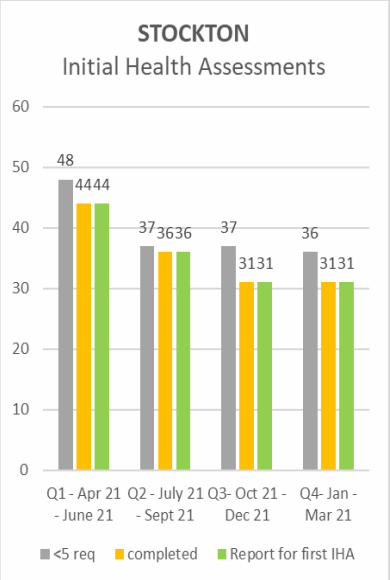
- The CIOC health provision has been an integral part of the Trust Safeguarding until commissioning of the Children's Health in Care Team was awarded to Harrogate and District Foundation Trust (HDFT) in April 2022. The Trust remains responsible for Initial Health Assessments (IHA).
- The Children's Health In Care Team (CHiC) has remained involved with the Lets Take Action group (CIOC, Stockton) and Children in Care Council (Hartlepool). These groups facilitate the voice of children in our care and support them to influence care provision.

28 Children's Health in Care Arrangements and Provision – IHA's

2.1 Initial Health Assessments (IHA) are a statutory requirement. All children who come into care must be offered an Initial Health Assessment (IHA) by a suitably qualified medical practitioner, and reported upon to form the child's Health Care Plan by the time of the child's first Looked after Review (LAR) within 20 days of the child coming into care.

28.2





The tables represent the number of children coming into care who require an IHA, how many received an IHA and report provided with timeframe.

HDFT are commissioned to continue to 'coordinate' IHA's as requested by Local Authority with the relevant Health Trust.

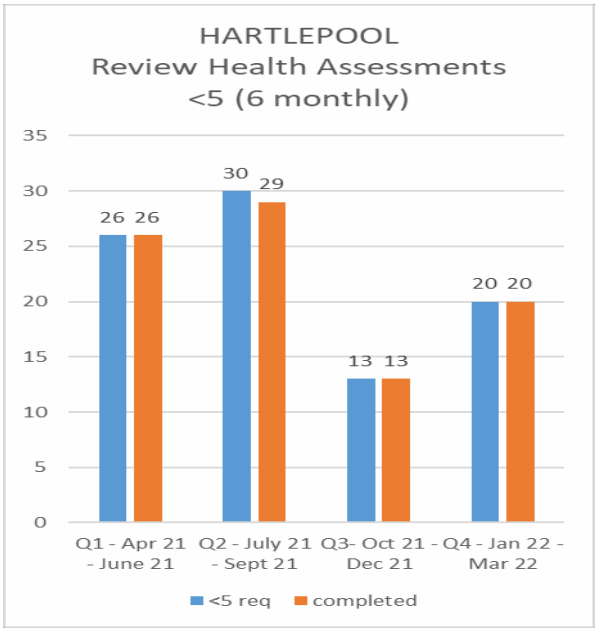
28.3 Any reduction in compliance has been addressed weekly by the Senior Nurse following an agreed escalation process. Service demand is monitored so that resilience plans can be implemented to ensure there is sufficient capacity to respond. Points to note in relation to reduced compliance include, not receiving timely admission notifications or consents for IHA's and on occasion children and young people choosing not to engage with assessments.

29 Review Health Assessments

29.1 Review Health Assessments are undertaken at 6 monthly intervals for children under five years; annually for those over five up until they turn 18 years old.

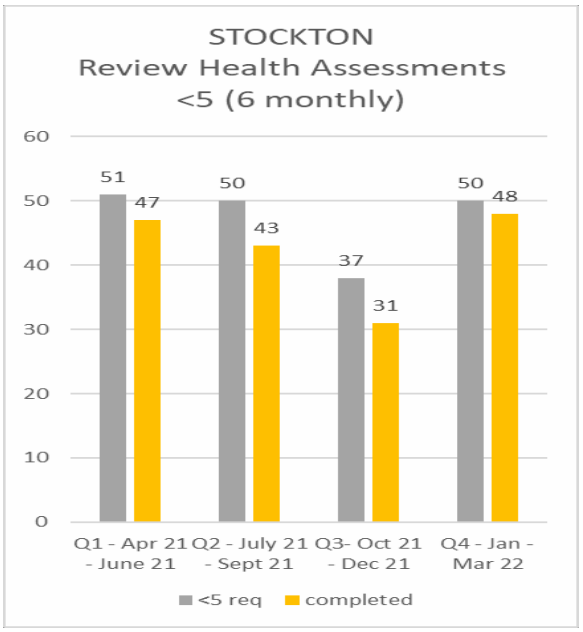
29.2 Reviews are designed to identify and monitor the health needs of Children in Our Care (CIOC) and are a statutory obligation. The Trusts Children's Health in Care team were commissioned to complete all RHA's for Hartlepool LA CIOC and have coordinated Stockton RHA's as the service model includes Health Visitors and School Nurses who undertake the RHA for those children in our care.

29.3



% RHA's completed for < 5's within TimeScale for HARTLEPOOL by NTHFT CHiC Team

Q1	Q2	Q3	Q4
100%	97%	100%	100%

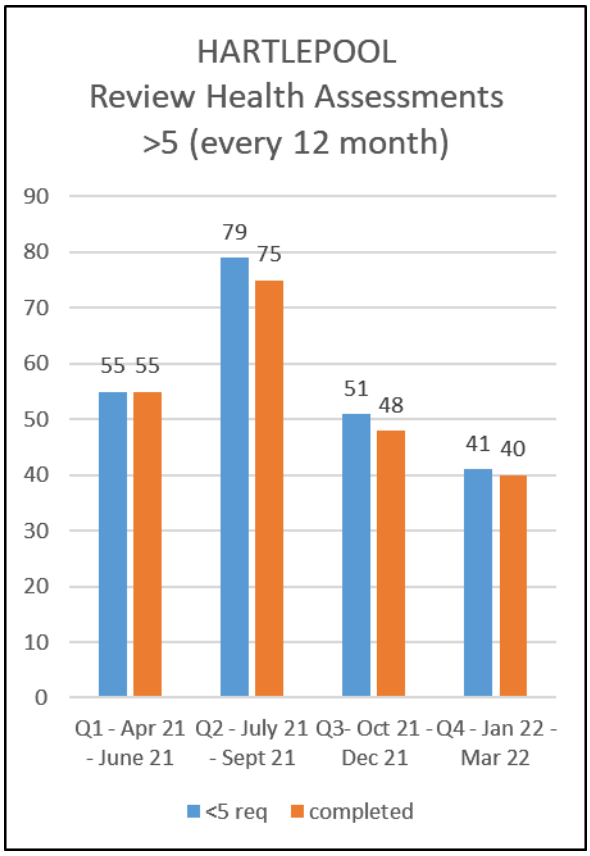


% RHA's completed for <5's within TimeScale for STOCKTON by HDFT

Q1	Q2	Q3	Q4
92%	86%	82%	96%

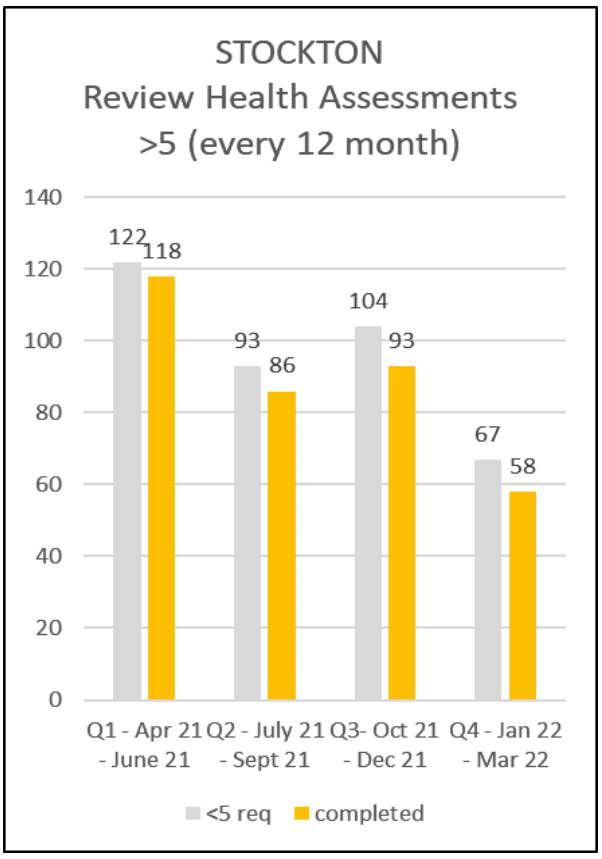
29.4 The CHiC team have remained committed to improving LAC services and as evidenced in the sustained improvement in compliance as a dedicated resource to undertake LAC assessments.

29.5



% RHA's completed for >5's in TimeScale for HARTLEPOOL by NTHFT CHiC Team

Q1	Q2	Q3	Q4
100%	95%	94%	98%



% RHA's completed for >5's in TimeScale for STOCKTON by HDFT

Q1	Q2	Q3	Q4
97%	92%	89%	87%

29.6 Further data has been gathered by the team that has identified issues where compliance has not been maintained and has enabled the team to address and support the increased pressure on service delivery during COVID in particular with our Looked After Children placed outside our areas such as.;

- Capacity to undertake the RHA in services provided by out of area Providers.
- Review assessments cancelled by carers.
- Movement of placement without notification from the LA's to the CHiC Team.

29.7 A robust Standard Operational Procedure for out of area RHA and escalation pathway sent out with every out of area request so that all agencies are aware of expected timescales and actions our CHiC team will take if the RHA cannot be completed within timescales continue to support maintaining compliance and a timely service for our Children in Care.

30 Children's Health in Care – Key Achievements 2021 - 2022

- The Trust and Children's Health in Care Team (CHiC) have responded creatively to the challenges in contacting children presented due to the Pandemic and restrictions by continuing to maintain face to face contact with children. Initial Health Assessments have been completed by telephone to minimize risk around clinic contact or face to face consultation. Review Health Assessments have been conduct- ed either virtually by 'Attend Anywhere ' or by responding to the children / young people preference of 'WhatsApp.'
- Engagement has remained positive with carers and children / young people, despite the adjustments to alternative working practices.
- Completion of IHA's and RHA's within appropriate timescales have been maintain despite challenges, ensuring a health care plan continues to be provided within 20 days.
- Virtual face to face has also enabled our CHiC team to complete RHA's for Children placed Out of Area to reduce the delay in assessments from services under additional pressures.
- The CHiC Team continue to capture the views and needs of the young people, adjust targeted health promotion advice, and refer to services as required, tailored to the challenges faced by each individual child within the context of their environment and who cares for them. Working closely with

31 Children's Health in Care – Key Priorities – 2022 - 2023

- The Trust will continue to work closely with the Children's Health in Care Team now commissioned by HDFT to ensure that our Looked After Children receive Initial Health Assessments and Adoption medicals timely. Any variance to compliance around availability of IHA / Adoption medical appoint- ments and reporting continue to be monitored as a core offer from the Trust.
- The Trust has worked closely with HDFT to support changes to processes required to accommodate TUPE of service. All CHiC teams members choose to transfer with the service demonstrating their ongoing commitment. Despite being a challenging and unsettling period for staff, compliance and service delivery has been maintained up to the point of handover of service.

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Vulnerability Team Summary

It is the human right of both children and adults to feel safe and protected from harm. Our duty of care is to safeguard and work in partnership to identify risk, provide or find the right support to prevent any future harm.

The Vulnerability Team is committed to providing leadership support, advice and guidance to staff across North Tees and Hartlepool Foundation Trust, ensuring that the Trust provides the highest level of care to all its patients and their families.

Safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and vulnerable adult must remain central to care provided.

Director of Infection Prevention and Control Report 2021-22

Executive Summary

This report describes the activities we have undertaken to improve and sustain safety for our patients, visitors and staff across all of our healthcare settings, achieved in collaboration with partner organisations and system working.

We have a number of successes to celebrate across 2021-22 including the reduction of healthcare associated infection within the Trust despite the challenges of an ongoing Covid-19 pandemic.

Our successes were in MRSA, C difficile, E coli, and Klebsiella. We also saw a significant reduction in the number of outbreaks due to diarrhea and vomiting, but an increase in outbreaks due to Covid in line with local community transmission rates.

Our commitment and focus to achieving excellence as standard for our population is a strong as ever despite and because of the pandemic.

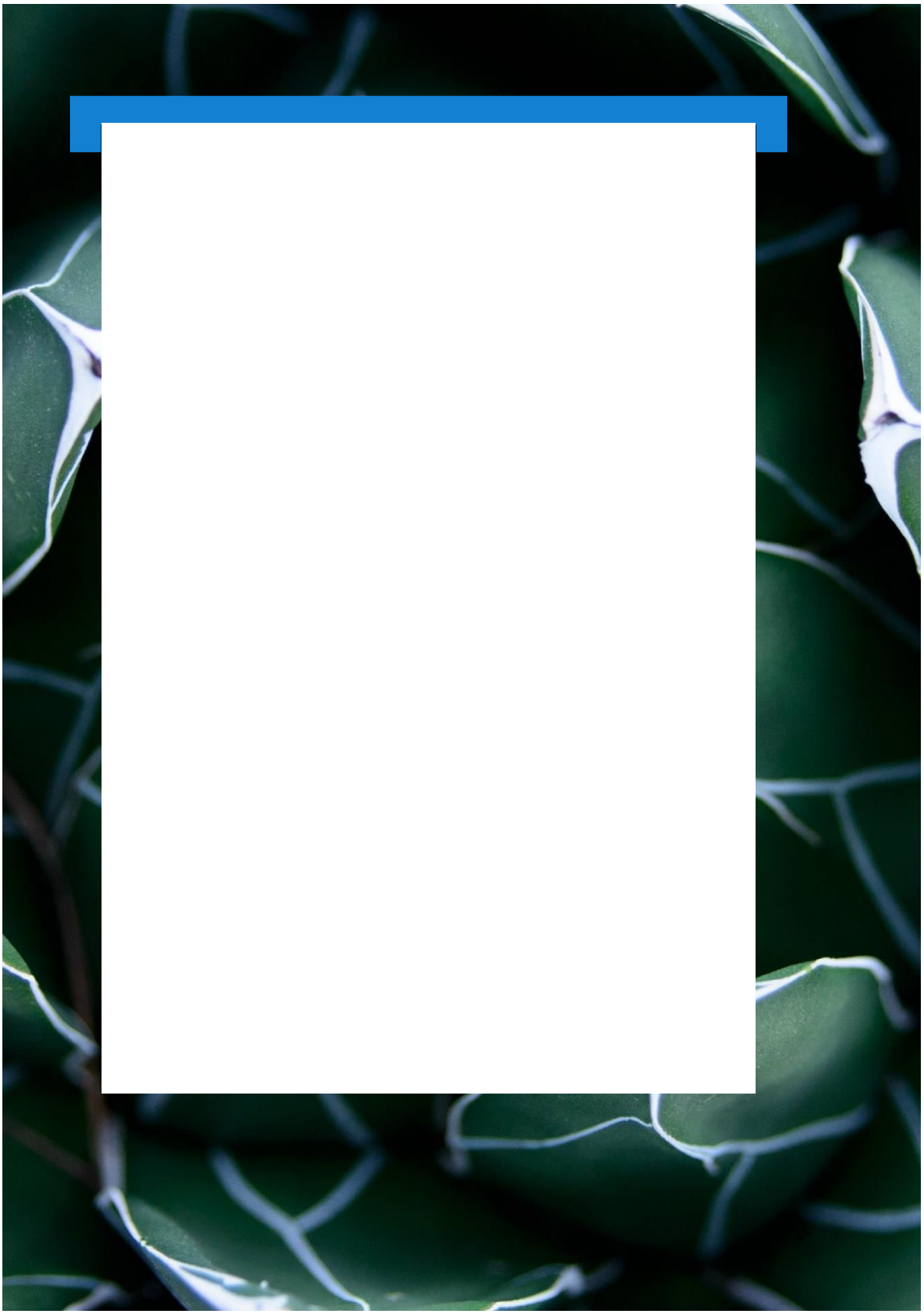
Lindsey Robertson, Chief Nurse, Director of Patient Safety and Quality, Director of Infection Prevention and Control

Contents

Infection prevention and control arrangements

The Infection Prevention and Control (IPC) Team provide a service covering all Trust settings and support local care homes, hospices and an independent hospital. We have a team of experienced IPC nurses supported by clerical and surveillance staff, who work in close collaboration with Consultant Microbiologists, biomedical scientists, the antimicrobial pharmacist and clinical teams. The Director of Infection Prevention and Control (DIPC) who is also the Chief Nurse and Director of Quality and Patient Safety is supported in leading improvement in infection prevention across the Trust by the Associate Director of Nursing, Patient Experience & Quality and the Lead Nurse for IPC.

The DIPC provides an update to each Board of Directors via an Integrated Compliance and Performance Report. A performance update is provided monthly to the Patient Safety & Quality Standards Committee, which is a subcommittee of the Board and is chaired by a Non-Executive Director. There is a quarterly Infection Control Committee (ICC) and quarterly Healthcare Associated Infection (HCAI) Operational Group, which provides operational information to the ICC. The HCAI Operational Group undertakes targeted pieces of work as required by publication of new guidance, recommendations from incident investigations or audit findings.



Healthcare associated infection surveillance and performance

The Trust participates in the mandatory HCAI surveillance programme facilitated by Public Health England including:

- Clostridioides difficile infection (CDI)
- Meticillin-resistant Staphylococcus aureus (MRSA) blood stream infection (bactereamia)
- Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia
- Escherichia coli (E coli) bacteraemia
- Klebsiella species bacteraemia
- Pseudomonas aeruginosa bacteraemia
- Quarterly Mandatory Laboratory Return (QMLR)

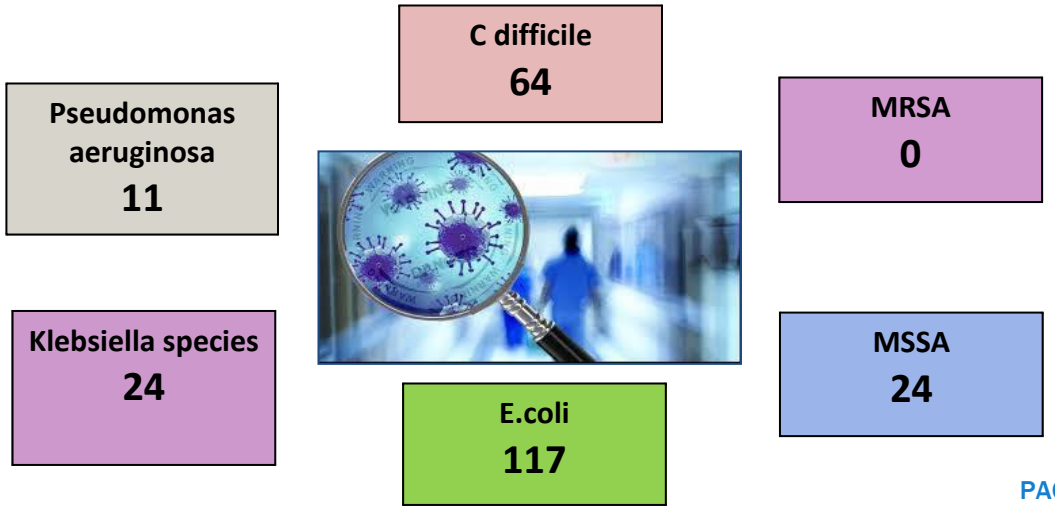
National criteria are applied to establish whether cases of the infections above are attributable to the Trust (healthcare associated).

For CDI cases taken three or more days after admission or those taken within 2 days of admission where the individual has been an in-patient in the Trust in the previous 4 weeks are considered healthcare associated and count against any Trust objective.

New criteria for healthcare associated cases using the same thresholds as for CDI were introduced in 2021-22 for blood stream infections.

National reduction objectives have been set for five of the six infections shown below and because of the impact of the Covid-19 pandemic on hospital admissions the baseline period used to set these objectives was the calendar year 2019. MSSA is the only infection without a national objective; however, the Trust set an internal objective to achieve a reduction in cases. The changes to criteria mean that comparison with previous years is not possible, except for MRSA and CDI.

Fig 1. Reduction objectives for infections in 2021-22



Clostridioides difficile infection (CDI)

Clostridioides difficile (C difficile) is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However, certain antibiotics can disturb the bacteria of the gut and the C difficile can then multiply and produce toxins, which cause symptoms such as diarrhea.

During 2021-22, we reported **50** healthcare associated cases of CDI, a good position against the **objective of 64 cases**. Although it appears that performance has deteriorated since 2020-21 it should be remembered that hospital admissions reduced significantly for part of that year, and that patients being admitted with Covid-19 have often-required antibiotic treatment, which increases the risk of CDI. Root cause analysis is carried out on each healthcare associated case and any themes from these investigations are discussed at clinical meetings.

Fig 2. C difficile cases 2018-22

Year	Healthcare associated cases	Community onset cases
2018-19	61	54
2019-20	53	39
2020-21	49	44
2021-22	**50**	**55**

Actions to reduce CDI form part of the Trust HCAI Improvement plan, discussed at regular meetings. These include a continued focus on hand hygiene and environmental cleanliness and promotion of good antibiotic stewardship.

MRSA bacteraemia

Staphylococcus aureus is a bacterium found commonly on human skin, which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases, it can cause blood stream infections. MRSA is a strain of this bacterium, which has developed resistance to many antibiotics, making it more difficult to treat.

Many individuals carry MRSA on their skin; this is called colonisation. It is important that we screen some groups of high-risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide treatment that helps to reduce the number of bacteria and therefore reduces the risk of infection developing.

In 2021-22, we reported **zero** healthcare associated MRSA blood stream infection. This is an improvement on the previous year. One community-associated case was reported and although the case does not count against the Trust, there was some learning identified relating to prompt screening and treatment.

Fig 3. MRSA bacteraemia cases 2015-22

Year	*Healthcare associated cases*	*Community onset cases*
2015-16	2	3
2016-17	1	2
2017-18	4	2
2018-19	0	0
2019-20	0	3
2020-21	1	2
2021-22	**0**	**1**

MSSA bacteraemia

MSSA is a strain of Staphylococcus aureus that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body for example via a wound or invasive device, and in serious cases, it can cause blood stream infections.

In 2021-22, we reported **38** healthcare associated cases of MSSA bacteraemia against the internal **objective of 24 cases.** Genetic typing was undertaken for a number of cases, which were suspected to be linked to particular wards. The results showed that cross infection had not occurred however, there was an increase in infections linked to phlebitis caused by intravenous cannula. The work plan for 2022-23 includes improvements to increase awareness of cannula care.

Fig 4. MSSA bacteraemia cases 2021-22

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	**38**	**54**

E coli bacteraemia

E coli is a very common bacterium found in the human gut, which can cause serious infections such as blood poisoning.

In 2021-22, we reported **78** healthcare associated cases against an **objective of 117 cases** successfully achieving a 5% reduction required by NHS England/Improvement. The most common source of infection remains the urinary tract, with some cases being related to urinary catheters. Quality Improvement work including agreeing criteria for urinary tract infections and improved testing and catheter care were commenced during this year.

Fig 5. E coli bacteraemia cases 2021-22

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	**78**	**184**

Klebsiella species bacteraemia

Klebsiella species are a type of bacterium that are found commonly in the environment and in the human gut, where they do not usually cause disease. However, in a vulnerable individual they can cause pneumonia, wound and surgical site infection and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

We reported **15** healthcare associated cases of Klebsiella bacteraemia in 2021-22 against **an objective of 24 cases**.

Fig 6. Klebsiella bacteraemia cases 2021-22

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	**15**	**44**

Pseudomonas bacteraemia

Pseudomonas aeruginosa is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections in those with a weakened immune system. It is resistant to many commonly used antibiotics.

In 2021-22, we reported **14** healthcare associated cases against an **objective of 11 cases.** The number of cases is still small in terms of identifying trends but a number of cases were identified in patients who were in need of critical care. It is possible that this was because of their increased length of stay and longer periods of mechanical ventilation, which increase the risk of infection.

Fig 7. Pseudomonas bacteraemia cases 2021 -22

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	**14**	**12**

Glycopeptide resistant Enterococcus (GRE)

Enterococci are normally found in the gut and are part of the normal human gut flora. Although a common cause of urinary tract infection, they can also cause serious infections such as endocarditis and can be a particular risk to immunocompromised patients.

The number of blood stream infections caused by GRE is low and sporadic in the Trust. In 2021-22, we reported **2** cases only which were both healthcare associated. Genetic typing did not show a link between the cases. More commonly, we see GRE from screening swabs which is more likely to be colonisation than infection.

Surgical Site Infection (SSI)

All trusts are required to submit surgical site infection data for a minimum of one quarter per financial year. Since 2019, we have been reporting data continuously across the year and have expanded the number of surgical procedures included in the surveillance to include breast, spinal, large bowel, small bowel, gastric and surgery. This year we have also added radius, ulna and humerus cases to the long bone fracture reductions, which will increase the total number of procedures. In early 2021-22, the number of procedures carried out continued were reduced due to Covid and restrictions. Surgical site infections identified are detailed in the table below. The national report has not been published for 2021-22 at the time of writing therefore we have been unable to benchmark our results against recent national figures.

All cases are subject to investigation and discussed at Infection Control Committee and the Service Line Meetings for the relevant specialties.

Fig 8. Surgical site infection data 2019-22

	2019 20	2020 21	2021 22	National average % 2015 20
Primary total hip replacement No of procedures/no of infections/%	322/0	146/0	238/3/1.2%	0.5%
Primary total knee replacement No of procedures /no of infections/%	399/0	146/0	327/0/0%	-
Reduction of long bone fracture No of procedures /no of infections/%	39/0**	186/0	303/4/1.3%	0.9%
Repair of neck of femur No of	79/0**	288/1	309/1/0.3%	0.9%

procedures/ no of infections/%				
Breast surgery No of procedures /no of infections/%	N/A	N/A	402/6/1.5%	0.8%
Gastric surgery No of procedures/ no of infections/%	N/A	N/A	39/3/7.7% (part year only)	2.4%
Large bowel surgery No of procedures/ no of infections/%	N/A	N/A	225/17/7.6% (part year only)	8.3%
Small bowel surgery No of procedures / no of infections/%	N/A	N/A	74/3/4.05% (part year only)	6.6%

** data submitted for one quarter only

Influenza

In 2020-21, we have seen much lower than usual numbers of patients being admitted with influenza.

Staff vaccination is always a priority for the trust and we were delighted that over 80% of our staff and volunteers accessed the flu vaccine between October 2020 and February 2021. The Occupational Health Department once again led the flu campaign to increase uptake, and were supported by peer immunisers in workplaces and senior staff who encouraged vaccination.

Hand hygiene

This year we have continued to carry out monthly self-audit of hand hygiene for our clinical teams, with quarterly assurance audits by the IPC team. Overall the target of 95% compliance has been achieved each month. The pandemic may have had a positive effect on hand hygiene so the completion of the assurance audits is a good measure of consistent improvement.

Fig 9. Hand hygiene compliance May 2021 to March 2022

Month	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
%	100	99.03	98.43	96.34	98.91	99.49	96.24	95.92	98.70	98.47	97.80	98.68
No of audits	22	40	42	65	49	47	28	37	47	56	84	102

Hand hygiene scores from the previous week are discussed at each safety huddle, where actions for improvement are identified and any issues causing poor scores are discussed.

We use opportunities such as World Hand Hygiene day to raise awareness for our staff and patients and staff produce displays to support this

Outbreaks

We reported one outbreak of diarrhea and vomiting in 2021-22, which was confirmed as Norovirus by stool sampling. The outbreak lasted 17 days and 16 out of 29 patients were affected and nine staff members. The index case was possibly a patient admitted from a care home, which also declared an outbreak.
An outbreak of Carbapenemase Producing Enterobacteriaceae (CPE) was also declared in October 2021. In total 29 patients have been linked to the same clinical area either by direct or indirect contact with a positive CPE case. Outbreak management included increased screening of all patients admitted to the ward and ongoing weekly screening for all inpatients. Despite environmental swabbing not identifying any concerns, domestic cleaning was increased in the clinical area and deep cleaning with hydrogen peroxide fogging was completed throughout. The ward matron and IPC team, with the use of educational displays on the risks of CPE, treatments and preventative measures, implemented a renewed focus on effective hand hygiene. Increasing hand hygiene observations and challenging poor practice was key to improving audit scores.

An outbreak of Vancomycin Resistant Enterococci (VRE) was declared in July 2021 on our Critical Care Unit (CCU). This involved five cases, linked directly by sharing the same environment/adjacent bed spaces. The challenges experienced in the CCU throughout the pandemic such as increased absence/vacancy, wearing personal protective equipment (PPE) for prolonged periods, including long sleeved gowns and increased prolonged activity on the unit have all impacted the daily routines and standards delivered by the team. The IPC team worked closely with the leadership team to deliver education directly to the team members, highlighting the importance of being bare below the elbows, hand hygiene and cleaning of the environment and patient equipment.

The IPC team continues to work with domestic and clinical staff to improve management of such outbreaks by early recognition, prompt action and enhanced cleaning, to reduce the impact on patient flow and outcomes.

COVID-19

The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases reported in the UK in January 2020. COVID-19 surveillance has been ongoing since January 2020, which due to the high number of cases, changes to guidance, outbreak management and completion of staff risk assessments continues to provide Infection Prevention and Control (IPC) teams with significant challenges.

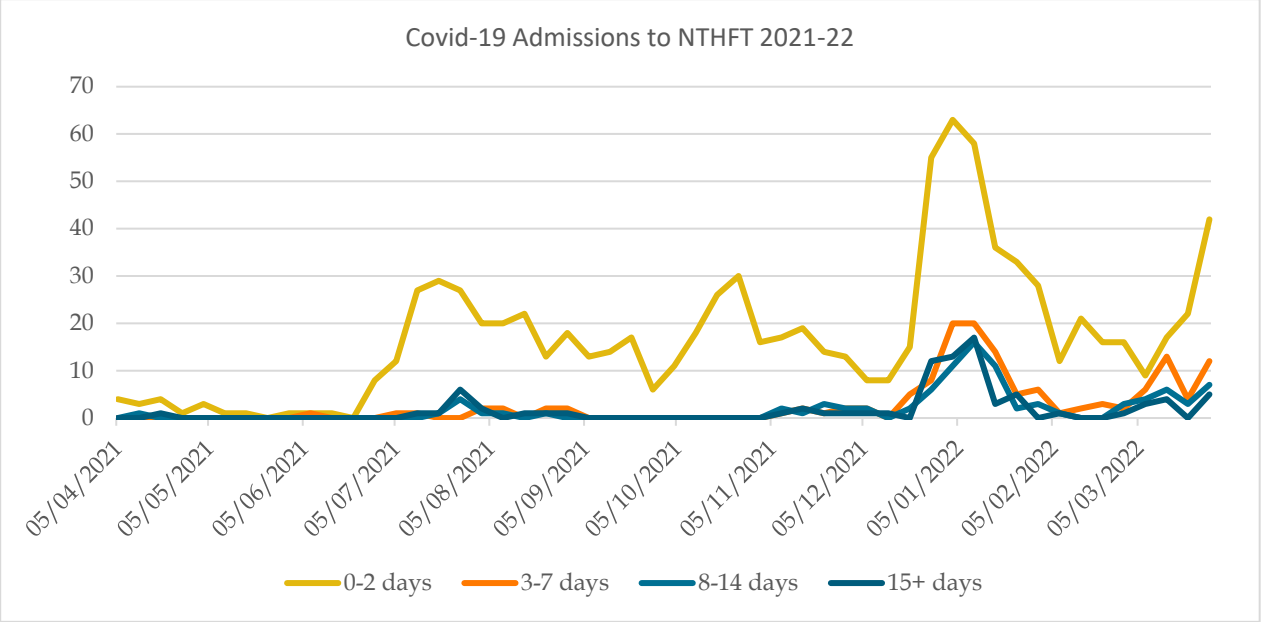
Multidisciplinary working groups continue to function within the trust and local authorities, ensuring that clinical decisions in relation to new and evolving guidance are discussed and implemented in a timely and appropriate way. The Trust continues to follow national guidelines and recommendations including the development of a Covid-19 vaccination program, working towards the Recovery Plan and continuing to deliver high quality care whilst maintaining strict infection control measures to provide safe environments for our patients, visitors and staff.

The trust has maintained a comprehensive screening service for staff, identifying staff contacts and outbreaks as early as possible. Over 1800 staff track and trace risk assessments were completed in 2021/22 by the IPC team, which was a challenge alongside maintaining all other mandatory surveillance. The IPC team remained responsive to changes in Covid-19 guidance and provided training, risk assessments and advice when required. Covid-19 compliance audits continue throughout the trust with over 800 audits completed, achieving a compliance rate of between 98-100%. In

response to increased demands during periods of high Covid-19 inpatient and staff cases, the IPC team continue to respond by providing a seven-day service when required.

From April 2021 to March 2022 the trust cared for 1231 patients positive for COVID-19, this is a slight decrease from the previous year where there were 1730 positive cases. 913 patients were admitted and had a positive Covid-19 result within 0-2days of admission compared to 1188 in 2020/21. A further 143 patients tested positive within 3-7 days of admission, a reduction to the previous year where 244 patients tested positive in the same time frame. Both of these categories remain attributable to the community. There were 91 cases identified within 8-14 days of admission and are possibly hospital acquired. This is a reduction of cases compared to 193 cases in the previous year. 83 patients tested positive after 15 days or more of admission, compared to 105 cases in 2020/21 and are categorised as definite hospital acquired cases.

Fig 10. Covid admissions 2021-22 by date criteria



During 2021/22, the trust saw an increase in the number of community-onset cases of COVID-19 infections from July 2021, in line with the reduction of measures as outlined by national guidelines. Despite these increases, cases of nosocomial Covid-19 infections (cases where the patient has been in hospital for 8 days or more) remain reduced from 2020/21. In 2020/21, 17% of Covid-19 cases admitted to the trust were in patients who had been an inpatient for greater than 8 days. This has reduced to 14% in 2021/22, despite activity within the hospital increasing. This is likely due to the increased screening regimes for patients and embedded infection control measures.

Outbreak management of the COVID-19 virus continues to be a challenge with increased activity and staff absences but continued collaboration with the regional IPC team's offers shared learning providing vital insight into outbreak management.

The Trust continues to provide IPC support to adult care homes and domiciliary care in Stockton and Hartlepool. The collaborative working with the local authorities continues to be strengthened throughout the pandemic and plans to focus on other public health priorities and quality improvement initiatives have begun.

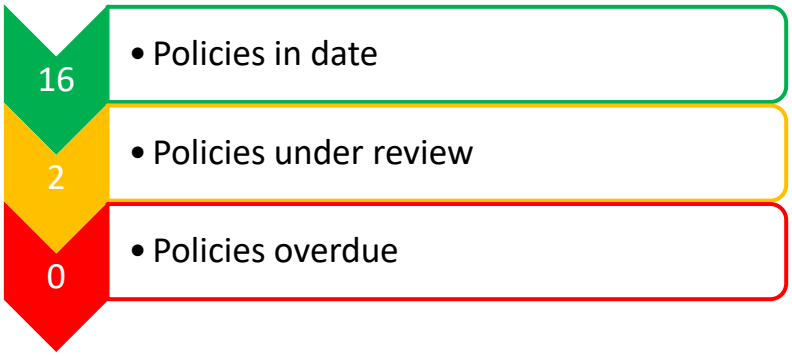
Our vaccination program began in December 2020, with redeployed staff supported by volunteers and temporary vaccinators, based in our vaccination hub. Between December 2020 and March 2022

96% of our staff and volunteers had received their first dose of vaccine and 94% had received both doses. The Covid-19 booster program in October 2021 continued to offer further protection to our staff with 82% receiving their third vaccine.

Policies

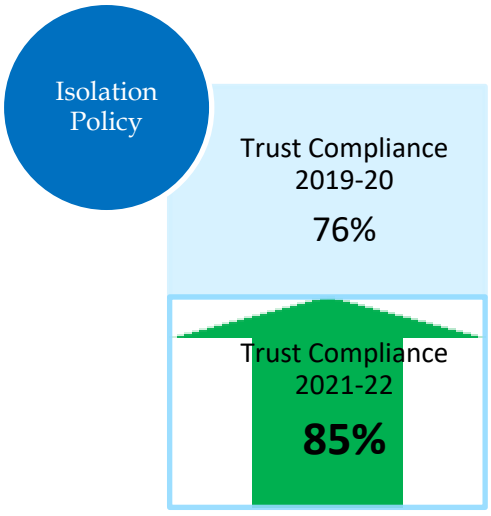
The Trust has a programme for review and revision of core infection prevention and control policies as required by *The Health and Social Care Act 2008. Code of Practice on prevention and control of infection and related guidance (2015).* All policies are available to staff on the trust intranet site and many are available to the public on the external website.

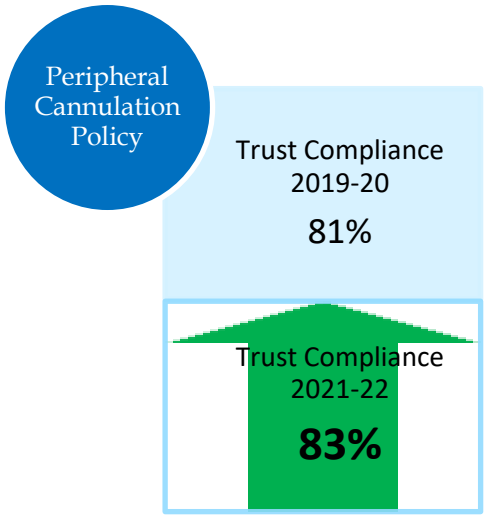
A schedule for review and revision of policies forms part of the annual IPC programme. The review of some policies were delayed by COVID-19 but there is plan for all to be completed by July 2021. There are 19 active policies and the status at the end of March 2021 is below:

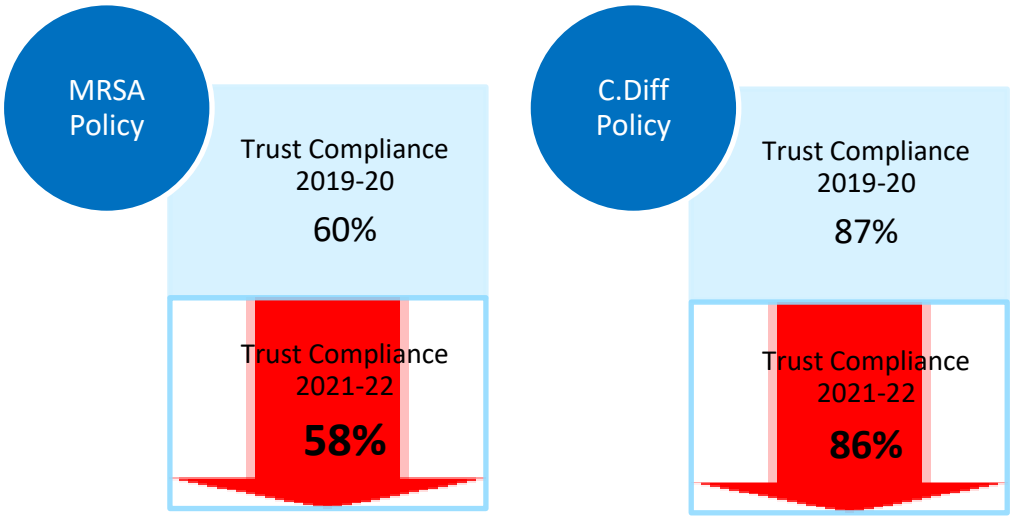


Audit programme

Usually a programme of audits are planned for each year as part of the IPC annual programme. This allows us to monitor adherence to policy and identify areas for focused work. Despite 2021-22 still being a challenging year with Covid-19, our audit programme on our policies was completed, as below.
The IPC team has also managed to complete some of our unannounced visits and a new programme has been developed for 2022/23.







Training

We apply a blended approach to IPC training with a mixture of face-to-face and online learning or workbooks to facilitate different learning preferences. As all training is in line with a regionally agreed programme and recorded on the electronic staff record (ESR) it is portable between organisations, which is beneficial for staff in rotational posts. Level 1 training is for non-clinical staff and is required every 3 years. Level 2 for clinical staff is required annually.

Antimicrobial Stewardship

Our overall aim is to develop a culture of antimicrobial stewardship where we promote education and empower staff to question antibiotic prescribing decisions, among not only medics but also non-medical prescribers. We aim to achieve this through four main principles:

- Provision of easy to use up to date guidelines
- Education
- Collaboration with South Tees University Hospitals NHS Foundation Trust, and development of a local antibiotic stewardship committee.
- Audit and feedback.

Provision of guidelines:

- Current progress with South Tees regarding regional empirical guideline update is ongoing.
- Once finalised this will be uploaded on to the MicroGuide® app to facilitate easy access and promote prudent empirical prescribing.

Education:

- Education based on audit of prescribing practice and feedback to prescribers.
- Involvement in junior doctor trust induction training sessions.
- Promoting education in non-medical prescribing, for example training has been provided for district nurses.
- Discussion around forum to discuss cases and share expertise among non-medical prescribers.

Collaboration with South Tees and development of a local antibiotic stewardship committee.

- Trust representative attending Antimicrobial Working Group meetings held by South Tees Trust.
- Highlighting antimicrobial related issues to key stakeholders within the CCG as part of trust collaboration.
- Issues include prescribing trends, new antimicrobial agents, guideline updates, C.difficile management/feedback etc.

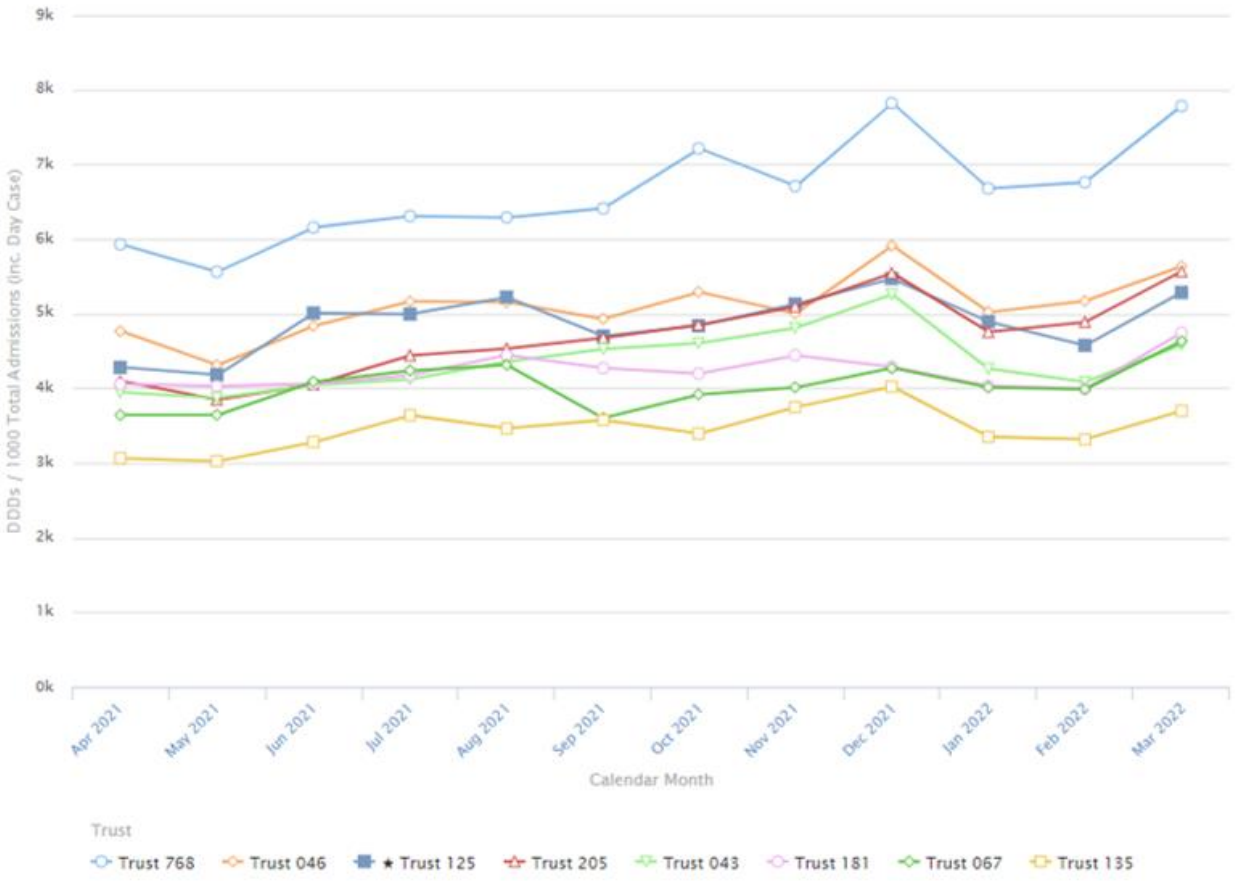
Audit and Feedback:

- Antibiotic consumption data across the organisation as a whole has shown reductions in key broad-spectrum antibiotics (Carbapenems) as a response to increased awareness and proactive interventions following prescribing reports and increased microbiology input.
- Overall, total consumption of antibiotics has steadily increased across all trusts within the region.

Outpatient Parenteral Antibiotic Therapy (OPAT)

- We have made great strides in providing OPAT services via the Accufuser® elastomeric device.
- This service allows us to provide equivalent IV antibiotic therapy in patients who require long-term antibiotics but are well enough to be treated in their own homes.
- Due to the nature of the 24 hour infusions provided by the device, this not only reduces the need for broad spectrum antibiotics with a more convenient dosing pattern but also improves rapid response nurse capacity due to once daily contact time.
- The long-term plan is to trial this device on base wards to determine if it will increase capacity for registered nurses.
- We are contributing capacity and consumption data to a national audit on the provision of OPAT services throughout the country.

Fig 11. Total antibiotic consumption, regional comparison (systemic antibiotics DDDs/1000 admissions. NTH = Trust 125



Decontamination of the Environment and Equipment

Decontamination is a process which removes or destroys infectious agents or other contaminants from equipment and the environment in order to reduce the risk of cross contamination and subsequently the spread of infection. Cleaning is always the first step in this process, followed then by disinfection or sterilisation depending on the circumstances in which the equipment is used. An example of this would be a piece of medical equipment that is classed as 'reusable invasive equipment'; this requires all of the above steps. The Decontamination Strategy document (Strat 09) has been ratified and is available via the trust intranet.

The Sterile Services Department is responsible for reprocessing reusable invasive medical devices and flexible endoscopes. All processes are fully validated and compliant to national standards HTM 01-01,HTM 01-06, ISO 13485:2016 and UK MDR 2002 (as amended) Part 11 Reg 14 and internally and independent externally audited process. In the last 12 months, the department has had 3 x new steam sterilisers installed which are more reliable and will help future proof the service. Disposable items are efficient and used whenever possible.

Decontamination audits are completed annually in departments where local decontamination takes place; this for example would be where a piece of medical equipment is being decontaminated within a department outside of centralised sterile services. The Decontamination Manager and IPC Nurse carry out assurance audits and all results of such audits are reported to the Decontamination Group, which reports into the Trusts Infection Control Committee.

The endoscope decontamination units (EDU) on both sites are validated and compliant with national requirements HTM 01-06 and compliant to Joint Advisory Group (JAG) as part of the Endoscopy services accreditation. The EDU at Hartlepool has recently been upgraded with new endoscope washers and drying cabinets. An Independent Authorising Engineer (Decontamination) validates annual reports produced for compliance.

The provision of cleaning services in our hospitals and other premises is provided by 'NTH Solutions'. Quality Monitors undertake performance monitoring and the results measured for compliance with the Trusts cleanliness standards and in line with National Standards of Cleanliness. The outcomes from these audits are reported into the Decontamination Group and the Trusts Infection Control Committee via a quarterly report presented by the Assistant Director of Operations (Decontamination Lead). A response team and hygienist team with programmes in place for equipment deep cleaning provide enhanced cleaning. All decontamination staff have been a vital part of the work to reduce infections and particularly delivering the additional measures taken to mitigate the risk during the global pandemic. The teams have worked flexibly, often in unfamiliar settings and wearing full PPE supporting the clinical teams. We continue to be grateful for their continued support as part of our wider team.

Conclusion

Reflecting on the last year, reducing the risk of infection has been our priority and remains so in the coming year. 2021-22 has continued to be a year of challenge and adaption for the trust in response to the Covid-19 pandemic. There have been and continue to be challenges in terms of the ability to respond quickly to rapidly changing national guidance, ongoing anxiety in staff and patients, changing community transmission rates of COVID-19, which impacts our patient pathways; impacting upon by workforce challenges. Antimicrobial stewardship and the availability of single rooms are two priorities for improvement in 2022-23 and we will continue to build on the collaborative relationships with our colleagues across the North East and North Cumbria Integrated Care System to make those improvements.

As we move forward with the national plan 'Living with Covid' we must continue to evaluate and consider each step to ensure that patient safety remains at the forefront, as well as the wellbeing of our staff, who continue to rise to the challenge in a way that makes us very proud.

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FACE
SPACE
Hand washing only