North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 22 September 2022
at 9.30am

Boardroom
University Hospital of North Tees
and via MS Teams

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
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15 September 2022

Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 22 September 2022 at 9.30am** in the **Boardroom, University Hospital of North Tees.** Lunch will be provided following the meeting.

Yours sincerely

Professor Derek Bell,
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 July 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.	(10.20am)	Report of the Chief Executive **(enclosed)**	J Gillon
	Performance Management		
9.	(10.35am)	Board Assurance Framework Quarter 2 Interim Report 2022/23 **(enclosed)**	H Heslop
10.	(10.45am)	Integrated Compliance and Performance Report **(enclosed)**	L Hunter, L Robertson, N Atkinson, S Cook
Operational Issues			
11.	(11.00am)	Care Quality Commission Update (verbal)	L Robertson

12. (11.10am)	Maternity Safety Report Quarter 1, 2022/23 **(enclosed)**	L Robertson
13. (11.20am)	Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation **(enclosed)**	L Robertson
14. (11.30am)	Responsible Officer's Medical Appraisal & Revalidation **(enclosed)**	D Dwarakanath
15. (11.40am)	Foundation Trust Governance Update **(enclosed)**	H Heslop
16. (11.45am)	Review of Trust Constitution **(enclosed)**	

Items to Receive

17. (11.50am)	Equality, Diversity & Inclusion Annual Report 2021/22 **(enclosed)**	S Cook
18. (11.55am)	Estates and Facilities Annual Report 2021/22 **(enclosed)**	N Atkinson
19. (12.00 noon)	Any Other Business	Chair

Date of next meeting
(Thursday, 24 November 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 Our People

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

Transforming Our Services

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

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

DRAFT Minutes of a meeting of the Board of Directors held on Thursday, 28 July 2022 at 10.00am at the University Hospital of North Tees / Via Video Link

Present:

Professor Derek Bell, Joint Chair*	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	Vice Chair
Ann Baxter, Non-Executive Director*	AB
Fay Scullion, Interim Non-Executive Director*	FS
Chris Macklin, Interim Non-Executive Director*	CM
Ian Simpson, Interim Non-Executive Director*	IS
Julie Gillon, Chief Executive*	CE
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Neil Atkinson, Director of Finance*	DoF
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Levi Buckley, Chief Operating Officer*	COO
Gillian Colquhoun, Interim Chief Information and Technology Officer	ICITO
Linda Hunter, Interim Director of Performance and Planning	IDoP&P
Graeme Raffell, Interim Deputy Chief People Officer	IDCPO
Ruth Dalton, Associate Director of Communications & Marketing [via video link]	ADoC&M

In Attendance:

Matt Brown, Managing Director, NENC Provider Collaborative (items 1 – 8)
Mary Bewley, Head of Communication and Engagement, North East Commissioning Support Unit
Sarah Hutt, Company Secretary [note taker]
David Jennings, Vice Chair, South Tees Hospitals NHS Foundation Trust
Lynda White, Elected Governor, Stockton

BoD/4832 Apologies for Absence / Welcome

Apologies noted from Susy Cook, Interim Chief People Officer, Gillian Colquhoun, Interim Chief Information Technology Officer and Hilton Heslop, Associate Director of Corporate Affairs and Strategy.

The Joint Chair welcomed everyone to the meeting.

BoD/4833 Declaration of Interests

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

BoD/4834 Patient Story

The CN/DoPS&Q shared a story from a patient and the patient's daughter. The patient had become unwell at home and the family suspected they had suffered a stroke. The lady was assessed by the Stroke Team and prepared for discharge, however, the family were concerned with the significant changes they could see with their loved one and were able to share these concerns with staff. Further tests were carried out and the lady was admitted, receiving great care. St John's campaign was initiated. The family felt nobody had taken the time to explain to them what to expect and what would happen. The patient is now back at home and doing well. It highlighted that an important part of the process is to meet with patients and their families to listen to their experience. The CN/DoPS&Q had contacted the patient as a follow up and during the conversation asked whether the patient felt they needed more care, which they felt they did so a further care package was put in place. The family wished to express their gratitude. A brief discussion ensued. The CE thanks to the patient and family

for sharing their story. It was a reminder that patient experience and patient care is at the centre of all we do. The requirement to deliver care collaboratively across the system was ever more important and sharing patient experience with partners to share learning and improve patient care. Following a query, the CE reported that a meeting with Primary Care Network (PCN) leaders had been set-up to further explore working with GPs as well as widening communication networks.

Lynda White, Elected Governor for Stockton requested to share the story as part of the patient group she attended.

It was still being explored how best to thank patients for sharing their stories and providing valuable feedback.

Resolved: (i) that, the patient story be noted; and
(ii) that, a mechanism to thank patients for their stories be considered.

BoD/4835 Minutes of the meeting held on, Thursday, 8 June 2022

Resolved: that, the minutes of the meeting held on, Thursday, 8 June 2022 be confirmed as an accurate record.

BoD/4836 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/4837 Report of the Joint Chair

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

- The Joint Chair and AB had met with a cohort of new junior doctors as part of their induction. Noted the increasing number of trainees from a wide range of countries it was important to ensure everyone received a warm welcome. The meeting was positive and the trainees actively participated
- The report from the NHSE governance review had been further delayed. It was noted that external audit required sight of the report before issuing the value for money statement.
- The report from the Care Quality Commission (CQC) was anticipated in mid-August, following the focused inspection and well-led review.
- The Messenger Report into leadership in health and social care is published and contained seven recommendations. There was a strong focus on the EDI agenda and support and development of management at all levels.
- The second of the Joint Board Away Days took place on 15 June 2022. A full meeting of the Joint Partnership Board (JPB) was held on 20 July 2022. Discussions were on-going with Sam Allen, Chief Executive, NENC ICS regarding joint working progress.
- A Joint Non-Executive Director session was scheduled for 4 August at the University Hospital of Hartlepool to be preceded with a site visit. The Vice Chair reported that a more cohesive relationship was developing with Board colleagues from South Tees and David Jennings as Vice Chair.
- The COVID-19 Public Inquiry was formally launched on 21 July 2022 by the Chair of the Inquiry, Baroness Hallett. The Inquiry was down into three areas of focus.
- Monthly visits to the University Hospital of Hartlepool continued with Governors in attendance and feedback was positive. A recent visit had included the Integrated Single Point of Access (iSPA) and clinical triage, and the Holdforth Hub. A visit to Peterlee Community Hospital was proposed in August. A shared programme of visits across the Trust and South Tees was being developed for the Non-Executive Directors.
- The plan for digital health and social care was published on 29 June 2022 and would be an enabler for digital transformation in health and social care with four key aims.

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

BoD/4838 Joint Partnership Board Update

This item was reported as part of the Joint Chair's Report.

BoD/4839 Report of the Chief Executive

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

- Following a decline in cases in May, there had been an increase in Covid-19 patients during June and July and as of 27 July, the Trust was caring for 23 Covid-19 positive patients. There were no patients in ITU. The Trust was adhering to infection control measures to prevent spread, which had required the reintroduction of face masks in clinical and patient-facing areas for staff, patients and visitors. There was no change to the visiting policy at present.
- The CE and members of the Board had recently undertaken walk-abouts across the Trust as a witnessing the value of visitors being able to visit family and loved ones in hospital.
- The North East and North Cumbria (NENC) Integrated Care System (ICS) continued to see increased demand for services with increased Emergency and Urgent Care Department attendances. This had been exacerbated by the impact of ambulance diverts and deflections within the system. North East Ambulance Service (NEAS) were operating at Resource Escalation Action Plan (REAP) level 4, the highest level denoting extreme pressure. The Trust had been operating at the equivalent Operational Pressures Escalation Level (OPEL) 3.
- Reducing ambulance handover delays remains an area of focus for quality improvement, embedding changes, and sustaining performance. Despite the challenges, the Trust continued to be one of the better performing trusts regionally. Improvement during Quarter 1 2022/23 was evident, with the team presenting their success at the Celebrating Excellent event on 15 July 2022.
- There was a continued focus on timely discharge, patient flow and occupancy with use of the OPTICA discharge tool to support the management of patients who did not meet the criteria to reside as a key enabler in managing the current operational pressures.
- The Trust continued to work closely with system partners to reduce pressure across the system, and had provided additional capacity to reduce the Covid backlog and elective waiting lists.
- Staff were commended for the response to the recent Heat wave. A total of 2,500 ice lollies and 4,500 bottles of water had been distributed across the organisation and ward areas.
- The revised Health and Well-being Strategy was aligned with the staff survey, the overarching People Plan and the People Promise with a clear foundation of knowledge and understanding of the overarching areas to ensure staff feeling safe, healthy, and ready for the future.
- Areas of focus for Research and Development were identified in a 12 month improvement plan and included increased participation across a broader range of specialisms. The Trust was the top recruiting site for the Senior Randomised Intervention Treatment of Angina (RITA) cardiology trial and the fourth highest recruiting UK site for a randomised controlled trial of contrast-enhanced colonoscopy aimed to detect right sided bowel cancer (CONSCOP2) and reduce bowel cancer mortality.
- The recent Tees Valley Research Alliance event was successful with over 130 attendees. The Joint Chair delivered a keynote speech. A "Celebrating Excellence in research" event was planned in the Autumn. Board members, senior nursing and clinical directors would be invited.
- On 1 July 2022, the North East and North Cumbria Integrated Care Board (NENC ICB) became a statutory NHS organisation and held its first board meeting in public, with a focus on the approval of governance arrangements.
- The NENC Provider Collaborative continued to focus on governance arrangements and work plan in readiness for the new ICS formal structure. Two members of the NENC Provider Collaborative would join the Integrated Care Board.
- The Castlegate Campus site in Stockton had been identified as the new build site for the proposed Community Diagnostic Centre following an independently commissioned site appraisal across Tees Valley. It forms part of the Stockton on Tees Borough Council Waterfront Masterplan development. A partnership board had been established with Stockton on Tees Borough Council to ensure effective working relationships. The Outline Business Case (OBC) had been submitted

to the Trust Boards for approval to progress to the next stage of the process and submit the OBC to NHS England (NHSE).

- The NHS celebrated its 74th birthday on 5 July 2022. The Trust took part in celebrations reflecting and celebrating how the NHS has innovated and adapted to meeting the changing needs of each generation. In recognition of its 74 years service and for the exceptional efforts of NHS staff during the Covid-19 pandemic, her Majesty the Queen awarded the NHS the George Cross.
- The following Consultant appointments had been made since the meeting on 8 June 2022: Dr James Dundas, Consultant Cardiologist; Mr Siddek Isreb, Consultant Upper GI Surgeon and Mrs Angela Bolch, Chief Pharmacist.

FS sought to understand what plans were in place to ensure staff were as resilient as possible in preparation for winter. The CE explained there were a number of initiatives including developing leaders from the ground up, engendering staff to feel able to speak up and share ideas. It was highlighted that alterative workforce models were required. Following recent local and international recruitment campaigns cohorts of staff had been appointed.

AB highlighted the achievements of the Rowan Suite, being shortlisted for a national award and the Breast Screening Unit being cited as the best in the country for its elective recovery performance.

CM sought clarity regarding the increased number of diverts being received, prompting discussion. It was noted that there had been c.160 over the previous 8 months. The Trust was actively working on system wide transformation and implementing alternative models to support patient flow, sharing good practice with other organisations. The Joint Chair reiterated the importance of a system wide approach to continue to improve patient pathways and access.

Matt Brown, Managing Director, NENC ICS provided a summary of the proposed formal work structure and governance arrangements for the NENC Provider Collaborative including how the 11 foundation trusts would operate through the creation of a Provider Leadership Board (PLB) as set out in the three documents: the Ambition, Operating Model and Collaboration Agreement. These required the approval from each of the 11 foundation trust statutory boards. All foundation trusts were required to be part of a decision making body from 1 July 2022.

A Collaboration Agreement setting out the governance approach and key provisions had been developed with all 11 Trust members as signatories. The key vehicle for decision making for the Provider Collaborative was the establishment of the PLB, which would have representation from the Chief Executives of each of the 11 Trusts to oversee and direct the jointly agreed programme of work.

A robust discussion ensued.

Resolved: (i) that, the contents of the report be noted; and
(ii) that**,** 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
(iii) that, the progress to date of the NENC Provider Collaborative be noted; and
(iv) that, the proposed governance arrangements for the NENC Provider Collaborative be approved.

BoD/4840 Board Assurance Framework 2022/23: Quarter 1 Report

The IDoP&P presented the Board Assurance Framework (BAF) Report for Quarter 1 and highlighted the key points.

- There were 12 risk domains against the 4 strategic objectives;
- There were currently 4 principle risks that included a high risk rating;
- Two financial related risks had been reduced from high risk to moderate, which was reflected on the Radar document;
- All Board sub-committees routinely reported through the Executive Team Risk Management meeting to ensure oversight with appropriate actions being taken to mitigate risks.

Risk 6379 was discussed – Pathology Consultant Staffing, the DoF and MD/DCE explained that both the Trust and South Tees Hospitals NHS Foundation Trust were still required to have individual accreditation for both of the laboratories despite the establishment of the Tees Valley Pathology Group. In respect of staffing, the challenges of a shortage of consultant staffing and an increase in demand for pathology services were recognised and part of the collaborative work will explore innovative solutions.

Resolved: (i) that, the Board Assurance Framework Interim Quarter 1: 2022/23 Report be noted and specifically the risks with a current risk rating of >15 (High); and

(ii) that, it be noted that actions were in place to mitigate the risks which formed part of regular discussions at the key Committees as well as part of the monthly Executive Team Risk Management reporting.

BoD/4841 Integrated Compliance and Performance Report

The IDoP&P presented the Integrated Compliance and Performance report which outlined the Trust's compliance against key access standards in June 2022 including quality, workforce and finance. Operational and workforce pressures continued within the organisation and across the region affecting performance against key standards.

Highlights included:
Performance:

- Increasing number of requests for mutual aid and diverts with high numbers of patients requiring admission impacting on patient flow and occupancy. Additional beds opened within available resource;
- Performance against the Elective Recovery Plan continued with no patients waiting over 78 and 104 weeks. 62 patients were reported waiting over 52 weeks with a trajectory of zero patients by September;
- Continued increase in referrals compared to 2019/20 activity and an increase of 3.8% compared to the previous month;
- Trust's ambulance handover average turnaround time of 32 minutes, an improving position, second in the region;
- An improving position against two-hour urgent community response standard at 64.01% against 70% target;
- Challenges remain against the cancer standards with the two-week rule and 62-days standards not met (May latest position), reflecting a similar position regionally and nationally. There was a continued focus through the Cancer PTL to ensure all patients progressed as quickly as possible;
- Continued achievement against the 28 day faster diagnosis standard, one of hree trusts in the region;
- A continued focus on Patient Initiated Follow Ups in Outpatients was contributing to the plan to reduce clinic review appointments, reporting at 88.67% against a target of 85%.

Quality and safety:

- HSMR and SHMI remained positive within the expected range, with HSMR reporting at 84.18 and SHMI at 94.15;
- Overall reduction in the number of complaints and increase in the number of compliments. Slight increase in Stage 1 complaints which was reflected early resolution;
- No falls leading to harm were reported. National audit of inpatient falls for 2021 reported marked improvement of recording lying and standing blood pressure measurements;
- Increased number of category 1 pressure ulcers reported (May latest position) with 8 against the standard of 5. Category 2 and 3 pressure ulcers were within the accepted standard and there were no category 4 pressure ulcers;
- Hand hygiene across the Trust reported at 99%;
- The Trust reported below the projected trajectory for all infections with the exception of MSSA with 3 cases and Klebsiella reporting 2 cases;
- The Trust received 1,305 Friends and Family Returns (FFT) in June, with all three reporting

groups: Maternity, In patient and Emergency above the 75% standard.

Workforce

- Sickness absence had reduced overall at 5.51% with 2.30% short term and 3.21% long term. There was a reduction in Covid-19 related absence and the top reason for sickness absence was anxiety/stress/depression;
- Staff turnover had reduced by 0.13% reporting at 11.83%. The review of 'on-boarding' processes continued to ensure positive engagement from the commencement of employment.

Finance:

- A revised financial plan for 2022/23 of £4.35m surplus would be supported by additional income and an increase in CIP;
- At Month 3 the Trust was reporting a surplus of £2.262m and a year to date surplus of £4.340m, which was ahead of plan;
- Total income at Month 3 was £31.147m;
- Pay expenditure was £20.629m and non-pay expenditure was £8.235m.

The Vice Chair reiterated that behind every statistic was a patient, prompting discussion regarding the importance of gaining assurance from the level of detail provided in the report. The CE highlighted that the organisation remained focused on reducing waiting times and clinical reviewing patients to ensure there were no delays to treatments, particularly in relation to cancer patients.

Resolved: (i) that, the Trust's performance against the key operational, quality and workforce standards be noted; and
(ii) that, the ongoing operational pressures and system risks to regulatory key performance indicators and the associated mitigation be noted.

BoD/4842 Capital Programme Performance Quarter 1: 2022/23

The DoF presented the Capital Programme Performance Report for Quarter 1:2022/23. At Month 3 the overall capital programme plan was £21.983m: £21.584m CDEL and £0.399m Donated/grant funded assets. The plan demonstrated a continued commitment and investment to reducing the estates backlog, medical equipment, IT developments and supporting the Pathology collaboration. It included a contingency of £1.5m for emerging capital issues and business cases.

The annual Capital plan for 2022/23 would be presented at Capital and Revenue Management Group on 29 July 2022. Allocation of spend for the plan was in phases with the largest proportion of 58% in Quarter 4. At Month 3, the Trust had spent £0.7m against a year-to-date plan of £0.1m, which related to pre-committed schemes. The largest proportion of the plan was in relation to the Estate and the sustainability agenda. An intrusive structural survey had been carried out on the Tower Block, South Wing and North Wing following issues highlighted in the previous six facet survey to assess the extent of any additional remedial works required to ensure the buildings remained safe and operational for the remainder of the 10-year lifespan. The findings would be discussed at the Transformation Committee.

Noted the outcome of the Estates national bid had been delayed until the end of the year. A detailed discussion regarding the sustainability agenda was held at the Group Board of Directors meeting earlier that day. In respect of the carbon reduction programme, the Trust has successfully reduced its carbon footprint by 30%. Organisations are required to be carbon neutral by 2050. There had been a slight increase rather than a reduction due to the impact from the pandemic requiring a greater use of energy.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the position on capital schemes up to 30 June 2022 be noted.

BoD/4843 Care Quality Commission Update

The CN/DoPS&Q provided an update following the focused maternity, childrens and young persons' services inspection and well-led review by the Care Quality Commission (CQC) in May. The report had

not yet been published. It was noted that a new single assessment framework had recently been published by the CQC and details would be brought to a future meeting.

Resolved: that, the verbal update be noted.

BoD/4844 Learning from Deaths Report Quarter 1: 2022/23

The MD/DCE presented the Learning from Deaths Quarter 1: 2022/23 Report and highlighted the key points. The latest HSMR value was 84.18 (March 2021 to February 2022) and the SHMI value was 94.15 (February 2021 to January 2022) both are good and within expected ranges and were the lowest regionally. The Trust maintains a high level of clinical coding, with a current average of eight co-morbidities recorded for patients, which reflected the local health issues and deprivation. population.

All in patient deaths were reviewed by the Medical Examiners (ME) team, by April 2023 this would also include deaths in the community. During 2021-22, there had been one mortality case reviewed and assessed to have been "Possibly preventable greater than 50-50"; this case was reported and investigated as a serious incident. To date in 2022-23, there were two cases being investigated as Serious Incidents, the outcome of these investigations would be reported in future reports.

Recognition and management of the deteriorating patient had been identified as one of the most important areas of learning and a Deteriorating Patient Group had been established to provide oversight and was linking with the regional group to share information for wider learning. It was noted that the Surgical department undertook reviews of all in-hospital mortalities at a monthly Mortality and Morbidity (M&M) meeting, in addition to regularly reviewing other cohorts of patients and had agreed regular shared clinical governance sessions with other specialities to ensure a broader review of cases to improve patient experience and enhance patient safety.

A review of the pathway for children attending the Trust had been undertaken and a Paediatric Integrated Assessment Unit (PIAU) had recently been implemented to ensure that the child/young person and their families were at the centre of all decision-making and seen at the right time, by the right person in the right setting. An in-depth process for the review of paediatric deaths, although rare, had been implemented to ensure learning, in addition to the implementation of the regional Paediatric Early Warning Score (PEWS) to support the management of acutely ill children.

CM sought to understand whether there were any link or triggers around deteriorating patients, the CN/DoPS&Q explained that where identified causes were attributed and shared, and the wider use of digital observations was being introduced across the Trust. Primary Care Network leads were invited to attend the weekly Patient Safety meetings to take away any learning.

Resolved: (i) that, the content of the report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover be noted; and
(ii) that, the on-going work programme to maintain the mortality rates within the expected range for the organisation be noted; and

BoD/4845 NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard 2022

The IDCPO presented the Workforce Race Equality Scheme (WRES) Report 2022 and the Workforce Disability Scheme (WDES) Report 2022 and the key points were highlighted.

In the WRES Report there were positive improvements in indicators 1-4, however, there had been a reduction in staff experience for indicators 5-8. Promotion of the areas of good practice and activities such as the Trust's BAME Staff Network and the Cultural Ambassadors programme continued.

In the WDES Report there were some good results for indicators 1-3 and improved staff experience for indicators 4 and 7. It was noted there had been an increase in the number of staff declaring a disability

which was positive. The activities and areas of good practice such as the Disability Staff Network, the Cultural Ambassadors programme, fair and transparent recruitment processes and promotion of various leaderships and development opportunities continued to be promoted.

The data for both WRES and WDES would be shared with staff to listen and understand their experiences in order to develop solutions and reduce the current disparity. A comprehensive action plan had been developed and was aligned to the wider EDI review.

The CE highlighted that race and equality was very important for a learning organisation and to involve staff within the work streams. Steve Hall, Vice Chair had been appointed as the EDI Board Champion and Jagtar Singh had been appointed as an independent advisor working with the Trust as part of its EDI ambitions.

There was a requirement to publish WRES and WDES data nationally by 31 August 2022, following which it would be published on the Trust's website.

Resolved: (i) that, the Workforce Race Equality Scheme 2022 data be noted, and
(ii) that, publication of the Workforce Race Equality Scheme Report 2022 by 31 August 2022 be approved; and
(iii) that, the Workforce Disability Equality Scheme 2022 data be noted; and
(iv) that, publication of the Workforce Disability Equality Scheme Report 2022 by 31 August 2022 be approved.

BoD/4846 Quality Accounts 2021/22

The CN/DoPS&Q presented the Trust's Quality Account 2021/22 and highlighted key points. Despite the impact from the Covid-19 pandemic, there had been some significant achievements during the year including dementia care and infection control improvements. Delivery against the quality metrics continued to be monitored closely through the established internal governance structures regardless of operational pressures. The Quality Accounts would be published on the Trust' website.

Resolved: that, the Quality Accounts 2021/22 be accepted.

BoD/4847 Carbon Reduction Programme Performance Targets 2021/22

The DoF presented the Carbon Reduction Programme Performance Targets Report 2021/22.

Resolved: that, the Carbon Reduction Programme Performance Targets Report 2021/22 be accepted.

BoD/4848 Health, Safety and Security Annual Report 2021/22

Ian Simpson, Non-Executive Director presented the Health, Safety and Security Annual Report 2021/22.

Resolved: that the Health, Safety and Security Annual Report 2021/22 be accepted.

BoD/4849 Any Other Business

There was no any other business reported.

Resolved: that, the verbal update be noted.

BoD/4850 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 22 September 2022 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 12.20pm.

Signed:  Date: 22 September 2022

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
27 May 2021	BoD/4537	***Maternity Services*** Market place event to be considered to showcase the great work being done within Maternity Services	L. Robertson			An event will be planned for September.
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			An updated Terms of Reference with changes to the membership and quoracy were presented on 14 June 2022, prior to ratification at the Joint Partnership Board on 20 July 2022.
8 June 2022	BoD/4795	***Patient Story*** A mechanism to thank patients for their stories to be considered.	L. Robertson			An appropriate way to thanks patients for sharing their stories and providing valuable feedback was being considered.
8 June 2022	BoD/4802	***Integrated Compliance and Performance Report*** A further understanding of sickness data to be presented in future Integrated Performance Reports	S. Cook		28 July 2022	The IPR was a dynamic document with improvements being made regarding data presentation and content.
8 June 2022	BoD/4804	***Nursing and Midwifery Workforce Report*** The disparity in turnover data compared to the data in the Integrated Performance Report to be reviewed as part of a workforce review.	L. Robertson			
8 June 2022	BoD/4804	***Nursing and Midwifery Workforce Report*** An update to be provided at a future meeting regarding the integration of the newly appointed international nurses from the Philippines and India into the Trust.	L. Robertson			
8 June 2022	BoD/4806	***Maternity Update*** An update regarding Ockenden Report: Part 2 to be presented a the Board of Directors meeting in October 2022.	L. Robertson			
8 June 2022	BoD/4807	***Freedom to Speak Up Annual Report*** A Governor Development Session on Freedom to Speak Up to be arranged.	S. Hutt		##########	Fiona Gray, Freedom to Speak Up Guardian presented an overview of Freedom to Speak Up at a Governor Development Session on 8 September 2022.
no new actions from the meeting on 28 July 2022.						

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Chair's Report										
Date:	22 September 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;
- Care Quality Commission;
- Department and site visits;

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

22 September 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

A further meeting of the Joint Partnership Board was scheduled to take place on 21 September. To further explore the collaborative opportunities and future plans an external firm, Carnell Farrell had been jointly procured with the North East North Cumbria Integrated Care Board (NENC ICB) to develop an options appraisal through engagement with a wide range of stakeholders internal and external to the two trusts.

2.2 NHS England

The report detailing the outcomes and recommendations from a governance review carried out by NHS England earlier in the year had been received and was being reviewed. The content will be shared in due course and with the Council of Governors.

2.3 Care Quality Commission

The report detailing the outcome of the focused service inspection for maternity services and children & young people services and a well-led review undertaken by the Care Quality Commission (CQC) in May had been released. Staff were commended for their contributions as part of the inspection process. I would also like to thank the executive team and all staff for the significant work they have undertaken in regard to this report.

2.4 Department and site visits

The programme of monthly site visits continued. In August a number of Governors attended a visit to Peterlee Community Hospital to review the X-Ray pathway, in addition to meeting the community midwifery service. A further focused visit took place this month at the University Hospital of Hartlepool to review departmental signage across the site with HealthWatch representatives for Hartlepool. This work will be part of an on-going process of review.

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:	22 September 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 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, operational challenges and continued recovery
- Culture and Leadership Development
- 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
- Faculty for Leadership and Improvement
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy
- Secretary of State for Health
- Improving Mental Health Support to Families
- Bowel Cancer Screening sharing Good Practice across the Globe
- Developing Leaders across the Organisation

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

22 September 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 Current Position and Continued Recovery

2.1.1 COVID-19

There has been a steady reduction in covid positive patients over the last week of August and into September. As at 14 September 2022, the Trust is caring for 22 Covid-19 positive patients, one of which requires critical care intervention.

The Trust has continued to review IPC requirements in line with national guidance. In September the organisation announced that due to the low covid community prevalence the wearing of face masks has been reduced to high risk areas. This means that staff, patients and visitors will only need to wear a face mask in the emergency departments, respiratory wards, haematology unit, ITU, special care baby unit and the chemotherapy day unit.

The Trust will commence both covid booster and flu vaccinations for staff and vulnerable patients during September. This will include supporting vaccinations for social care colleagues.

2.1.2 Operational Challenges

High levels of urgent and emergency care activity have been experienced across the North East and North Cumbria in August and September. This has resulted in continued pressure on ambulance services. The Trust continues to be a high performer in terms of ambulance handover times and minimising the time that ambulance crews are unavailable, however there remains a consistent focus on ensuring the timely handover of patients with a focus on minimising the risk of harm that can result from delayed handover times.

NHE released an Urgent and Emergency Care plan on 15 August 2022. The Trust is working with partners across the ICS to align internal winter plans with the wider system. The national plan identifies six key metrics that will be used to monitor the performance of every integrated care system this winter. This includes a broad range of objectives to boost capacity across the system through a mix of new hospital beds, increased non-acute capacity and virtual wards and a boost in urgent and emergency call handlers. The objectives of the plan are system orientated:

1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.

2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.

3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers in 111 and 999 services.

4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.

5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.

6) **Reduce hospital occupancy**, through increasing capacity of general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.

7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners.

8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

2.1.3 The Trust is implementing a new and refreshed operating model to add a fundamental building block to operational sustainability initially for the winter period inclusive of alternative frailty model, additional bed capacity, patient flow capacity and workforce solutions, improvements to emergency department patient experience and workforce recruitment options.

Staffing remains a limiting factor with safe staffing a priority and alternative workforce model in place to manage the acuity, dependences and case mix of patient demographics

3. Strategic Objective: Health and Wellbeing

3.1 Culture and Leadership Development

Culture is the bedrock to any organisation and we are committed to continue our culture journey. The Trust is therefore embarking on a collaboration with Clever Together, an organisation which works with teams to develop stronger staff engagement, as a means of empowering individuals to speak up, be the change and feel they are listened to and valued. A Big Conversation involving our staff will begin from mid-October and will run for three weeks using the Clever Together platform using the organisations associated branding and communications. The information received from this exercise will be thematically analysed and will be used to develop a culture programme and inform the broader cultural work the People Directorate is undertaking in relation to reward and recognition, health and wellbeing and leadership and management development.

The work is complemented by a review and re-launch of the management development programme; incorporating actions from the EDI review to ensure alignment of all work strands. We are also embarking on the implementation of the national Scope for Growth pilot, an approach that uses career conversations to support staff at all levels to grow and develop talent. This is aimed at all levels across the organisation and is truly inclusive.

The work from the Clever Together, Scope for Growth, Leadership and Management programmes will be monitored at the newly formed People Group, which in turn will provide assurance at the People Committee.

3.2 Research and Development

Research and development activity remains vibrant, to date there have been 1015 participants recruited so far this year across 25 specialties. Higher than at the same point in previous pre-COVID years.

Following discussions with the University of Teesside, plans are being finalised to offer PhD studentships for Nursing, Midwifery and Allied Health Professionals. Further details to follow but

outline plans are that the University will fund the tuition fees and the Trust will be asked to support 0.2 WTE staff time to complete the course over 4 years.

The Tees Valley Research Alliance (TVRA) has revised the memorandum of understanding which will be shared with the Executive Team on 20 September for sign off. . A replacement Non-Executive Director with responsibility for Research will be nominated in due course.

The annual target of 90 responses for the NIHR Patient Research Participation Survey (PRES) has already been surpassed with 103 responses, this attracts an in-year additional payment from the NENC Clinical Research Network.

Accolades:

The Tees Valley Research network was recognised as the top recruiter in the United Kingdom in July for Smoking Cessation in Pregnancy Study (SNAP3) and was the top UK recruiting site for SENIOR RITA trial- Cardio treatment Randomised Control Trial.

Grants

Donna Wakefield, Consultant in Palliative Care was successful in obtaining a grant from Mesothelioma UK for a Chief Investigator led study - end of life care for patients with malignant pleural mesothelioma and Matt Dewhirst, Consultant Cardiologist has applied for funding for a grant for a heart failure treatment trial in collaboration with colleague as South Tees.

4. Strategic Objective: Transforming our Services

4.1 Integrated Care System (ICS)

4.1.1 Integrated Care Board (ICB)

Governance and Leadership continues to develop within the ICB and the associated key objectives across the system. The ICB now has delegated authority via the Oversight Framework and monitoring of performance of Foundation Trusts. The ambition is to support all Trusts in the NENC to a SOF segmentation two position.

4.2 North East and North Cumbria Provider Collaborative (PvCv)

The NENC Provider Collaborative Leadership Board met during August in which discussions took place around non-surgical oncology service, a regional clinical model for Gynaecology Oncology, and winter preparedness (as mentioned above at 2.1.2). An overview of current oncology services alongside workforce challenges (28% shortage by 2025) included a review of the outreach clinic locations for first outpatient appointments across the region.

A regional clinical model for Gynaecology Oncology Services to address capacity and resilience issues is in development with clinically agreed principles i.e. strong co-ordination and navigation of patients across the region via 3 sites, 2 centres and 1 regional service providing additional capacity; formalisation and consistency of out of hours cover with agreed standards and consistency of decision making. An Operational Clinical Working Group will develop the model with NHS Specialised Commissioning working with providers to establish contracting arrangements and timescales for implementation. Local Authority and Regional Oversight Committees are involved in decision making with the Northern Cancer Alliance.

4.3 Tees Provider Collaborative

4.3.1 Service and Estate Developments

4.3.1.1 Community Diagnostic Centre – Proposed Plans Teesside

A strategic plan for the health system in Tees Valley to develop diagnostic capacity, including a proposed new build Community Diagnostic Centre (CDC) by the end of 2025 has been agreed by the system. A programme board has been established to take forward the development of the CDC which reports into the Clinical Services Strategy Board. Subject to final approval of a business case in line with a national process, the planned CDC will be developed on the Castlegate Campus site in Stockton on Tees and will be part of the Stockton on Tees Borough Council Waterfront Masterplan development. The site recommendation was considered and approved by the former Tees Valley CCG following an independent site appraisal.

Good progress continues to be made in relation to delivering the strategic plan. The Outline Business case (OBC) has been completed with involvement of clinical teams and stakeholders. The OBC has been submitted to NHS England (NHSE) for review. A final business case will be developed for approval by Trust Boards and the Integrated Care Board of the ICS before submission to NHSE for final agreement and sign off. A partnership board has been established with Stockton on Tees Borough Council to ensure effective working relationships are developed, that there is development of clear communications, governance and decision making between the respective schemes and that timelines are aligned to meet the requirements of the NHSE CDC capital funding timescales.

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

4.3.1.2 Endoscopy Training Academy

The Academy is being developed and delivered collaboratively with South Tees NHS Foundation Trust. An official opening and launch event is being organised for the 7 October 2022. This will provide an excellent opportunity to showcase the work of the clinical and managerial teams and the expertise and support provided by the estates team within the NTH Solutions LLP.

5. Strategic Objective: Valuing our People

5.1 Faculty for Leadership and Improvement

The 100 Leaders midpoint showcase for cohort 2 was successfully delivered on 1st August, which allowed Pack Leaders to celebrate their successes and highlight challenges experienced on their journey.

Our second Quality, Service Improvement and Redesign programme commenced in September and colleagues from cohort 1 will be available to support new delegates through their programme of learning and developing. This programme continues to build QI capability within the workforce with opportunities to become experts in the field.

The 100 Leaders Programme has been successfully shortlisted for a Shining Stars Award, and the communications campaign around the programme has been recognised nationally for an NHS Communicate Award.

5.2 North Tees and Hartlepool NHS Trust Estate Strategy

Following the approval of the Estates Strategy and the resulting case for investment into future service and estate provision, the Board of Directors will consider the Strategic Outline Case (SOC) later this month.

The SOC includes the development of an options appraisal with stakeholders, a compelling case for change, vision for the future, value proposition and benefits realisation which is supported by robust demand & capacity, financial and economic models

The way forward based on quantitative and qualitative appraisals will be fully considered in September and further engagement work will continue.

5.3 Secretary of State for Health

Following the confirmation of Liz Truss as Prime Minister on 6 September 2022, the PM swiftly moved to confirm members of her cabinet which includes Therese Coffey as the new Secretary of State for Health and Social Care. Mrs Coffey is the fourth Health Secretary over the last five years and it is hoped this will signal a period of stability for the NHS to gather momentum on investment and transformation..

5.4 Improving Mental Health support to Families

The Trust recently welcomed BBC Look North in to the organisation as they interviewed Midwife Sonographer Nicola Threadgold and charity partner Leo's Neonatal's about the support offered to parents of children in the special baby care unit. This is a new scheme, the very first of its type in the country which offers mental health support to parents during what can be a very stressful period.

5.5 Bowel Cancer Screening sharing Good Practice Across the Globe

Three members of the bowel cancer screening team are heading to Mauritius this month on a fantastic endeavour to help the local government set up a cancer screening programme. Clinical Director of Bowel Screening and Consultant Gastroenterologist Professor Matt Rutter, Programme Manager Andrew Henson and Lead Specialist Screening Practitioner Kelley Williamson flew out on Friday 9 September to join the Prime Minister of Mauritius and government and health representatives.

5.6 Developing our Leaders across the Organisation

Stories such as that of emergency nurse Danielle Jamieson show the power of our 100 Leaders programme that challenges staff to make a courageous changes to deliver the strategic objectives. Danielle, who is a pack leader in the programme's second cohort, has spoken glowingly about the initiative and how it has helped her develop in her own role. Danielle is leading a project to improve the green spaces across the organisation – something which will undoubtedly benefit both staff, patients and relatives.

6. 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 2 2022/23 (interim)										
Date:	22 September 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 2 2022/23 and the actions for addressing the identified gaps in controls and assurance. This is an interim report covering July – August 2022.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting Patients First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

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

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

Strategic Risk 1A has a high risk (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.

Strategic Risk 1A – has one associated risk (6379) 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.

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

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

22 September 2022

Board Assurance Framework, Quarter 2 Interim Report (July-August) 2022

Report of the Associate Director of Corporate Affairs and Strategy

1 Purpose

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

2 Background

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

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

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

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

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

2.5 The Board of Directors is required to review the risk appetite and the appropriateness of its strategic risks on a regular basis. This will require the Board to consider the Trusts appetite for exploring and managing risks in patient safety and quality; compliance, regulation and finance; innovation and transformation; workforce; technology; and reputation. This will require a discussion based around the themes of avoid, minimal, cautious, open, seek and mature, and will be considered in light of the many changes that have taken place during the last months.

2.6 This may span the advent and rise of COVID through to the changes in governance with the formation of the ICS and the role of ICBs alongside other critical policy developments within healthcare that may impact on the Trust. The Board will review the risk appetite for the Trust at Board Seminar on 22 September and this will take into account a review of all risk domains currently within the BAF. In addition to this, the Board will wish to review the strategic risks within the BAF and ensure that they are relevant to the

organisation and its strategic direction, and also if there any additional risks not currently covered by the BAF.

3 Details

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

3.2 There are currently three principal risks 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. However, the principal risk of 'Patient Safety' includes two (2) aligned threats linked to operational issues e.g. procurement and pathology staffing. Whilst these threats do not impact on the overall risk rating of the principal risk it is general practice to include in the BAF.

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 2: 2022/23

Strategic Risk Patient Safety 1A

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

3.7 Risk 6379 relates to 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.

Strategic risk Finance 3C

3.8 Risk 6188 relates to the delivery of savings within the Trust's Cost Improvement Programme (CIP) and specifically the challenges to deliver the CIP programme for 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.

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

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 NHS 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, whilst the broad threat to the principal objective includes four specific areas (ICP/ICS, Clinical Services Strategy, Provider Collaborative and NHS Long Term Plan) it is clear that the Tees Provider Collaborative needs time to embed the structure, governance and cultural changes 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 Board has discussed previously that the work to mitigate the two risks relies heavily on the progress of collaboration with partners, as well as the input from the Integrated Care Board (ICB) with the focus 'place' based planning and delivery. Whilst the two risks are rated as HIGH, there is a likelihood that both risks can be reduced as governance and collaboration expectations within 'place' become clearer.

3.14 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 updated on a quarterly basis to illustrate the movement of risk ratings.

4 Significant Risks

4.1 In Quarter 2 no overall strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated specific threats as noted above and included in the table below. In respect to linked risks from the Corporate Risk Register, the following have been identified as a significant risk based on a current risk rating of >15 (High):

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	**3C**	**16**	**16**	**9**
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**

5 Key Findings

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

Risk to Objective	Risk Rating (Sept 2021)	Risk Rating (Dec 2021)	Risk Rating (Mar 2022)	Risk Rating (June 2022)	Risk Appetite
Patient Safety - 1A - There is a risk that the organisation will fail to implement safe and effective clinical practice					
The following High/Red rated risks were identified and continue to be monitored throughout Quarter 4 linked to Patient safety and Quality with risk reduction plans to mitigate risks: • Risk 6434 (High) - Procurement: Inability to easily identify real time stock position; • Risk 6379 (High) – Insufficient consultant staff to support clinical services. Risk 6426 (Moderate) – Adverse impact on the Trust, both internally and externally, from outcomes of employee relations cases/ET. Previously a high rated risk in Q3, remains a moderate risk in Q1 and continues to be monitored closely. 6529 (Moderate) - Agency staff do not currently meet the MRHA training requirements for administration of blood products 6508 (Moderate) - Pathology workforce below minimal levels 6531 (Moderate) - A number of registered nurse vacancies within CYPED due to maternity leave and staff moving to new posts as part of progression 6517 (Moderate) - Obstetrics and gynaecology consultant labour ward cover 6516 (Moderate) - Current workforce structure in obstetrics and gynaecology may not meet correct skill mix to cover all actions in the Ockenden review 6528 (Moderate) - Increased vacancies on ward 26 and EAU and a consistent gap in safe care data on ward 36. 6515 (Moderate) - Inability to provide a 7 day midwifery bereavement service in line with Ockenden action 13 These risks are currently monitored and managed through quarterly updates to Ps & Qs. All current and existing moderate related risks feature as part of ongoing quality data collection results with updates to PS&QS, updates for CCG via CQRG and Excellence is our Standard monitoring and identification of quality improvement activity.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Minimal**

Patient Experience - 1B - There is a risk that patients and service users do not receive high quality care which impacts on patient and carer experience					
There are three new risks identified in this quarter: • 5779 (Moderate) risk of delay in diagnosis from delay in radiological reporting • 6495 (Moderate) significant waiting times for new allergy clinic appointment • 6448 (Moderate) risk of injury to staff or patients due to violence and aggression The following existing Moderate risks have appropriate controls in place with stringent monitoring and mitigation processes through Patient feedback monitoring, reviewed during Patient Safety & Quality Standards Committee, Patient and Carer Experience Committee, Senior Clinical Professional Huddle, Safety Panel and Executive Reports. The risks include: • 6396 - risk of Covid 19 transmission (Elective Surgical Patients; • 6442 - Risk of disruption to planned care due to Covid 19 pandemic • 6454 - risk to the delay in receipt of clinic letters by patients and GPs • 6222 - Significant harm to patients from healthcare acquired skin injuries; • 6285 - Low rates of medicines reconciliation on EAU due to low resources; • 6428 - Risk of a delay in diagnosis; • 6383 - Violence and aggression from patients who have taken excessive illegal drugs and alcohol; A comprehensive and detailed risk reduction plan includes the need for clear guidelines to be available to clinical teams on an escalation plan when patients are diverted from another organisation with a formal agreement within the Trust and other organisations to avoid the risk occurring. Other planned outcomes include enhanced monitoring and education to reduce risk of significant harm to patients; medicines reconciliation; encourage high utilisation rates in theatres; raise awareness of accessibility standards; and improvements to complaint/patient feedback process.	**9 3x3**	**9 3x3**	**9 3x3**	**9 3x3**	**Minimal towards Open**

Performance & Compliance - 1C - There is a risk that the performance management framework does not identify and manage risk to compliance in a timely way					
No new risks identified. • Risk 6325 MOD 12 (4x3) Recover compliance and performance following delays caused because of covid • Risk 6393 MOD 12 (4x3) Non-compliance with cancer standards • Risk 6394 MOD 12 (4x3) Non-compliance with diagnostic standard • Risk 6392 MOD 12 (4x3) Non-compliance with RTT standard Implementation of recovery groups and actions plans, along with escalation policies and plans in place with Assurance Framework and Annual Planning ensuring mitigation of all risks through the provision of plans and forecast outturn for the financial year which is signed off by Board. Quality Accounts, Escalation plans have been developed for all Directorates covering Workforce, Bed Capacity, PPE Supplies, Oxygen supplies etc; System oversight framework released in June with internal baselines established, with risks reviewed and ratings remain unchanged as the Trust works towards recovery against planned trajectories. Revised plans following latest release of Planning guidance 2022/23 (24 December 2022). 30 June 22 - Revised annual plans submitted with monthly monitoring internal and external via NHSE/I	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Minimal**

Emergency Preparedness Resilience and Response (EPRR) - 1D - There is a risk that an internal and/or external incident could disrupt or present a catastrophic breakdown of services provided by the Trust.					
There is one new risk reported in this quarter: • Risk 6062 - Emergency Planning and Business Continuity (tolerated risk) This is a low rated risk with oversight and assurance of significant EPRR related risks through the Trust Resilience Forum including ongoing monitoring and reporting of relevant local and national risks and/or changes in legislation, including through use of NEY EPRR Regional Risk Register and links with LRF. Gaps in Business Continuity Planning were addressed through the rollout of new business continuity management arrangements (started 27th June 2022). Monitoring of 3 month implementation period to be conducted through the Trust Resilience Forum with anticipated completion by 30th September 2022. EPRR system changes have been addressed e.g.known and unknown impacts and changes to internal response arrangements relating to upcoming EPRR system changes including: the Introduction of Integrated Care Boards; and enhanced expectations on health commander competency through the introduction and ongoing rollout of Principles of Health Command training to all operational, tactical and strategic commanders. Mitigation includes the development and implementation of an EPRR training and exercise strategy to help re-establish an effective approach to EPRR training and exercising, including training linked to upcoming changes to health commander competencies through the delivery of Principles of Health Command training to operational, tactical and strategic response staff across the Trust. Risk reduction plan contains mitigating actions with current progress and planned areas of work including the development of a severe weather plan as agreed at Trust Resilience Forum (TRF).	**12 4x3**	**12 4x3**	**12 4x3**	**9 3x3**	**Avoid/Minimal**

Valuing People & Workforce - 2A - There is a risk that the People Strategy principles are not fully embraced or embedded across the Trust resulting in not attracting, developing or retaining the workforce we need in order to take forward the Corporate Strategy and Clinical Services Strategy					
No new risks identified. **Attract** • Risk 5573 - Inability to recruit or retain quality staff – managed through a change in approach to workforce planning resulting in gaps in readiness of leaders in relation to thinking differently with regards to recruiting and flexibility of employment. Longer term plans regarding AfC terms and conditions from a national perspective are under consideration;	**9 3x3**	**16 4x3**	**12 4x3**	**12 4x3**	**Open**
Develop • Risk 5572 - Limited access to training / non-release of staff to ensure compliance. Mandatory training and appraisals are regularly monitored and reported at a senior level across the Trust. Assurance is provided through Mandatory training and appraisals that are regularly monitored and reported at a senior level across the Trust. • Risk 5574 – Failure to establish effective leadership and talent management interventions with evaluation of training programmes underway	**12 3x4**	**9 3x3**	**9 3x3**	**9 3x3**	**Open**
Retain • Lack of achievement in sickness absence targets (5805) managed through regular and meaningful engagement with staff in relation to workplace risk assessments and mitigation put in place to reduce associated risks. Focus on a prevention approach to absence management in place, specifically in relation to emotional and mental health and wellbeing. • Staff networks for protected characteristics are now fully embedded within the Trust with Terms of reference in place for groups. Process of monitoring will continue as a priority.	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Open**

Valuing People & Workforce - 2B – There is a risk that people processes, procedures and policies are not sufficiently robust or consistently applied resulting in ineffective people management practices and employee relations cases/employment tribunals that will have an adverse impact on the Trust from a performance, finance, reputation, quality and people perspective					
• Risk 6426 - Adverse impact, internally and externally from outcomes of employee relations/ET cases. Plan in place in response to audit recommendations with positive progress made to date. Risk management and mitigation through Executive reports. This risk is mitigated through implementation of appropriate plans, policies and e-learning and managed through People Committee. A full risk reduction plan has been implemented with monitoring of actions by Interim Chief People Officer and Chair of People committee. • All employment policies and procedures relating to Employee Relations to be updated, reviewed and agreed by Workforce committee; • Planned programme of lead investigators rolled-out and reviewed with monitoring to ensure consistency of approach, improve understanding and knowledge of process/policy; • Communication packs for managers implemented via e-learning on ESR to minimise escalation towards grievance and whistle-blowing; • Implementation of schedule of internal audits on ER processes.	**N/A**	**N/A**	**16 4x4**	**12 4x3**	**Cautious**

Transforming our Services- 3A – There is a risk of failure to develop a system wide approach with adverse impact upon flow and capacity within the system					
There are no new risks identified in this Quarter. Advent of COVID-19 and actions taken to ensure all strategic risks associated with the pandemic are being reviewed through : • Workforce (completion of risk assessments for BAME and vulnerable lists and minimising any risks by redeploying at risk staff into safe working environments); • Service Provision (every service reviewed priority cases and ensure priority patients are seen first); • Local partners and Social Care (Regular contact with providers, continuation of community bed base provision, safe transfers and issues arising from provision of care home beds for positive COVD patients); • Demand v Capacity (ensure accurate activity position for future service provision by preventing fragmentation of services and the emergence of undetected/late diagnosis). Planning and Performance - access to Systmone strategic extract. Consultant deployed to support S1 data extract to support informed decision making. MSK pathways identified as area to consider first - tables loaded and ready to be linked to yellofin July 2022. Development of virtual wards - virtual beds established in H@H, Residential/nursing homes - bid in place to support expansion. Ageing Well (UCR 2 Hour response) - Workforce being established, funding received (combination of NREC and REC). Working with partners to understand remote home monitoring to support patients to self-manage and early intervention. Consultant in Public health is currently accelerating the development of the health inequalities agenda in collaboration and partnership with Directors of Public Health work and population health management agenda. Trust work plan for working with system partners has been produced.	**9** **3x3**	**9** **3x3**	**9** **3x3**	**9** **3x3**	**Open**

Transforming our Services (Internal) - 3B - There is a risk of failure to deliver transformational improvements that are sustainable, financially effective, aligned with local and national requirements, beneficial and which have secured commissioner support					
No new risks identified. • PMIO conduct evaluation of supporting project documents and consider levels of expertise with a view to delivering pre-project workshops. Process developed to identify required QIA documents reported through Excellence as our Standard; • Reviewed and improved process for business cases with strategic alignment resulting in a more robust process; • Cross-Care Group Transformational Programme provided through PMIO with service developments identified part of annual business planning rounds. Exception report provided to Transformation & Improvement Board to be clear about any projects off track. Internal oversight of the CSS work stream delivery via the Transformation & Improvement Board, ensures projects are supported and on track to deliver, providing escalation through the appropriate governance structure; • The strategy document has been revised to include the transformation and improvement that has been identified including those identified as a result of the response to the Covid 19 pandemic. The completion of the Clinical Service Strategy will provide assurance and a platform of change. • All projects are monitored through the Project Management & Improvement Office as part of the delivery assurance monitoring, with Business Team providing oversight. A full Clinical Services review and a Trust strategy is in progress. The CSS is currently in development stage and will be finalised during Q3.	**12** **4x3**	**12** **4x3**	**12** **4x3**	**12** **4x3**	**Seek**

Finance - 3C - The Trust does not deliver the 2021/22 financial plan as submitted to NHSI/NHSE (including future years)

There are no new risks identified in this Quarter. The following three high rated threats were identified as part of the work of the Finance Committee in Q3 and remain on the risk register as Moderate risk with the exception of Risk 6188 which retains a High risk rating.

- Risk (6203) of cost containment which is paramount to the sustainability of the Trust in order to the deliver the financial plan for 2021/22. This risk has carried forward from Quarter 2 and is linked to a shortfall on CIP identification and delivery, failure to operate within control totals and excessive costs associated with Care Group arrangements (e.g. new posts, governance arrangements, and service developments).
- There is a Moderate risk that Wider Health Economy Issues (6205) are impacted by the draft 6 Facet Survey report and this underlines the significance of capital investment in our estate due to the fact that there is approximately 10 years of remaining life in some of the buildings (e.g. North Wing and Tower Block);
- However, a High risk remains relating to 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. Upon further scrutiny at Finance committee in July, this risk may be down-graded.
- The review of the Master Services Agreement has been completed and there are 13 proposed service specifications to replace the original 16 specifications. This has been shared with Care Groups for comment and has been presented to the MSA Operational and Strategic Groups. The new KPIs have been piloted between April and June 2022 and will require formal approval.
- This action will remain open in the BAF until a final decision is made.

ICP/ ICS 12 4x3	ICP/ ICS 12 4x3	ICP/ ICS 12 4x3	ICP/ ICS 12 4x3	Open
Contract 6 3x2	Contract 6 3x2	Contract 9 3x3	Contract 6 2x3	
Cost 12 4x3	Cost 12 4x3	Cost 12 4x3	Cost 12 4x3	
Savings 12 4x3	Savings 12 4x3	Savings 16 4x4	Savings 16 4x4	
LLP 9 3x3	LLP 9 3x3	LLP 9 3x3	LLP 6 2x3	

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

- Corporate risk register contains a high rated threat/risk relating to ICT staffing levels to return to business as usual (Risk 6404) linked to ongoing recruitment and retention and potential for this to be exacerbated as a result of COVID-19. This risk is monitored and managed through the appropriate workforce channels and through the Digital Strategy Committee. If continuous investment is not made, the successful digital maturity the Trust has gained could diminish and impact negatively on Trust reputation.
- The dependency on key resources has identified a range of controls including formalised and documented standard operating procedures (SOPs). Following discussion at Digital Strategy Committee, it was agreed to raise the risk level due to the current challenges of recruitment and retention of I&TS workforce.
- Risks relating to cyber threats continue to pose a threat to the organisation as the Trust does not currently carry out regular training of all staff on cyber threats. Staff need to take personal responsibility for understanding how technologies will provide support to business functions and undergo necessary training (including mandatory) in accordance with Trust policy.
- Significant events (i.e. pandemic, organisational form impact) pose a potential risk linked to changing health and care landscape, may adversely impact on Trust strategic plans and delivery priorities. Provider Collaborative "Joint" Governance and formal strategic agreements including agreed digital strategies and plans. However, there is no current ICP/Tees Valley Provider joint digital strategy.

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

New system implementations				Open
8 2x4	8 2x4	8 2x4	8 2x4	
Data breaches and cyber threats				
8 2x4	8 2x4	4 1x4	8 2x4	
Inappropriate use of systems				
4 1x4	4 1x4	4 1x4	4 1x4	
Dependency on key systems, resource and significant events				
4 1x4	4 1x4	4 1x4	4 1x4	

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

ICS

- There is a risk of limited active engagement in the development of the North East & North Cumbria Integrated Care System pending the handover of statutory powers to the ICS in April 2022 which could result in an adverse impact on commissioning of acute services once this role is subsumed into the ICS. The Trust will review the governance arrangements as they evolve within the ICS.

ICP Clinical Strategy

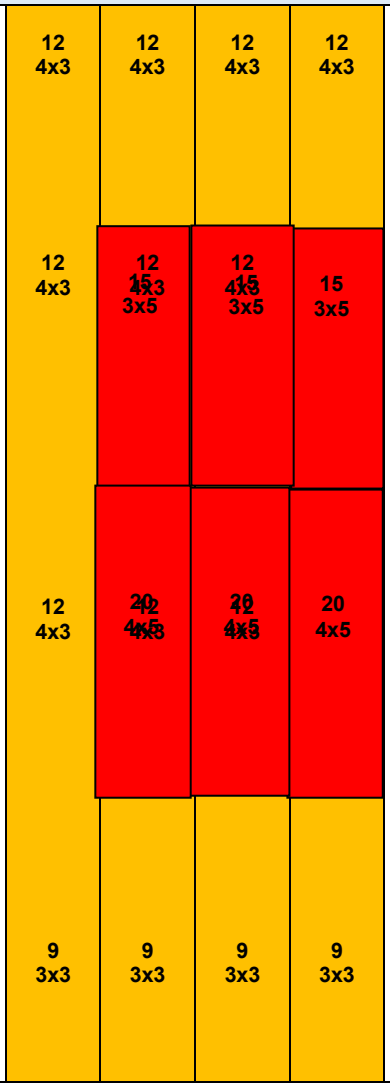
- Transformation & Improvement Programme Board within the Trust provides support to the clinical teams in terms of progress and escalation of barriers to change. Transformation & Improvement Board, ensures projects are supported and on track to deliver, providing escalation through the appropriate governance structure as necessary. Assurance is provided through weekly Executive reports, monthly updates to Trust Board, regular updates to Transformation Committee providing assurance to ETM in regard to the detailed work being undertaken and escalation of risk and issues

Tees Valley and North Yorkshire Provider Collaborative

- The publication of the ICS Design Framework provides the next level of detail about how they will operate from April 2022 and the core expectations as part of the ICS establishment as well as ICS Transition and Development, with guidance and resources available for both areas. The CEO is part of the ICS Design Group therefore providing an opportunity to be part of the change that is underway, providing a voice for both the South ICP and the Trust in terms of the proposed changes.
- The risk clearly remains with the uncertainty faced across the ICS and the time needed to embed the structure, and this will continue to be monitored and reflected in the BAF.

Long Term Plan

- Annual plan continues to manage the current position against key elements of the LTP. However, detailed assurance is provided through the Care Group structure and key areas of responsibility; Transformation Committee oversee LTP progress and the delivery of LTP supporting projects. The development of a Population Health strategy in line with Health & Wellbeing Board objectives along with the appointment of a Consultant in Public Health provides the assurance that health inequalities are being targeted at a local level.



Health & Wellbeing - 4A - The Trust fails to effectively address population health, prevention issues and strategic co-ordination of the public health agenda across Stockton, Hartlepool and the wider geographies as evidenced by an increase in admissions and patient pathways					
• No new risks identified. • COVID-19 and actions taken to ensure all strategic risks associated with the pandemic are being reviewed under Workforce, Service Provision and Local Partners (Social Care). Every service completed an estate risk assessment to ensure social distancing is maintained - reviewed regular, every service reviewed priority cases and ensure priority patients are seen first, full review of wait times, estimation for recovery based on new referrals and backlog. Trajectory planned for recovery in most services. Prioritisation given to cancer patients (service has been maintained throughout COVID19 position) • Further prioritisation of RTT through e-review service (via NECS) • Development of iSPA facility to provide MDT approach to patients including health, social and mental health provision • MSK actions to support patients waiting over 18 weeks implemented - increase F2F appointments • Recovery continues, MSK RTT within tolerance, ongoing plan in paediatrics and gynaecology to continue to recover RTT • Cancer waits for gynaecology improving, 1 patient at 104 days (with South Tees), 5 patients currently at 62 days - all have a plan • Evaluation of schemes deployed in response to COVID19 - Holdforth Hub and Homefirst schemes - Data collection available for initial review of impact. Requirement to summarise position to date and to look to continue with schemes to further evaluate impact • Engagement around Personalisation as a system and development of Leadership, incorporating LA, Primacy Care, Patient Representative and Foundation Trust is ongoing; • Development of Health Inequalities dashboard - Ability to understand which people are most at risk of not engaging with healthcare, ability to potentially put an intervention in place to proactively support these people This risk will be reviewed as part of the ongoing work on health inequalities and disparities.	**12** **3x4**	**12** **3x4**	**12** **3x4**	**12** **3x4**	**Seek**

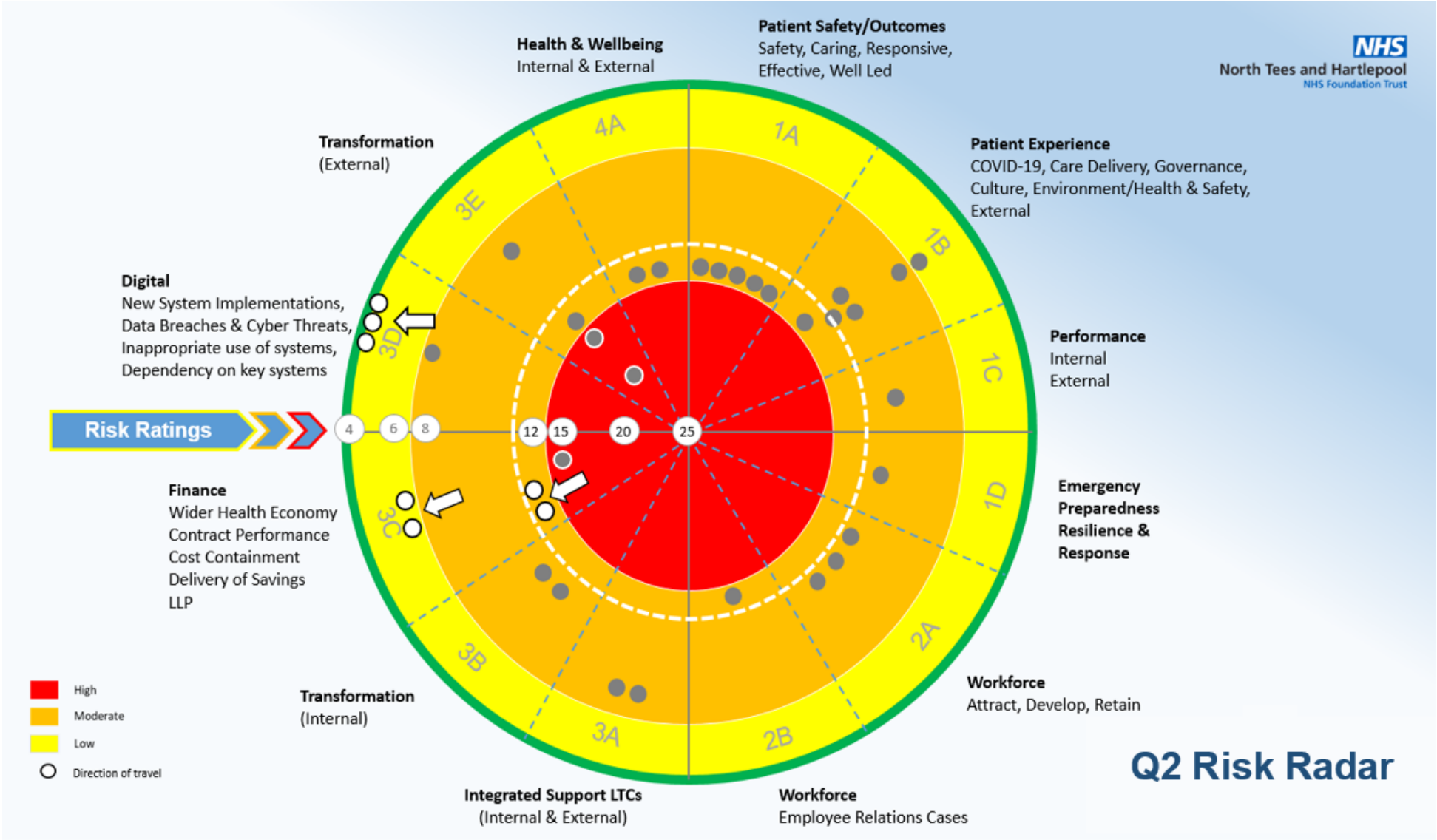
6. Recommendations

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

6.2 The Board of Directors are 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
Performance
Internal
External
Risk Ratings
4
6
8
12
15
20
25
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings
LLP
Emergency Preparedness Resilience & Response
4A
1A
3E
1B
3D
1C
3C
1D
3B
2A
3A
2B
High
Moderate
Low
Direction of travel
Transformation
(Internal)
Workforce
Attract, Develop, Retain
Integrated Support LTCs
(Internal & External)
Workforce
Employee Relations Cases
Q2 Risk Radar

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

This front sheet should be appended to all reports, presentations and documents being presented at Board of Directors.

Title:	Integrated Performance Report														
Date:	16 September 2022														
Prepared by:	Lindsey Wallace - Interim Deputy Director of Planning and 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 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 August 2022 including quality, workforce and finance.

Summary

- Operational and workforce pressures continued in August, 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.
- 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.
- The number of patients waiting longer than 52 weeks has decreased from 73 in July to 49 in August
- The Trust achieved three of the nine cancer standards in July 2022
- Long Term staff sickness has seen a slight increase for July 2022, this will be continuously monitored.
- Staff Turnover has seen a continued decrease from the previous month, with a positive move toward target.

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, and staffing resource.	
Committees/groups where this item has been discussed	NA
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
Next steps for presentation eg Board Committee/Board meeting	Planning, Performance & Compliance Committee Board of Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report

September 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 August 2022 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance. To view the July 2022 position, please refer to the individual SPC charts.

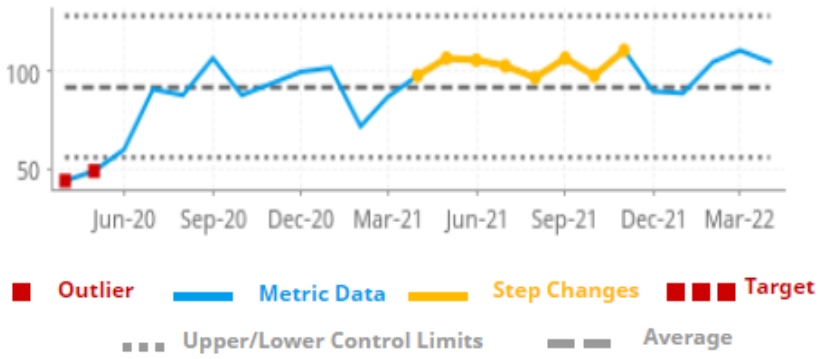
Statistical Process Control (SPC) Charts

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

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

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

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



Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

SOF and Efficiency & Productivity

The Trust continues to work towards the delivery of trajectories outlined in the annual operating plan for 2022/23 the overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position. Additional capacity continues to be delivered through a combination of insourcing and prioritising capacity within the elective programme whilst the internal workforce gaps are addressed

The Trust continues to face the challenge of increased activity, responding to system pressures with requests for mutual aid, diverts and deflections from across the system, often resulting in these patients converting to admissions. High bed occupancy rates have impacted upon the waits in the Emergency Department for a ward bed continues to be a challenge.

The Trust is achieving three out of the nine cancer standards, with a very similar picture across the region. The Trusts performance on Cancer 31 Days has dipped in July, however the Trust continues to achieve the 28 day faster diagnosis standard (FDS) with a significant improvement noted for July.

Elective recovery continues with patients who have waited the longest being given dates before the end of September 2022 in accordance with the annual operating plan.

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 92.45 (July 2021 to June 2022), with the latest SHMI value is now 95.89 (April 2021 to March 2022) which remains within the control limits.

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

The number of complaints received during August 2022 has seen a decrease within Stages 1, 2 and 3. The number of complaints received this month continues to be consistent with pre-pandemic levels.

The number of high risks has reduced to below the mean this month and this remains within the expected variance, demonstrating a dynamic risk management process.

Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Workforce

The sickness absence rate for July (latest available data) reported an increase of 0.83% (from 5.97% in June to 6.8%). Whilst there was a slight increase in non-Covid absence (+0.3%), there was a greater increase in Covid related absences (+0.53%) in July from June.

There was a further decrease in staff turnover in July compared to the previous month (11.19% from 11.44%).

Overall mandatory training compliance has slightly reduced by 0.15% but has remained at the 90% standard. It is acknowledged there is still work to be done on raising the compliance on topics which are lower than required.

Appraisal compliance has increased by 0.42% but further work is required to increase this further to the required standard.

Finance

For 2022/23, the Trust has a revised surplus financial plan of £4.35m.
Delivery of the revised plan is supported by additional income and additional CIP.

At month 5, the Trust is reporting an in-month surplus of £37k against a surplus plan of £4k, which is £33k ahead of plan.

The Trust is reporting a year to date surplus of £4.199m against a plan of £3.268m, which is £0.931m ahead of plan.

Total Trust income in M5 is £31.512m (including donated asset income and finance Income).

M5 pay expenditure totalled £21.350m of which £0.09m is additional spend related to the Covid-19 response (including testing costs).

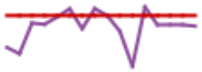
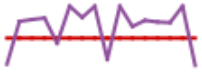
M5 non-pay expenditure totalled £10.153m.

The month 5 year to date net contribution from Optimus is £0.116m against a plan of £0.068m (£0.048m ahead of plan) and the year to date net contribution from the LLP is £0.659m against a plan of £0.993m (£0.334m behind plan – this includes reinvestment spend).

The main reason for the Trust being ahead of plan at Month 5 is due to being underspent on non-recurrent funding.
The key risks at Month 5 continue to be run rate increase and CIP identification and delivery.

System Oversight Framework 6

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
New Cancer Two Week Rule	✗	Jul-22	85.77%	93.00%	
Breast Symptomatic Two Week Rule	✓	Jul-22	95.53%	93.00%	
28-day Faster Diagnosis	✓	Jul-22	81.65%	75.00%	
New Cancer 31 Days	✗	Jul-22	92.74%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Jul-22	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	Jul-22	91.67%	94.00%	
New Cancer 62 Days	✗	Jul-22	63.77%	85.00%	
New Cancer 62 Days (Screening)	✗	Jul-22	85.51%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✗	Jul-22	72.22%	85.00%	

Narrative

Cancer

July is the latest validated position in regard to the cancer standards, with the Trust achieving three out of the nine cancer standards, with a very similar picture across the region. Cancer 31 day has seen a decrease in performance from June to July, this is due to a combination of complexity, patient choice and surgical capacity.

A high volume of referrals continues to impact 2 week rule appointments, predominantly in Gynaecology where a 20% increase in referrals is reported across the region. Teams are working with ICB colleagues and the PCN network to address these issues with support from the Northern Cancer Alliance to understand the reasons for pathway changes.

Whilst the outcome of the national consultation to review existing cancer standards has not yet been announced, the Northern Cancer Alliance remains focussed on achieving the 28 day FDS and is supporting all Trusts within the network.

The cancer 62 day standard remains a pressure, although an improvement can be seen in the July position with no Trust in the region achieving this. Issues in breast, gynaecology, colorectal and urology continue both locally and regionally, a continued focus remains through the underpinning governance processes to ensure all patients progress along the pathway as quickly as possible.

Roll out of the Targeted Lung Health Check Programme is expected week commencing 26th September. This has been recognised by both the Cancer Alliance and the LMC as one of the most positive collaborative projects to have worked on.

Cancer Delivery Groups continue to meet on a monthly basis to support and encourage change solutions and understand issues around complex pathways to help recover the Trusts position and improve overall waiting times and patient experience. A Trust cancer action plan has been agreed and is monitored through the robust governance structure in place.

System Oversight Framework 7

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Referral To Treatment Incomplete Pathways Wait (92%)	Aug-22	80.20%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	Aug-22	28.28	28.00	
Incomplete Pathways Wait (Median)	Aug-22	9.00	7.20	
Incomplete Pathways Wait (>52 Week Wait)	Aug-22	49	5	
Diagnostic Waiting Times and Activity	Aug-22	76.23%	99.00%	

Narrative

RTT

49 patients were waiting longer than 52 weeks at the end of August, against a planned trajectory of 5. Plans are in place to accommodate dates in September which will see an improved recovery position, with a trajectory of 27.

The Trust continues to report low numbers of 52 week waiters, including compliance against the RTT standard reporting at 80%, with the regional position reporting at 72.3%.

At the end of August 2022 the Trust maintains its trajectory in line with NHS England's Phase 1 and Phase 2 elective recovery and reports no patients waiting longer than 78 and 104 weeks.

There is a continued to be a clear drive to reduce the number of patients waiting over 52 weeks with clear oversight and plans in place to ensure all long waits are seen and treated in accordance with policy and clinical opinion, in the best interests of the patient.

Diagnostics

Performance has seen a reduction in August compared to July with pressures primarily related to staffing capacity in a number of key areas with the largest impact seen in Ultrasound additional capacity to assist in reducing the number of patients waiting over 6 weeks was introduced in August.

Additional MRI capacity to reduce the backlog has been available via a mobile scanner, which is planned to continue in the short term. The implementation of the new contract is providing opportunities to review provision. Successful training of 1 new and 1 existing staff has enabled a slightly improving trajectory for CT.

Endoscopy are reporting an improved position of 130 breaches in July with 22 additional Saturday lists in month (holding 151 lists over a 4 week period). This is compared to 197 breaches reported the previous month with 20 additional lists (holding 147 lists over a 4 week period).

Outsourcing of Radiology reporting continues but with reduced capacity as the outsourcing companies are experiencing resource pressures. However, final infrastructure testing is underway to increase capacity with an additional new outsourcing company, to increase reporting capacity with anticipated start of early October.

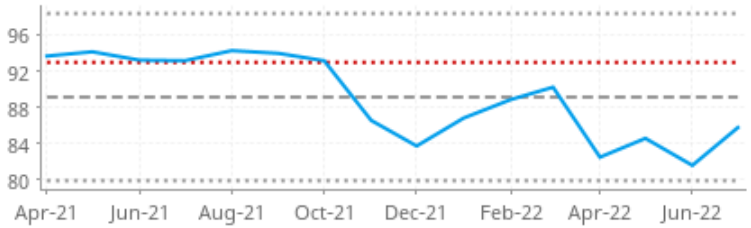
System Oversight Framework 8

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

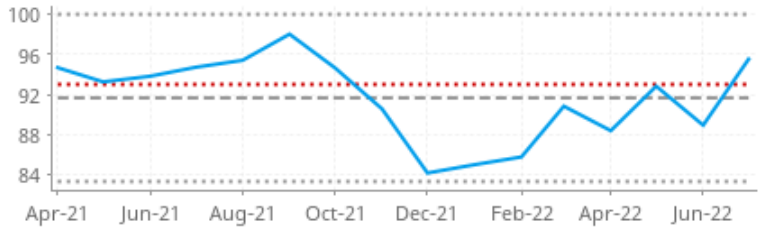
Cancer - 2 Week Rule

Month	Performance	Standard
Jul-22	85.77%	93.00%



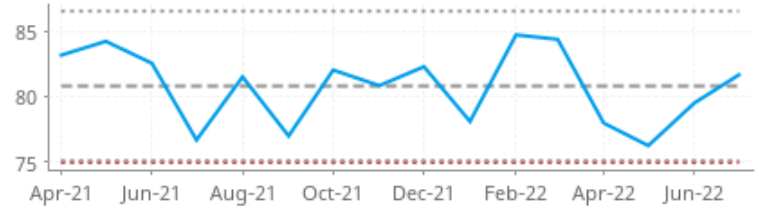
Cancer - Breast Symptomatic

Month	Performance	Standard
Jul-22	95.53%	93.00%



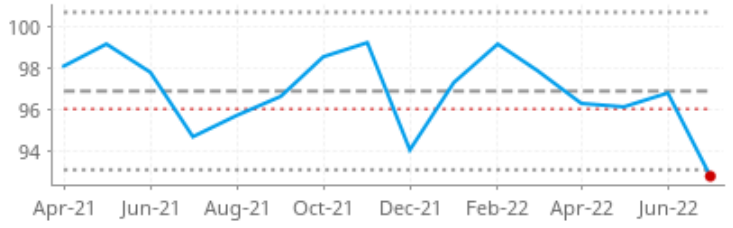
Cancer - 28 day Faster Diagnosis

Month	Performance	Standard
Jul-22	81.65%	75.00%



Cancer - 31 days

Month	Performance	Standard
Jul-22	92.74%	96.00%



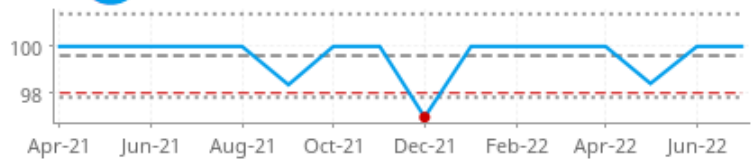
System Oversight Framework 9

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

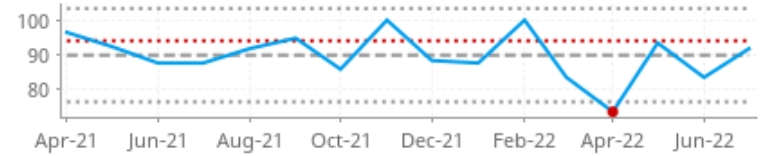
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
Jul-22	100.00%	98.00%



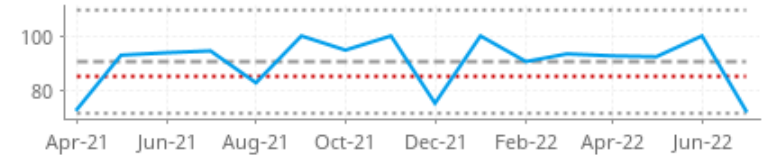
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
Jul-22	91.67%	94.00%



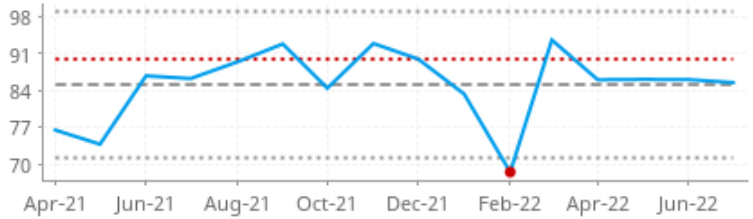
Cancer - 62 Consultant Upgrade

Month	Performance	Standard
Jul-22	72.22%	85.00%



Cancer - 62 Days Screening

Month	Performance	Standard
Jul-22	85.51%	90.00%



Cancer - 62 Days

Month	Performance	Standard
Jul-22	63.77%	85.00%

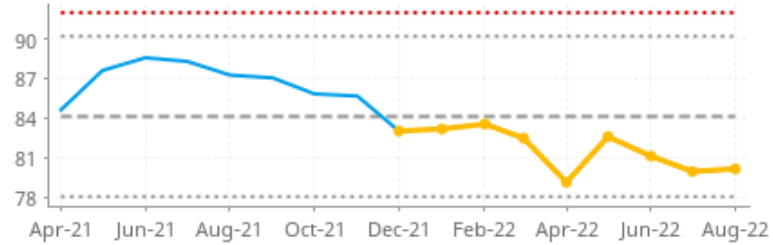
System Oversight Framework 10

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

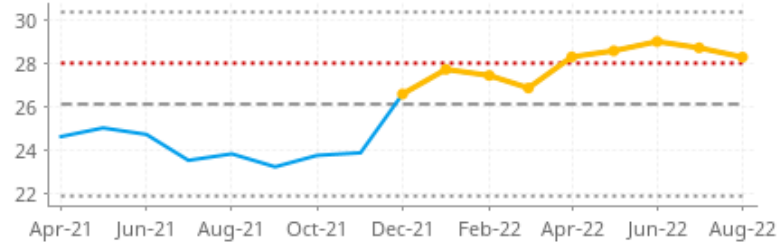
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Aug-22	80.20%	92.00%



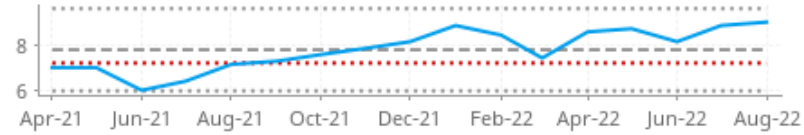
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Aug-22	28.28	28.00



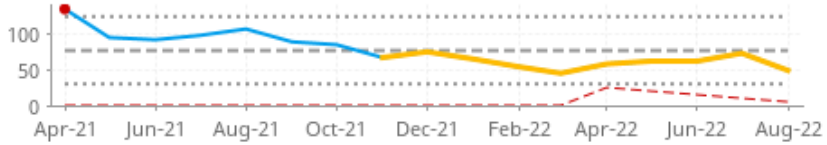
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Aug-22	9.00	7.20



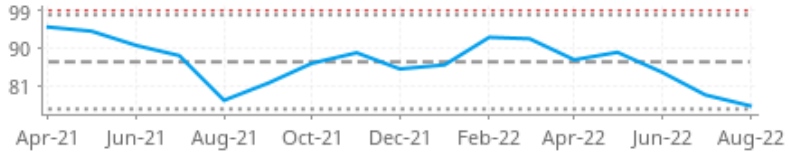
Referral To Treatment- Incomplete Pathways Wait (>52 Week Wait)

Month	Performance	Standard
Aug-22	49	5



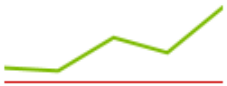
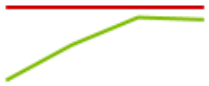
Diagnostic Waiting Times and Activity

Month	Performance	Standard
Aug-22	76.23%	99.00%



Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Decision To Admit (DTA) (over 12 hours)	Aug-22	18	0	
Time to Initial Assessment (mean) Type 1 & 3	Aug-22	12.44	15.00	
Number of Ambulance Handovers waiting more than 60 Mins	Aug-22	25	0	
65% of Ambulance Handovers completed within 15 Mins	Aug-22	35.28%	65.00%	
95% of Ambulance Handovers completed within 30 Mins	Aug-22	67.92%	95.00%	
2 hour Urgent Community Response	Jul-22	68.04%	70.00%	

Narrative

Urgent and Emergency Care

The Trust continues to triage patients within the required national standard of 15 minutes.

Pressures are noted with ambulance handovers however, the number of handovers over 60 minutes was less than the reported July position.

NEAS reported the Trust at 53.3% of ambulance turnaround times within 30 minutes (arrival to clear), which places the Trust joint 1st regionally with an average turnaround time of 32 minutes compared to the regional average of 40 minutes. The Trust is committed to improving compliance with ambulance turnaround times and continues to work in partnership with NEAS colleagues.

The trust continues to receive a number of ambulance diverts and deflections and mutual aid requests from neighbouring trusts which adds to the pressures within ED. 63 patients were received during August 2022, with 38 going on to be admitted as an inpatient, with an average LOS of 5.8 days.

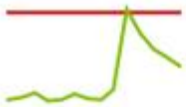
The implementation of the new operating model is fundamental to improve the flow with a number of key changes to be undertaken.

Urgent Community Response

Whilst this is a new national standard from 1st April 2022, compliance has seen a steady improvement with the latest period seeing a continued improvement to 68.04%, the Trust remains on track to achieve the standard of 70% by end of Quarter 3.

Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	Performance	Standard	Trend
Outpatient Did Not Attend (Combined)	Aug-22	9.33%	9.20%	
Reducing Reviews	Aug-22	110.09%	85.00%	
Patient Initiated Follow Up (PIFU)	Aug-22	2.20%	5.00%	
Advice and Guidance	Jul-22	12.08%	16.00%	
Diabetic Retinopathy Screening	Aug-22	98.95%	95.00%	

Narrative

Outpatients

An improvement in performance against DNA rates is noted in August with a continued upward trend evident as more patients are seen in an outpatient setting coming out of the pandemic.

The continued focus on Patient Initiated Follow Ups (PIFU) has seen additional, clinically appropriate, patients placed on a PIFU pathway. Although below the trajectory additional services have yet to implement PIFU with plans to complete this over the coming months and will feature as a Trust initiative as part of the national drive 'Super September'. In addition to this the Trust held an outpatient workshop as part of the Planning and Recovery Group with a focus on improving capacity to not only meet new demand but also manage review appointments. A plan is under development with key priorities defined for September.

The organisation continues to aim to reduce the number of patients seen in review clinics, set at 85% of 19/20 activity, The Trust is currently reporting an increase from the July position 25.09%, up from 2.31% over that plan for August. This large increase is due to a reduction in the months trajectory, but also a significant increase in activity.

The planning submission for 2022/23 has a target of 16% of referrals, following clinical review, to be referred back with advice and guidance as a means of ensuring patients receive the most appropriate care.

Efficiency & Productivity

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North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Electronic Discharge Summaries	✗	Aug-22	88.90%	95.00%	
Super Stranded	✗	Aug-22	60	43	
Average Depth of Coding	✓	Jul-22	6.39	3.01	
Length of Stay - Elective	✓	Aug-22	2.64	3.14	
Length of Stay - Emergency	✓	Aug-22	3.08	3.35	
Day Case Rate	✓	Aug-22	86.23%	75.00%	
Pre-op Stays	✓	Aug-22	1.77%	4.50%	
Trust Occupancy	✗	Aug-22	93.95%	90.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	✗	Jun-22	8.90%	7.70%	
Not reappointed within 28 days	✗	Jul-22	4	0	

Narrative

Electronic Discharge Summary (EDS)

All summaries are being completed however some are outside of the required 24 hours.

A working group has been established to review the full end to end process of EDS, with the view to standardise EDS reports to enable a more targeted view of the ward position.

Trust Occupancy

Trust occupancy has increased by 0.86% in August from the July position, operating at a heightened occupancy rate (93.95% average) with surges in activity seen throughout the month. A decrease in Covid admissions has been seen throughout August, reducing to 23 patients with no patients on ITU at month end.

Readmissions

A number of initiatives are ongoing including; discharge board improvement, collaborative working with community matrons, discharge checklist within nursing documentation, Frailty team support with education for back of house discharge planning, frailty network leading collaborative readmission audit and Systmone access through TrakCare to improve discharge.

Virtual wards and support from Hospital at Home are also enabling improvements in readmission rates across respiratory medicine, which is one of the main reasons for readmission.

Efficiency & Productivity

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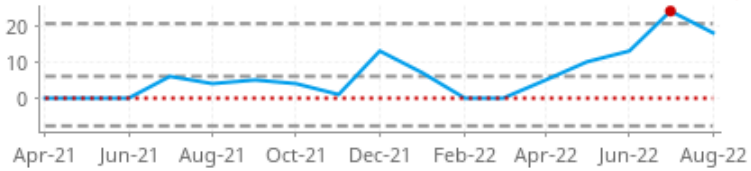
NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Decision to Admit (DTA) (Over 12 hours

Month	Performance	Standard
Aug-22	18	0

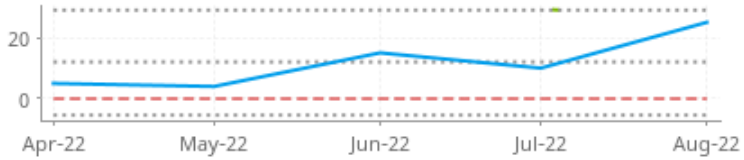


Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Aug-22	12.44	15.00

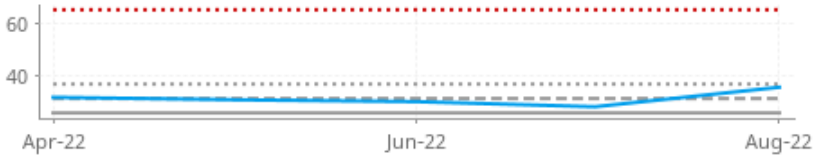
Number of Ambulance Handovers waiting more than 60 mins

Month	Performance	Standard
Aug-22	25	0



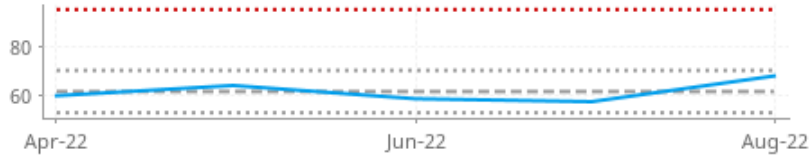
65% of Ambulance Handovers completed within 15 mins

Month	Performance	Standard
Aug-22	35.28%	65.00%



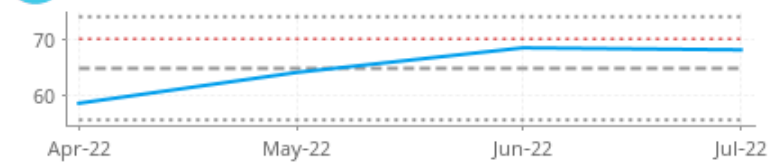
95% of Ambulance Handovers completed within 30 mins

Month	Performance	Standard
Aug-22	67.92%	95.00%



2 hour Urgent Community Response

Month	Performance	Standard
Jul-22	68.04%	70.00%



Efficiency & Productivity

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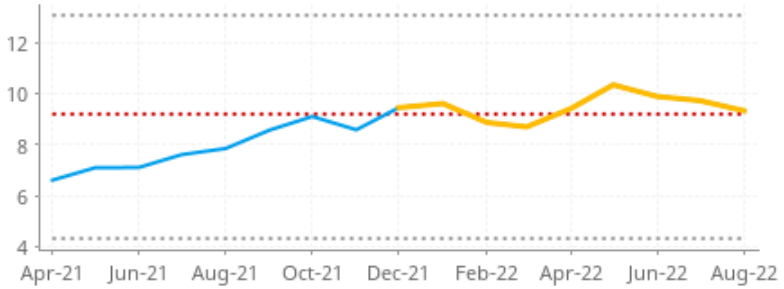
North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

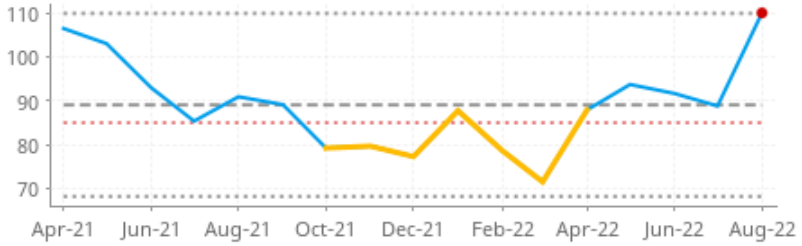
Outpatient Did not Attend

Month	Performance	Standard
Aug-22	9.33%	9.20%



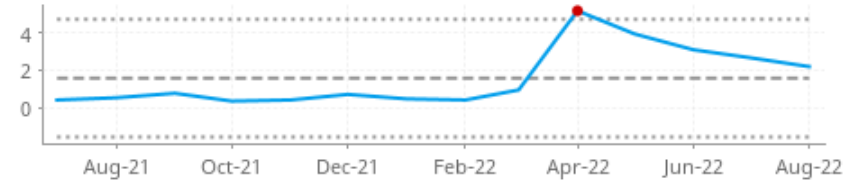
Reducing Reviews

Month	Performance	Standard
Aug-22	110.09%	85.00%



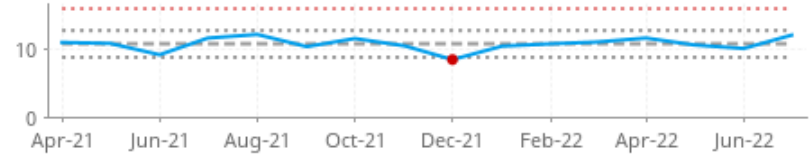
Patient Initiated Follow up

Month	Performance	Standard
Aug-22	2.20%	5.00%



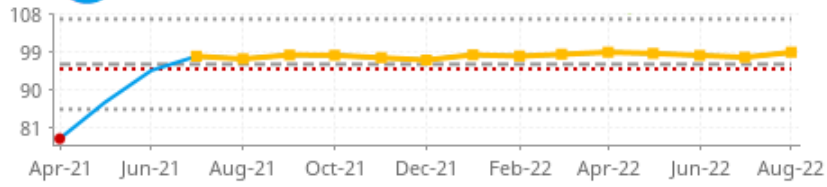
Advice and Guidance

Month	Performance	Standard
Jul-22	12.08%	16.00%



Diabetic Retinal Screening

Month	Performance	Standard
Aug-22	98.95%	95.00%



Efficiency & Productivity

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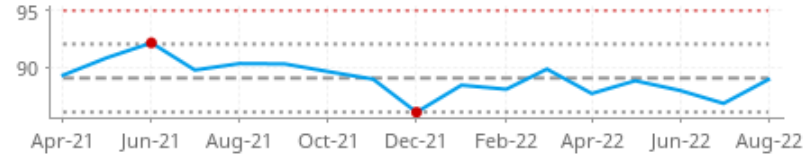
NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

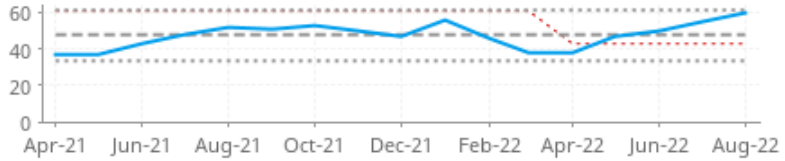
Electronic Discharge Summaries

Month	Performance	Standard
Aug-22	88.91%	95.00%



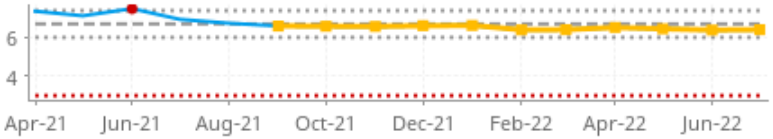
Super Stranded

Month	Performance	Standard
Aug-22	60	43



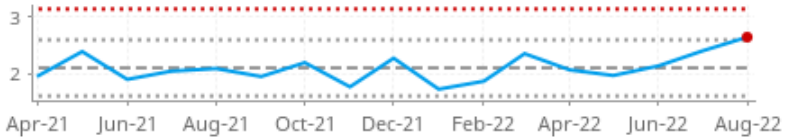
Average Depth of Coding

Month	Performance	Standard
Jul-22	6.39	3.01



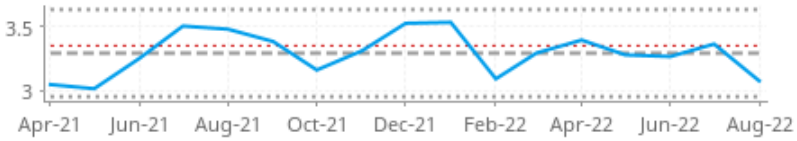
Length of Stay - Elective

Month	Performance	Standard
Aug-22	2.65	3.14



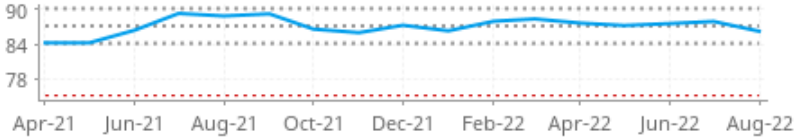
Length of Stay - Emergency

Month	Performance	Standard
Aug-22	3.08	3.35



Day Case Rate

Month	Performance	Standard
Aug-22	86.23%	75.00%



Efficiency & Productivity

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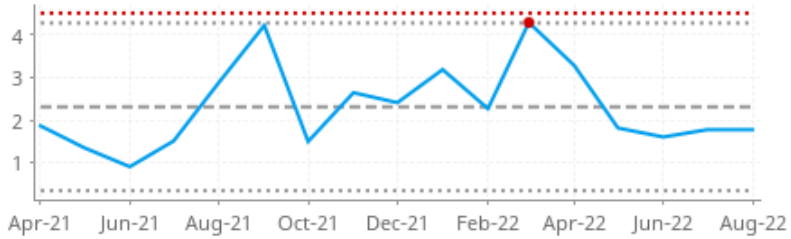
North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

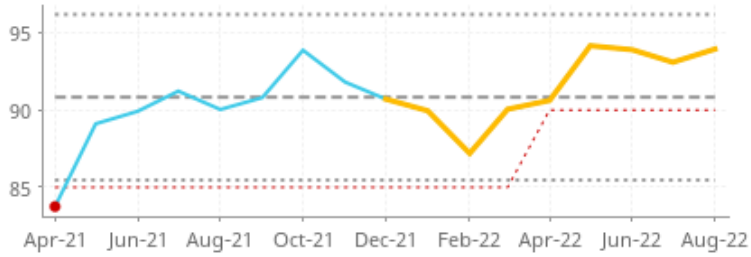
Pre-op Stays

Month	Performance	Standard
Aug-22	1.77%	4.50%



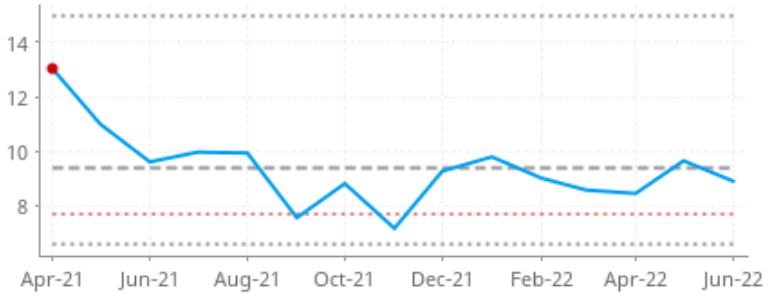
Trust Occupancy

Month	Performance	Standard
Aug-22	93.95%	90.00%



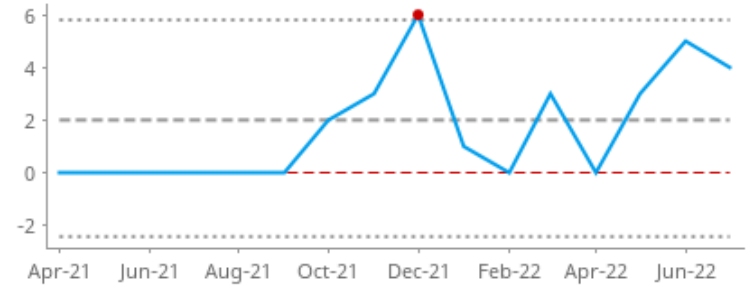
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Jun-22	8.90%	7.70%



Not Reappointed within 28 days

Month	Performance	Standard
Jul-22	4	0



Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Jul 21 - Jun 22	92.45	
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Apr 21 - Mar 22	95.89	

Standard	Standard Achieved	Month	Performance	Standard	Trend
Stage 1 Complaint	✗	Aug-22	120	106	
Stage 2 Complaint	✓	Aug-22	5	6	
Stage 3 Complaint	✗	Aug-22	14	10	
Compliments	✓	Aug-22	394	262	

Narrative

Mortality

The latest HSMR value is currently reporting at 92.45 (July 2021 to June 2022) which has increased from the previous rebased value of 90.61 (June 2021 to May 2022). The latest SHMI value is now 95.89 (April 2021 to March 2022) which has increased from the previous rebased value of 95.64 (March 2021 to February 2022).

Complaints

The number of complaints has decreased by 13 in August, compared with the previous month. The total number of Stage 1 complaints received is 120, which is 7 less than the previous month, with a decrease of 5 Stage 2 complaints (from 10 in July) and a slight decrease of 1 in Stage 3 complaints (15 in July). 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.

During August 2022, communication was the highest theme mentioned in 28 complaints, with a decrease of 4 in relation to treatment and procedure delays, failure to monitor was mentioned in 23 complaints which is an increase of 3 on the previous month.

Increased analysis has been undertaken in relation to communication and this continues to be presented and discussed during the weekly Safety Panel meetings. Trend analysis is also addressed during weekly Senior Clinical Professional Huddles. This robust process continues to support timely identification of the themes.

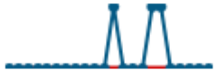
The number of formal complaints received within the Trust is monitored in relation to the Regional position, to provide a comparison of complaint numbers received by local Trusts. This data will be presented to the Patient Safety Panel meeting on a quarterly basis.

Compliments

The Trust records the compliments received onto the Greatix platform. For August 2022 the number of compliments received is 394, which is higher than the mean of 258 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	Month	Performance	Standard	Trend
High Risks	✓	Aug-22	3	4	
Never Events	✓	Aug-22	0	0	
VTE %	✓	Aug-22	96.60%	95.00%	
Fall No Harm	✗	Aug-22	106	85	
Fall Low Harm	✗	Aug-22	29	16	
Fall Moderate Harm	✓	Aug-22	1	2	
Fall Severe Harm	✓	Aug-22	0	0	

Narrative

Falls

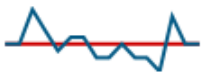
There has been a total of 136 falls reported in August and 6 near misses. 106 falls were reported as no harm. Low harm falls have increased to 29 from 14 when compared to the previous month and falls reported as moderate harm reduced in August by 1 to 2 falls.

The two falls reported as moderate harm are currently under investigation. The Trust Falls lead has identified some earlier learning and is working with the Senior Clinical Matrons to implement training alongside appropriate support to staff in the identified ward areas.

The Falls Assurance Framework continues to capture learning from incidents and any on-going service improvement projects. This is discussed in the falls group which has good representation from care groups and community services ensuring falls prevention is a priority from admission through to discharge and beyond.

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Pressure Category 1 (inpatient)	✓	Jul-22	4	4	
Pressure Category 2 (inpatient)	✓	Jul-22	19	20	
Pressure Category 3 (inpatient)	✓	Jul-22	1	1	
Pressure Category 4 (inpatient)	✓	Jul-22	0	0	

Narrative

Pressure Ulcers

In the July 2022 reporting period, there were four Category one pressure ulcers validated, which is in line with our expected standard. A increase in Category two pressure ulcers is noted to 19, which is slightly below the accepted standard of 21 cases. There has been one Category three pressure ulcers identified in July 2022 and zero Category four pressure ulcers reported, both of which are in line with or below our expected standard.

Ongoing work continues with the validation of pressure ulcers, due to the difference between validated and un-validated data positions.

Safety & Quality

NHS
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Standard	Month	Performance	Standard	Trend	Standard Achieved
Hand Hygiene	Aug-22	96%	95%		✓
Clostridioides difficile (cdiff)	Aug-22	8	4		✗
MRSA	Aug-22	0	0		✓
MSSA	Aug-22	3	2		✗
Ecoli	Aug-22	5	6		✓
Klebsiella	Aug-22	0	2		✓
Pseudomonas	Aug-22	4	1		✗
CAUTI	Aug-22	21	19		✗

Narrative

Infections

In August 2022, the Trust reported eight cases of Clostridioides difficile infection across six different clinical areas, which is twice as many as our projected trajectory of four. A Period of Increased Incidence (PII) has been initiated on ward areas where there have been two positive results within 28 days. This includes close auditing and monitoring of the infection prevention and control measures in these areas with education for staff to ensure that all measures are adhered to. RCAs are underway for all cases, although early reviews have shown no linked cases. Our yearly objective for 2022-23 is 54 cases of Clostridioides Difficile, with our current case figure of 24.

The Trust has reported 5 E-coli bacteraemia in August 2022, which is the same as the previous month and under our projected case rate of six. Our yearly objective for E-coli bacteraemia for 2022-23 is 73 cases, which is a significant reduction on the previous year and we currently have had 38 cases since the start of the financial year.

There have been four trust attributable cases reported for Pseudomonas infections, which are above our projected case rate of one for August. All four cases are in differing clinical areas and have different sources identified. Our 2022-23 objective is 12 cases, and we currently report six to date. The trust reported zero cases of Klebsiella in August 2022, after a steep start earlier in the year. This remains below our projected trajectory of two cases for the month of August. Our yearly objective for Klebsiella species for 2022-23 is 21 cases, currently the trust stand at 11 cases.

There have been three healthcare-associated cases of MSSA in the month of August, which is above our monthly projected trajectory of two 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. The trust have had 14 cases in total for this financial year. For the month of August, 21 CAUTI cases were reported for the trust, compared to 25 cases in August 2022. Quality Improvement work is underway to ascertain and identify CAUTI correctly, with education and review of assessment tools planned.

The trust continues to report 0 MRSA bacteraemia, with a zero tolerance target for 2022-23.

Hand Hygiene compliance throughout the trust stands at 96%, against a target of 95%.

Safety & Quality

22

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	Aug-22	84.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	Aug-22	97.00%	75.00%	
Friends and Family Test (FFT) - Maternity	Aug-22	100.00%	75.00%	
UNIFY - RN Day	Aug-22	74.94%	>=80% and <=109.99%	
UNIFY - RN Night	Aug-22	88.96%	>=80% and <=109.99%	
UNIFY - HCA Day	Aug-22	78.58%	>=80% and <=109.99%	
UNIFY - HCA Night	Aug-22	128.31%	>=110% and <=125.99%	

Narrative

Friends and Family

For August 2022 the Trust received 1,349 FFT returns, this is a decrease on the previous months return of 1,502. The Very Good or Good responses returned for August 2022 is 91.03%.

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 continue to be safely managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse. The nursing fill rates presented in August 2022 show that these pressures are still evident but continue with a positive forecast emerging from October/November 2022 following further recruitment plans and the deployment of planned international nurses.

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

Monthly recruitment processes are on-going for both Registered Nurses and Unregistered Nurses and cohort 3 of Team Support Workers (24wte) were recruited in June 2022. The next cohort is to be recruited in November 2022. Approx. 35wte Pre Reg Nurses were also interviewed and offered positions across all clinical areas with an expected start date of September/October 2022.

The international recruitment of registered nurses is currently underway with 43wte recruited to date with further interviews scheduled. This will further support increasing the shift fill rate and reducing the overarching nursing vacancy level.

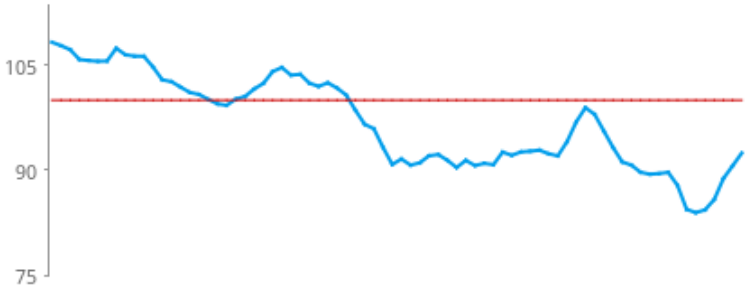
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Additional Detail Charts

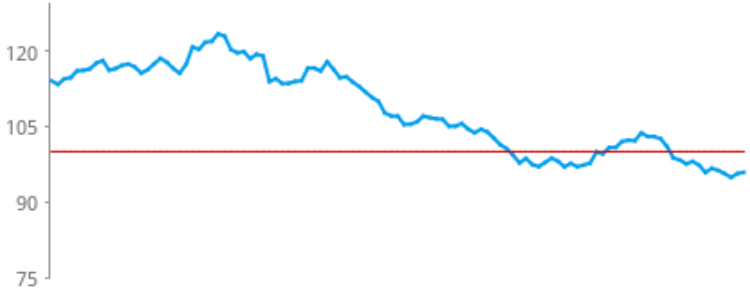
Hospital Standardised Mortality Ratio

Month	Performance
Jul 21 - Jun 22	92.45



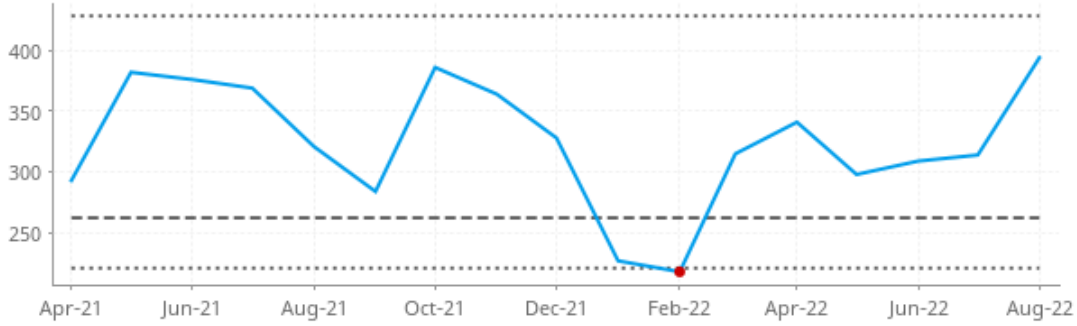
Summary Hospital-Level Mortality Indicator

Month	Performance
Apr 21 - Mar 22	95.89



Compliments

Month	Performance	Standard
Aug-22	394	262



Safety & Quality

NHS
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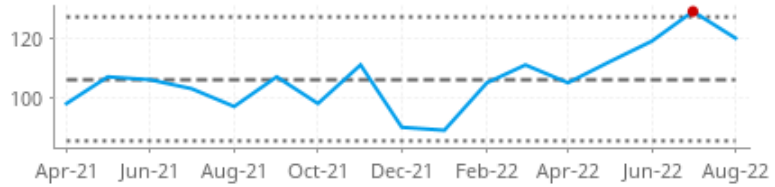
Statistical Process Control (SPC) Charts

Stage 1 - Informal

	Month	Performance	Standard
✗	Aug-22	120	106

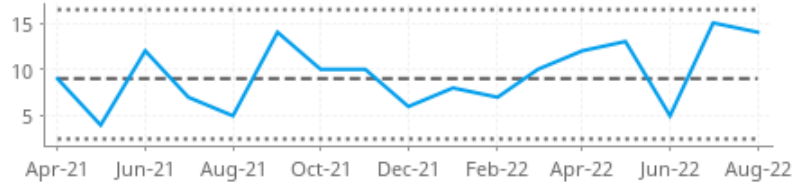


Stage 2 - Meeting

	Month	Performance	Standard
✓	Aug-22	5	6

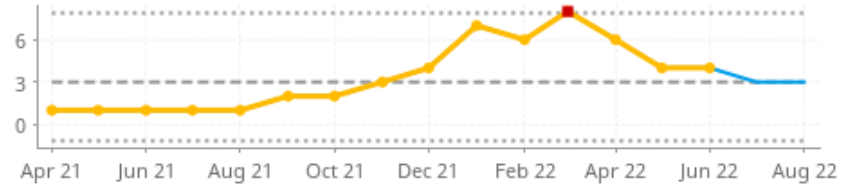
Stage 3 - Formal

	Month	Performance	Standard



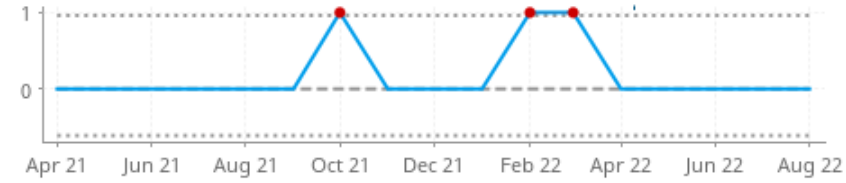
Red Risks

	Month	Performance	Standard
✓	Aug-22	3	4



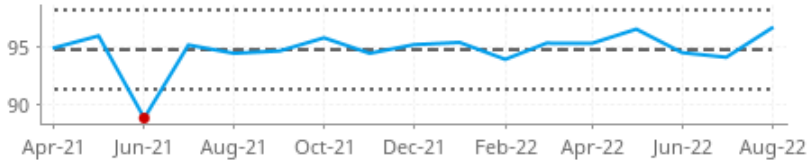
Never Events

	Month	Performance	Standard
✓	Aug-22	0	0



VTE %

	Month	Performance	Standard
✓	Aug-22	96.60%	95.00%



Safety & Quality

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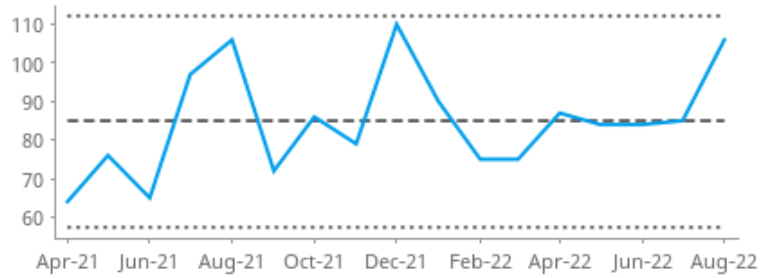
Statistical Process Control (SPC) Charts

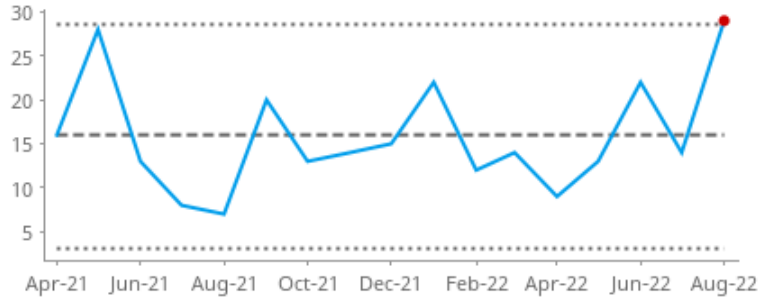
Fall No Harm

Month	Performance	Standard
Aug-22	106	85



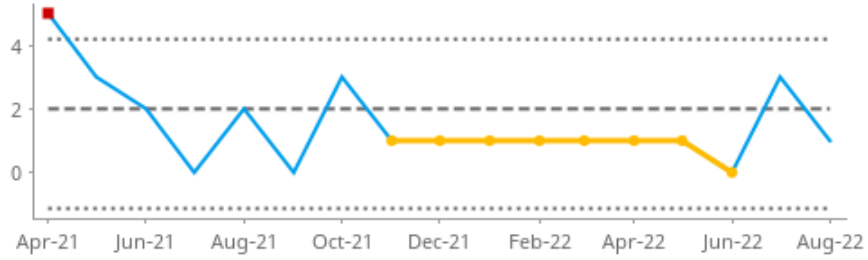
Fall Low Harm

Month	Performance	Standard
Aug-22	29	16



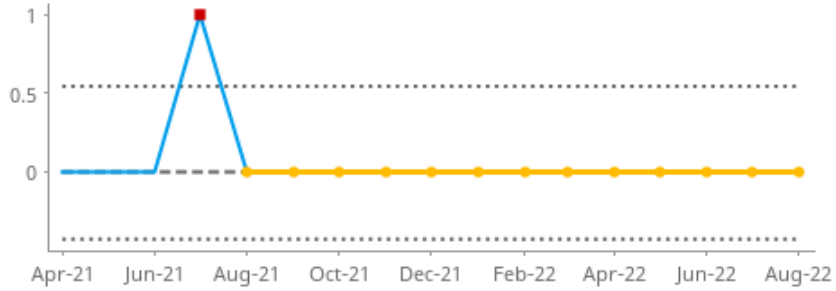
Fall Moderate Harm

Month	Performance	Standard
Aug-22	1	2



Fall Severe Harm

Month	Performance	Standard
Aug-22	0	0



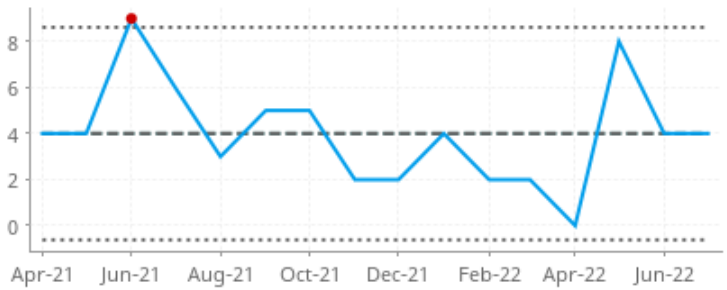
Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

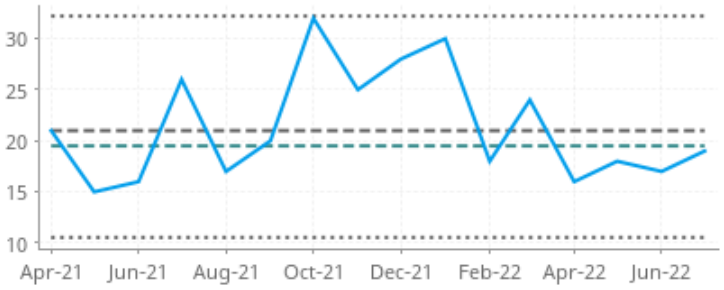
Pressure Ulcer Cat 1

Month	Performance	Standard
Jul-22	4	4



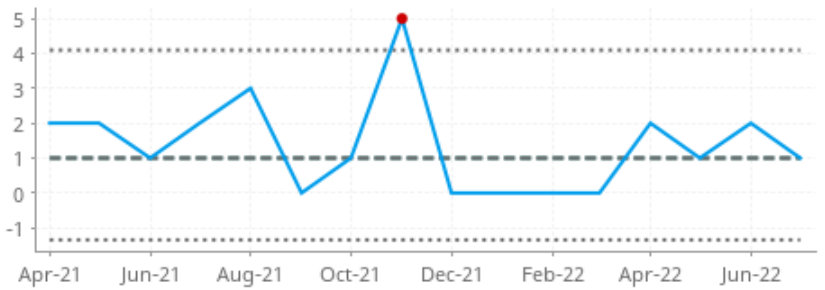
Pressure Ulcer Cat 2

Month	Performance	Standard
Jul-22	19	20



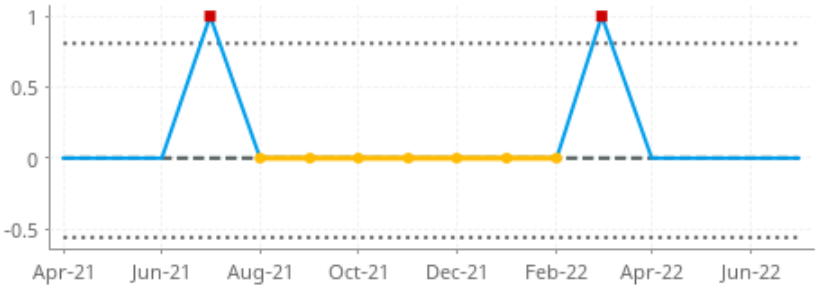
Pressure Ulcer Cat 3

Month	Performance	Standard
Jul-22	1	1



Pressure Ulcer Cat 4

Month	Performance	Standard
Jul-22	0	0



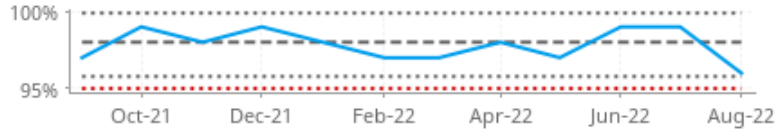
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

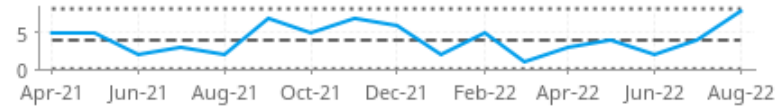
Hand Hygiene

Month	Performance	Standard
Aug-22	96%	95%



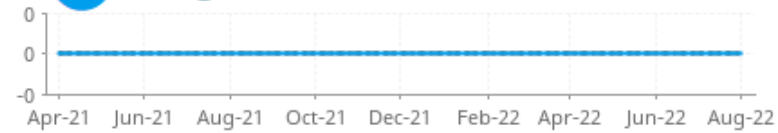
Cdiff

Month	Performance	Standard
Aug-22	8	4



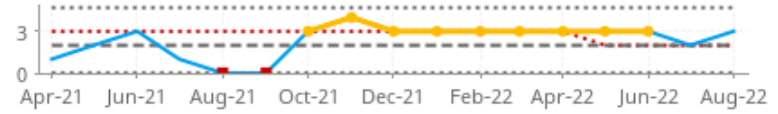
MRSA

Month	Performance	Standard
Aug-22	0	0



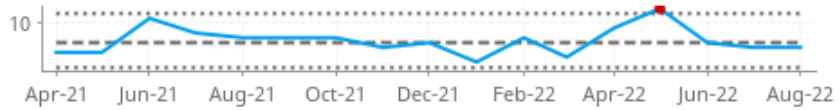
MSSA

Month	Performance	Standard
Aug-22	3	2



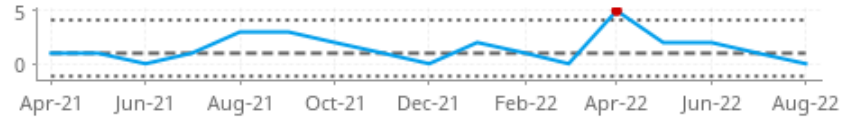
Ecoli

Month	Performance	Standard
Aug-22	5	6



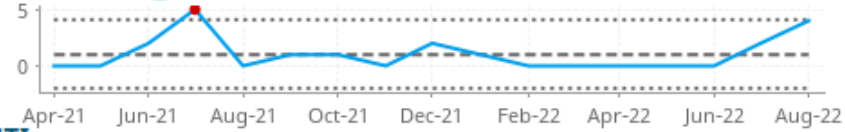
Klebsiella

Month	Performance	Standard
Aug-22	0	2



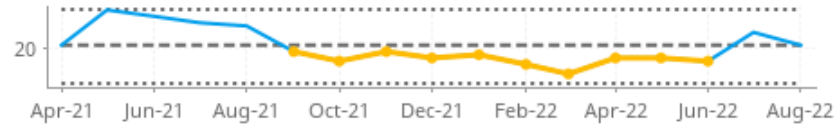
Pseudomonas

Month	Performance	Standard
Aug-22	4	1



CAUTI

Month	Performance	Standard
Aug-22	21	19



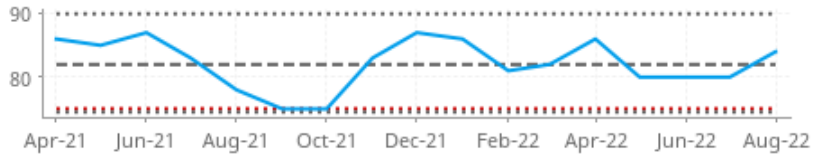
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SCP) Charts

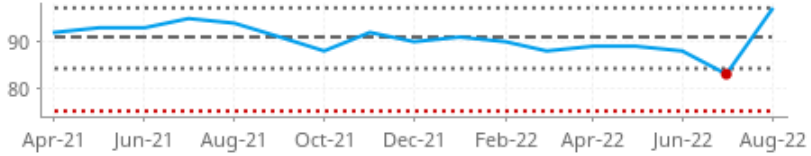
FFT Emergency Care

Month	Performance	Standard
Aug-22	84.00%	75.00%



FFT Inpatient

Month	Performance	Standard
Aug-22	97.00%	75.00%



FFT Maternity

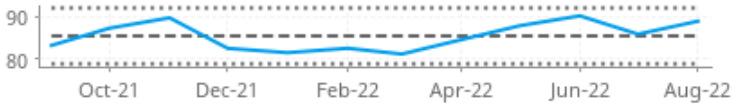
Month	Performance	Standard
Aug-22	100.00%	75.00%

UNIFY RN Day

Month	Performance	Standard
Aug-22	74.94%	>=80% and <=109.99%

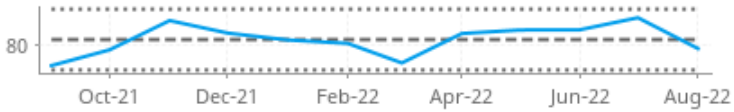
UNIFY RN Night

Month	Performance	Standard
Aug-22	88.96%	>=80% and <=109.99%



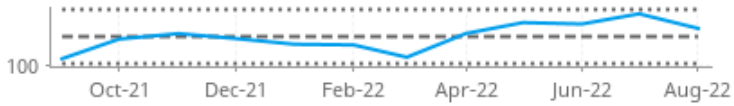
UNIFY HCA Day

Month	Performance	Standard
Aug-22	78.58%	>=80% and <=109.99%



UNIFY HCA Night

Month	Performance	Standard
Aug-22	128.31%	>=110% and <=125.99%



Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved				Narrative
	Month	*Performance*	*Standard*	*Trend*	
Sickness - Overall					
	Jul-22	6.80%	4.00%		
Sickness Breakdown					
Short Term	Jul-22	3.49%			
Long Term	Jul-22	3.31%			

Sickness absence rate for July reported an increase of 0.83% (from 5.97% in June to 6.8%). Whilst there was a slight increase in non-Covid absence (+0.3%), there was a greater increase in Covid related absences (+0.53%) in July from June.

Almost 32% of absences in July were linked to chest and respiratory conditions (including Covid), followed by stress, anxiety and depression which accounted for 22% of absences. This is a change from the June 2022 data where 22.5% of absences were due to chest and respiratory conditions.

An action plan has been developed and to be discussed at People Committee in September 2022. The plan was developed through a MDT approach with input from key stakeholders across the Trust; this will be implemented via the time limited task and finish group currently in place.

Activity on ensuring the support offer to our people from a health and wellbeing perspective continues to be developed, considering mental, physical and financial welling.

Workforce

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Appraisals				
✖	Aug-22	85.29%	95.00%	
Turnover				
✖	Aug-22	11.19%	10.00%	
Mandatory Training				
✔	Aug-22	90.31%	90.00%	

Narrative

Appraisals – Compliance from August's overall Trust RAG has increased by 0.42% compared to July's figure. Scheduled appraisal training sessions are delivered monthly and are advertised through the monthly Trust Education Bulletin. Work continues to support Care Groups and Corporate areas to complete appraisals, with many additional training sessions provided to staff and managers with regards to utilising the Performance and Behaviour Framework. Using Microsoft Teams for training has allowed increased attendances where staff are unable to leave their immediate work area. A reminder system is in place via ESR which sends managers a notification at 3 months and 1 month for staff within their hierarchy to conduct appraisals which are imminently due.

Staff Turnover - A further decrease of 0.25% is noted from the previous month (11.19% from 11.44%). The current trend we continue to see is a positive one, with movement towards the target. It is envisaged that this will be positively influenced with the development of such projects as Scope for Growth, the embedding of our leadership and development strategy, ongoing health and wellbeing support and continued roll out of the EDI activity.

Mandatory Training – Compliance from August's overall Trust RAG is 90.31% (green) which is a slight decrease on July's figure. Whilst this figure remains above the 90% standard, it is acknowledged there is still work to be done on raising the compliance on topics which are lower than required. Examples include a number of resuscitation courses with plans in place to increase the number of courses available to increase compliance. Support continues to be offered in a variety of ways to these areas including educators attending team day sessions, individualised reminders, flagging of DNA's to senior managers and offers of support in accessing ESR e-learning modules.

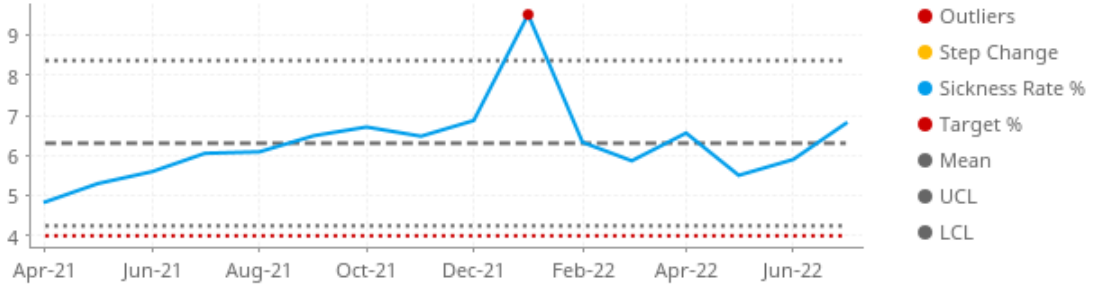
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

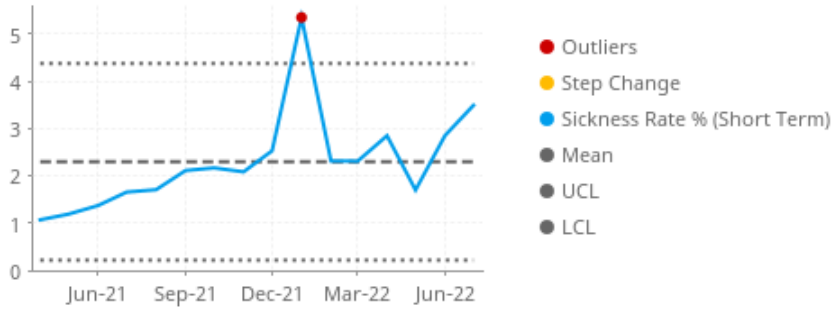
Sickness - Overall

Month	Performance	Standard
Jul-22	6.80%	4.00%



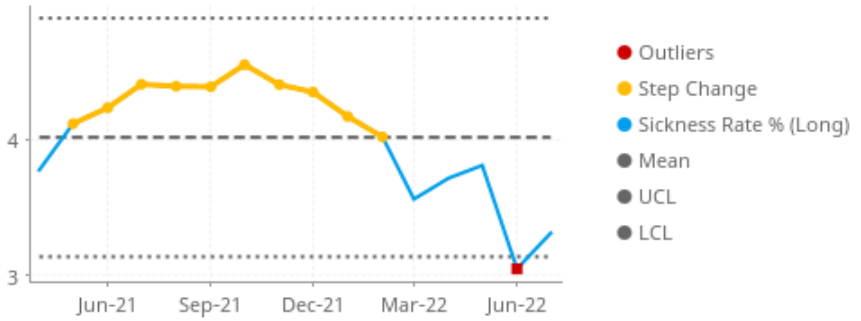
Short Term

Month	Performance
Jul-22	3.49%



Long Term

Month	Performance
Jul-22	3.31%



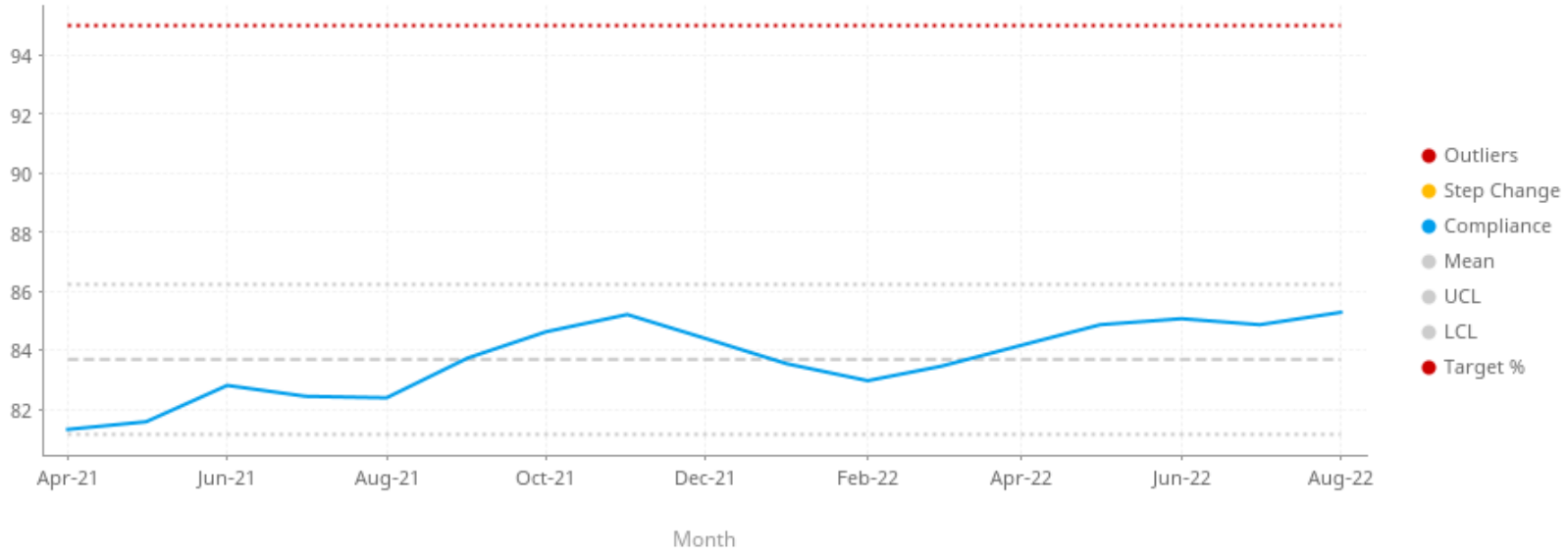
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Appraisal

Month	Performance	Standard
Aug-22	85.29%	95.00%



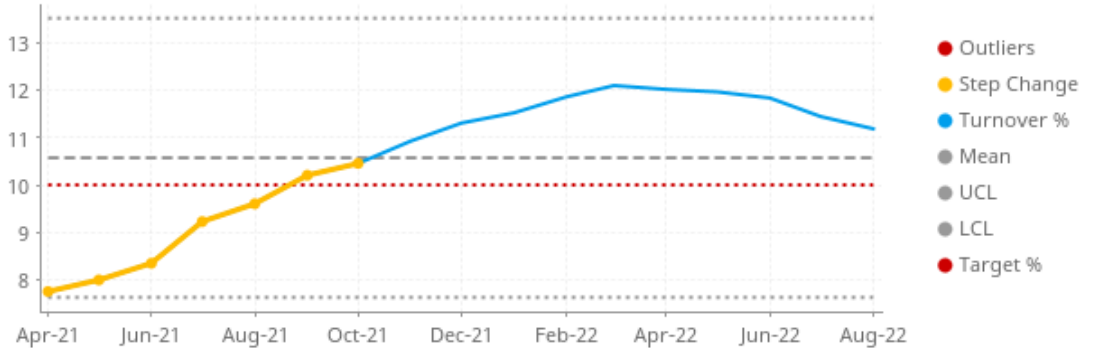
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

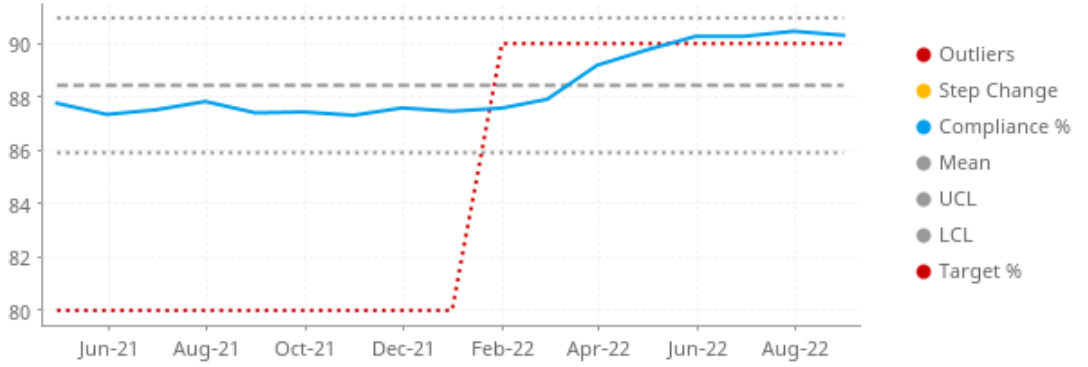
Turnover

Month	Performance	Standard
Aug-22	11.19%	10.00%



Mandatory Training

Month	Performance	Standard
Aug-22	90.31%	90.00%



Finance

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North Tees and Hartlepool NHS Foundation Trust

Finance Overview - Month 5

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	4	37	☺
Year to Date	3,268	4,199	☺

Balance Sheet

£m

Cash Actual	79.9
Cash Plan*	69.4

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

Capital (*)

	Plan (£m)	Actual (£m)	
In Month	1,032	642	😐
Year to Date	2,151	2,435	☺

* Capital plan rephased to commence from 01 July 2022

NHS Oversight Framework (Issued 27 June 2022)

Segment Position 2

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

North Tees and Hartlepool NHS Foundation Trust

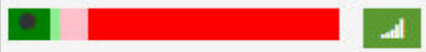
Appendix 1

RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - July 22										
Incomplete Pathways waiting <18 weeks	61.0%		80.0%	79.7%	62.1%	75.7%	70.0%	83.7%	65.5%	70.6%
Half of incomplete patients wait less than	13		8	9	13	10	11	10	12	10
Half of admitted patients wait less than	12		8	16	26	15	11	12	8	9
19 out of 20 admitted patients wait less than	65		38	41	64	48	63	44	55	57
Half of Non admitted Pathways waited less than	8		5	7	9	5	6	7	6	7
19 out of 20 non admitted patients wait less than	49		28	27	49	31	38	35	33	27
Incomplete Pathways waiting >52 weeks	377689		73	107	779	77	4437	7	1407	1302

Cancer Waiting times Summary		S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals		92.23 (1258/1364)	82.7 (1123/1358)	89.13 (910/1021)	79.03 (1809/2289)	94.15 (1643/1745)	53.08 (1070/2016)	85.77 (1019/1188)	77.47 (1661/2144)	79.95 (10493/13125)
Breast Symptomatic Referrals		0 (0/0)	78.18 (43/55)	94.55 (52/55)	66.91 (93/139)	89.62 (95/106)	78.57 (11/14)	95.53 (171/179)	72.81 (158/217)	81.44 (623/765)
31 Day First Treatments		99.07 (214/216)	97.8 (89/91)	98.65 (146/148)	81.85 (415/507)	96.84 (153/158)	92.42 (195/211)	92.74 (115/124)	94.84 (147/155)	91.55 (1474/1610)
31 Day Subsequent Treatments - Drugs		100 (108/108)	100 (7/7)	100 (58/58)	95.57 (194/203)	93.75 (15/16)	96.3 (78/81)	100 (69/69)	100 (10/10)	97.64 (539/552)
31 Day Subsequent Treatments - Radiotherapy		0 (0/0)	0 (0/0)	100 (1/1)	97.51 (353/362)	0 (0/0)	92.96 (198/213)	0 (0/0)	0 (0/0)	95.83 (552/576)
31 Day Subsequent Treatments - Surgery		92.86 (13/14)	83.33 (5/6)	100 (14/14)	60.19 (62/103)	88.89 (8/9)	22.22 (2/9)	91.67 (11/12)	80 (32/40)	71.01 (147/207)
62 Day Target - 2WW		67.76 (83/122.5)	41.13 (29/70.5)	67.59 (49/72.5)	49.63 (101.5/204.5)	70.85 (70.5/99.5)	62.9 (97.5/155)	63.77 (44/69)	80.8 (90.5/112)	62.4 (565/905.5)
62 Day Target - Screening		100 (1/1)	22.22 (1/4.5)	88.89 (28/31.5)	34.62 (13.5/39)	87.5 (3.5/4)	77.78 (3.5/4.5)	85.51 (29.5/34.5)	84.62 (5.5/6.5)	68.13 (85.5/125.5)
62 Day Target - Upgrade		81.43 (28.5/35)	61.11 (5.5/9)	66.67 (1/1.5)	69.57 (24/34.5)	78.57 (5.5/7)	77.78 (17.5/22.5)	72.22 (6.5/9)	73.91 (8.5/11.5)	74.62 (97/130)
28 Day Target - 2WW		72.29 (866/1198)	69.87 (858/1228)	76.31 (744/975)	67.39 (1405/2085)	67.84 (1040/1533)	64.44 (984/1527)	77.88 (778/999)	92.67 (1733/1870)	73.66 (8408/11415)
28 Day Target - Breast Symptomatic		0 (0/0)	89.36 (42/47)	100 (55/55)	84.09 (111/132)	61.86 (60/97)	87.5 (14/16)	99.43 (174/175)	91.9 (193/210)	88.66 (649/732)
28 Day Target - Screening		58.33 (7/12)		65.77 (73/111)	80.65 (125/155)	74.14 (43/58)	90 (9/10)	85.47 (147/172)	76.47 (39/51)	77.86 (443/569)
28 Day Target - Overall		72.15 (873/1210)	70.59 (900/1275)	76.42 (872/1141)	69.18 (1641/2372)	67.71 (1143/1688)	64.84 (1007/1553)	81.65 (1099/1346)	92.21 (1965/2131)	74.71 (9500/12716)

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 (Aug 2022)	8.67% (Jun 2021 - May 2022)	8.88% (May 2021 - Apr 2022)	-0.21 ↓	7.54%	7.31%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Aug 2022)	1.96% (Jun 2021 - May 2022)	2.03% (May 2021 - Apr 2022)	-0.07 ↓	2.31%	1.95%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Aug 2022)	4.56% (Jun 2021 - May 2022)	4.65% (May 2021 - Apr 2022)	-0.09 ↓	4.95%	4.18%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Aug 2022)	6.99% (Jun 2021 - May 2022)	7.09% (May 2021 - Apr 2022)	-0.10 ↓	7.08%	5.95%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Aug 2022)	9.91% (Jun 2021 - May 2022)	10.06% (May 2021 - Apr 2022)	-0.15 ↓	9.66%	8.11%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Aug 2022)	8.20% (Jul 2021 - Jun 2022)	8.03% (Jun 2021 - May 2022)	0.17 ↑	8.40%	7.81%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Aug 2022)	2.54 (Jul 2021 - Jun 2022)	2.54 (Jun 2021 - May 2022)	No Change	2.33	2.16	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Aug 2022)	0.00% (Jul 2021 - Jun 2022)	0.00% (Jun 2021 - May 2022)	No Change	9.20%	9.65%	
Rate of telephone or Telemedicine consultations (12 mth rolling) HES Outpatients (Aug 2022)	21.36% (Jul 2021 - Jun 2022)	21.33% (Jun 2021 - May 2022)	0.03 ↑	17.74%	21.69%	
Rate of telephone or Telemedicine consultations for followup consultation (12 mth rolling) HES Outpatients (Aug 2022)	22.00% (Jul 2021 - Jun 2022)	22.17% (Jun 2021 - May 2022)	-0.17 ↓	18.84%	24.18%	
Rate of telephone or Telemedicine consultations for first consultation (12 mth rolling) HES Outpatients (Aug 2022)	19.75% (Jul 2021 - Jun 2022)	19.19% (Jun 2021 - May 2022)	0.56 ↑	15.17%	16.35%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Aug 2022)	88.63% (Jul 2021 - Jun 2022)	89.56% (Jun 2021 - May 2022)	-0.93 ↓	79.89%	79.87%	
Cancer waiting times - 28-day Faster Diagnosis Standard (12 mth rolling) Cancer Waiting Times (Aug 2022)	80.09% (Jul 2021 - Jun 2022)	80.44% (Jun 2021 - May 2022)	-0.35 ↓	77.18%	71.40%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Aug 2022)	96.86% (Jul 2021 - Jun 2022)	96.95% (Jun 2021 - May 2022)	-0.09 ↓	91.79%	92.85%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Aug 2022)	65.87% (Jul 2021 - Jun 2022)	67.08% (Jun 2021 - May 2022)	-1.21 ↓	66.49%	65.93%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Aug 2022)	77.28% (Jul 2021 - Jun 2022)	77.07% (Jun 2021 - May 2022)	0.21 ↑	67.71%	62.31%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Aug 2022)	87.32% (Jul 2021 - Jun 2022)	87.60% (Jun 2021 - May 2022)	-0.28 ↓	84.60%	75.75%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Aug 2022)	84.03% (Jul 2021 - Jun 2022)	84.67% (Jun 2021 - May 2022)	-0.64 ↓	72.88%	58.86%	
Day case realisation rate (12 mth rolling) HES Inpatients (Aug 2022)	96.91% (Jul 2021 - Jun 2022)	96.91% (Jun 2021 - May 2022)	No Change	96.71%	96.65%	
Day case rate (12 mth rolling) HES Inpatients (Aug 2022)	86.32% (Jul 2021 - Jun 2022)	86.82% (Jun 2021 - May 2022)	-0.50 ↓	85.03%	72.79%	

Average excess length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.12 (Jul 2021 - Jun 2022)	0.09 (Jun 2021 - May 2022)	0.03 ↑	0.40	0.51	
Average length of stay (12 mth rolling) HES Inpatients (Aug 2022)	3.23 (Jul 2021 - Jun 2022)	3.23 (Jun 2021 - May 2022)	No Change	3.89	4.70	
Average elective length of stay (12 mth rolling) HES Inpatients (Aug 2022)	1.80 (Jul 2021 - Jun 2022)	1.87 (Jun 2021 - May 2022)	-0.07 ↓	3.21	4.50	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Aug 2022)	3.38 (Jul 2021 - Jun 2022)	3.36 (Jun 2021 - May 2022)	0.02 ↑	3.99	4.71	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.21 (Jul 2021 - Jun 2022)	0.21 (Jun 2021 - May 2022)	No Change	0.22	0.23	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.01 (Jul 2021 - Jun 2022)	0.01 (Jun 2021 - May 2022)	No Change	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.36 (Jul 2021 - Jun 2022)	0.37 (Jun 2021 - May 2022)	-0.01 ↓	0.41	0.47	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.81 (Jul 2021 - Jun 2022)	0.82 (Jun 2021 - May 2022)	-0.01 ↓	1.00	0.96	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	0.19 (Jul 2021 - Jun 2022)	0.19 (Jun 2021 - May 2022)	No Change	0.30	0.26	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Aug 2022)	1.27 (Jul 2021 - Jun 2022)	1.28 (Jun 2021 - May 2022)	-0.01 ↓	1.68	1.78	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Aug 2022)	35.97% (Jul 2021 - Jun 2022)	36.18% (Jun 2021 - May 2022)	-0.21 ↓	40.25%	34.44%	
Elective stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Aug 2022)	4.75% (Jul 2021 - Jun 2022)	4.87% (Jun 2021 - May 2022)	-0.12 ↓	11.05%	12.35%	
Emergency stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Aug 2022)	16.78% (Jul 2021 - Jun 2022)	16.74% (Jun 2021 - May 2022)	0.04 ↑	17.97%	21.42%	
Elective super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Aug 2022)	0.48% (Jul 2021 - Jun 2022)	0.58% (Jun 2021 - May 2022)	-0.10 ↓	2.05%	3.16%	
Emergency super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Aug 2022)	3.04% (Jul 2021 - Jun 2022)	3.00% (Jun 2021 - May 2022)	0.04 ↑	4.67%	5.77%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Aug 2022)	90.22% (Jul 2021 - Jun 2022)	91.37% (Jun 2021 - May 2022)	-1.15 ↓	72.33%	77.91%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Aug 2022)	0.24% (Jul 2021 - Jun 2022)	0.25% (Jun 2021 - May 2022)	-0.01 ↓	0.82%	0.90%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Aug 2022)	81.10 (Jul 2021 - Jun 2022)	80.71 (Jun 2021 - May 2022)	0.39 ↑	99.56	101.11	

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Maternity Safety Report – Quarter 1, 2022-23								
Date:	22nd September 2022								
Prepared by:	Rachel Scott / Dr Elaine Gouk / Angela Storr								
Executive sponsor:	Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality								
Purpose of the report	This report will provide the Board with an overview of the current progress in relation to quality and safety improvements within the Maternity services. The purpose of the report is to inform the Board of any current or emerging safety concerns across all parts of the multi-disciplinary, multi-professional maternity service.								
Action required:	Approve	X	Assurance	X	Discuss	X	Information	X	
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X	
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

1. This report provides an overview of the safety improvements, achieved and ongoing in quarter 1 in relation to Trusts Maternity services. The report demonstrates the significant amount of work being undertaken by the service to ensure safety is maintained, the highest quality of care continues to be delivered, and that opportunities for learning and improvement are embedded.
2. The report demonstrates clear pathways of communication between the staff in the maternity service, the Senior Management Team within the Care Group and the Board level Executive and Non-Executive Maternity Safety Champions.
3. The report identifies progress against both the MIS and the Ockenden IEAs, with plans in place to work towards compliance with all measures over the coming months. It is important to note that several national enquires are due to be published and are expected to result in further recommendations for implementation. As a result, there is a need to ensure a continued robust project structure is in place to prioritise and complete actions in the required timescales. To comply with the national recommendations, the department of Obstetrics and Gynaecology will require additional investment to enable safety and quality improvements across the service.
4. The report provides assurance that improvement is focused specifically on culture and leadership, workforce review, recruitment and retention, recruitment of the MVP chair and the creation of automated training dashboards.
5. The report also highlights the challenges in the service currently and provides details of the risks identified by the service to ensure management and Executive Team awareness of issues and support needed to overcome the challenges.

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

The Maternity Services has the following risks logged in relation to this report, there has been no requirement to change in the ratings for these risks as a result of the detail in this report:

- 6502 - Professional leadership in the Maternity services – linked on BAF 1A and 1B
- 6517 - Obstetrics and Gynaecology consultant labour ward cover - linked to BAF 1A and 2A
- 6516 - Current workforce structure in O&G may not meet correct skill mix to cover all actions in the Ockenden review – linked to BAF 1A, 1B and 2A

Committees/groups where this item has been discussed	Executive Team Patient Safety and Quality Standards Committee Maternity Improvement Group

Recommendation	1. The Board of Directors are asked to note the significant work being undertaken by the maternity services to deliver on the improvements required to achieve the MIS standards and the actions following publication of the recommendations from the key national enquiries and reports. 2. The Board are asked to note the significant work being undertaken in relation to leadership and culture across all areas of the service and the plans in place to maintain stability ensuring safety and quality are at the centre of care delivery. 3. The Board are asked to be aware of the impact upon the current workforce in relation to the national reports and the requirements for additional resources for further improvement, including additional workforce. 4. The Board are asked to note that the Maternity services are continuing to monitor for any emerging risk and manage the risks identified in this report, the service are providing updates in relation to progress against these to the Executive team, and also Patient Safety and Quality Standards committee each month.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

22nd September 2022

Maternity Safety Report – Quarter 1, 2022-23

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

1. Introduction

1.1 This report will provide the Board with an overview of the current progress in relation to quality and safety improvements within the Maternity services. The report outlines locally and nationally agreed measures that have been implemented to support monitoring of maternity and neonatal safety, as outlined in the NHS England / Improvement document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Board of any current or emerging safety concerns across all parts of the multi-disciplinary, multi-professional maternity service.

1.2 The Trusts maternity services provide midwifery and obstetric care for women across Hartlepool and Stockton geographical areas, with women from other areas also booking to have their babies in the Trust. Community midwifery services provide antenatal and postnatal care at a range of venues in the community, with a range of scanning, antenatal assessment and obstetric clinic services being available at both hospitals. The Maternity Unit at North Tees provides low risk midwifery and high-risk obstetric care for women who are assessed as needing additional obstetric management for a variety of complex problems. In Quarter one, there were 600 births in the Trust and of these, nine were born in the Midwifery Led Rowan Suite in Hartlepool.

1.3 The report will provide local progress in quarter one of the Maternity Safety Actions outlined in the NHS Resolution Maternity Incentive Scheme and an update on actions recommended in the Ockenden Reports of 2020 and 2022.

1.4 The Maternity and Neonatal Services work collaboratively with other units in the North East and North Cumbria (NENC) Local Maternity and Neonatal System (LMNS). The Trust is represented at the NENC LMNS Board, other LMNS committees and clinical networks.

1.5 In May 2022, the Maternity Improvement Group (MIG) was established and is chaired by the Healthy Lives Care Group Director and reports to the Trust's Quality Assurance and Safety Council. The multi-professional MIG meets bi-monthly and enables senior leadership, oversight and support to enable continued progress with the national and local maternity improvement plans.

2. Maternity Incentive Scheme (MIS)

2.1 NHS Resolution manages the Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme. The MIS requires trusts to fulfil specific requirements with an aim to incentivise improvements in maternity patient safety and quality across England. This scheme had been in

place for three years prior to the Covid-19 pandemic. NHS Resolution made the decision to suspend year 4 of the scheme during 2021. It remained suspended until May 2022 when a revised MIS Year 4 plan was published. The submission is due by 5th January 2023.

2.2 During each year of the scheme, ten maternity safety actions are incentivised. Trusts that demonstrate they have achieved all of the ten safety actions will recover their contribution relating to the CNST maternity incentive fund and potentially, receive a share of any unallocated funds. Any trusts that do not meet the ten-out-of-ten threshold do not recover their contribution, but may be eligible for a small discretionary payment to help them to make progress against actions they have not achieved. These discretionary payments will be at a much lower level than the 10% contribution to the incentive fund.

2.3 There are ten themes to the Maternity Safety Actions (MSA) and the theme for each is summarised below along with the progress made locally with achieving the standard.

2.4 MSA1: Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

2.4.1 There is a national surveillance programme for recording and monitoring of perinatal deaths. This is coordinated through the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) programme. Submission of information is via completion of the Perinatal Mortality Review Tool (PMRT). The PMRT facilitates a comprehensive, robust and standardised review of all perinatal deaths, including stillbirths, but excluding terminations, from 22 weeks of pregnancy to 28 days after birth; as well as babies who die after 28 days following receipt of neonatal care.

2.4.2 The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. Factual information about a case is entered in advance of a review by a multidisciplinary panel of internal and external peers; having external reviewers supports the independent 'Fresh eyes' perspective when examining cases. The tool is used to identify learning and improvement opportunities leading to the development of actions to be implemented, monitored and then evaluated, to assess the impact of changes in practice.

2.4.3 The initial notification of cases to MBRRACE-UK should be completed within seven days of death. During quarter one; there were seven cases and all details were submitted within time scales, this confirms that the Trust is complaint with this standard.

2.4.4 One key area of focus for the Trust has been to promote awareness around what pregnant women should do if they are concerned about their baby's movements. The maternity team have initiated a quality improvement project to examine all aspects of this common area of concern for parents to be; also during quarter one reduced fetal movements was one of the commonest reasons for women accessing the maternity day unit.

2.4.5 Another area of learning has been in relation to the use of alternative cardiotocograph (CTG) paper when recording a baby's heartbeat. There is a need to utilise specific paper for the recording equipment being used and using alternatives can affect the readability of the recording. The Maternity and Procurement teams have reviewed the provision of the paper provided to ensure in future that the correct paper is available for the recording equipment being used.

2.4.6 There is an established process, coordinated through the LMNS, for inviting external professionals to be part of the PMRT case review for learning process and the Trust fully engages in this process. The key learning from the PMRT case reviews is shared with teams at the safety meeting, safety circulars and incorporated into the mandatory training programme. The maternity risk assessment processes are assessed each year as part of the multidisciplinary mandatory training.

2.5 MSA2: Are you submitting data to the Maternity Services Data Set to the required standard?

2.5.1 During quarter one, the maternity service has worked on revising the digital maternity strategy and secured partial support to progress with the deployment of Badgernet electronic patient record in line with regional strategy. The revised digital maternity strategy was shared with the LMNS. A specific time limited project team to implement the Badgernet System will be developed in quarter two. The maternity specific system should enable more accurate data submission to meet the requirements of the Maternity Services Data Submission

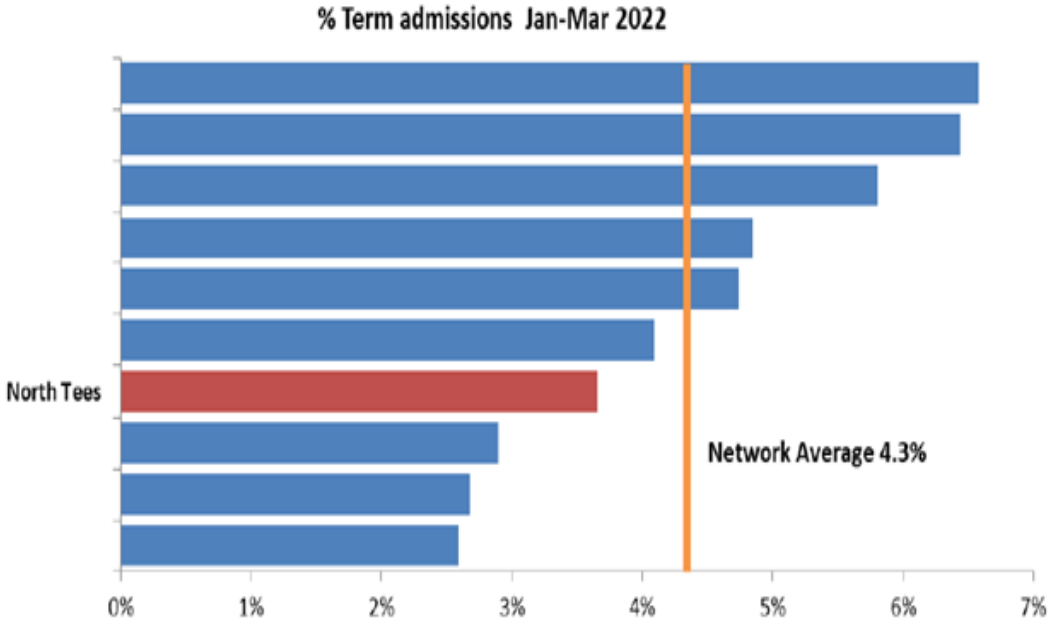
2.5.2 The service continues to submit the Maternity Services Dataset. In quarter one, the data submission was not achieving the standard set for CNST-MIS Year 4, achieving 4 of the 6 standards. The Head of Information Management has been in discussion with NHS Digital in relation to the smoking data submitted but not recorded as meeting the requirements. The current recording system in TrakCare does not support this data collection effectively, this should improve when the service moves to the Badgernet Maternity System. It is anticipated that Badgernet will be implemented by the end of quarter four, 2022-23. There was also an issue with the national submission of body mass index (BMI) data; this has now been addressed and should be reflected in the next monthly report received from NHS Digital. The Trust is on track to achieve the new standards set in the CNST-MIS Year 4.

2.6 MSA3: Can you demonstrate that you have transitional care services to support the "Avoiding Term Admissions into Neonatal" units Programme?

2.6.1 The Trusts maternity service is compliant with this requirement as it has a Transitional Care bay in the antenatal / postnatal ward; this area is staffed to enable enhanced care for babies and reduces the separation of parent and baby, which occurs if babies are admitted to the Special Care Baby Unit (SCBU). The Trust has ongoing improvement work in place to further develop the Transitional Care provision in line with the national programme of work to reduce avoidable term admissions to the neonatal unit (ATAIN).

2.6.2 In quarter 1, there were 19 admissions to SCBU of babies born at term. All of these admissions are reviewed; a monthly report is shared at the joint Maternity and Neonatal Departmental meeting to ensure that the admission was appropriate and managed as per guidance. It has been identified from the reviews, that some babies could be transferred and cared for in the Transitional Care bay due to the admission to SCBU being short term. The team are also looking at how short term attendances in SCBU are recorded; some of the babies are not admitted to the unit and should be recorded as ward attenders and not as admission. There were some babies admitted to SCBU during quarter one for social reasons, which may not be avoidable.

2.6.3 Monitoring of babies born at term and admitted to SCBU is undertaken using staff reporting on the Trusts incident reporting system. There is also external monitoring via the Northern Neonatal Network, during this quarter, the quarter 4 report was received from the Network. The aim for the Trust is to have a term admission rate to SCBU of less than 5%, the chart below shows that the Trust rate during quarter 4 is shown to have been just under 4%, having achieved the target. The service are continuing to work towards reducing this even further and updated results will be provided in future reports.



2.7 MSA4: Can you demonstrate an effective system of clinical workforce planning?

2.7.1 The service is on track with to meet this action, with work ongoing in regards to Obstetric Medical and Neonatal nursing workforce.

2.7.2 A departmental guideline was produced in 2021 based on the Royal College of Obstetricians and Gynaecologists (RCOG) publication on Roles and Responsibilities of the Consultant Providing Acute Care in Obstetrics and Gynaecology to guide on consultant attendance for emergency work. There is currently an emergency workforce model in place that has a minimum of 98 hours consultant presence 0800-2200 hrs, 7 days a week. There is also a separate consultant for gynaecology 0800-1200 hrs, supported by a separate middle grade doctor and junior doctor in the medical workforce for gynaecology, 0800-1600 hrs Monday to Friday. There is a consultant on call between 2200 hrs and 0800 hrs, 7 days a week. The guideline and the RCOG publication were discussed and supported at the MIG in June 2022. Any incidents relating to medical out of hours supervision will require a departmental discussion and an improvement plan; this will be implemented in quarter 2 and detailed in the monthly maternity report to the Trusts Patient Safety & Quality Standards Committee.

2.7.3 During quarter 1, the Obstetric Consultant workforce reduced by 0.23 whole time equivalent (WTE) from 14.71 to 14.48. Currently the Trust is recruiting to resolve this, it is anticipated that there will be a locum consultant obstetrician in post during quarter 2.

2.7.4 Work commenced during quarter 1 to produce a detailed Obstetrics and Gynaecology Workforce Strategy document. This document will detail skills and roles needed to ensure there is a consistent and sustainable workforce model to meet future service needs, supporting further recruitment.

2.7.5 The SCBU has a lead consultant in post, who works alongside the Trusts acute Paediatric consultants. During quarter 1, in order to evidence compliance with national standards, the team have reviewed how their training requirements are recorded, to ensure all have a minimum of eight hours dedicated neonatal training recorded each year.

2.8 MSA5: Can you demonstrate an effective system of midwifery workforce planning?

2.8.1 The service continues to experience workforce pressures within the maternity service; the department has a clear escalation plan to mitigate risks. To support this further, a workforce review and forward plan has been undertaken during quarter 1. There is a plan during quarter 2 to undertake an updated midwifery establishment review using the BirthRate+ tool; this is a nationally approved tool based around midwifery requirements for safety.

2.8.2 Staffing levels are assessed and monitored daily through the Maternity huddle, and also through the Trust wide twice daily staffing meetings where escalation plans are used when required. Safe staffing is also monitored daily, across the region, using a daily Sitrep to identify any Trust which maybe having staffing difficulties. There is the regional Maternity escalation policy and pathway to follow in the event of any maternity units requiring to close and divert patients. Within the trust when safe staffing has the potential to be compromised there is process to initiate an assessment of the wider teams current work, caseloads, both clinical and non-clinical to support safe and efficient redeployment of staff.

2.8.3 Midwifery staffing has been identified as a concern through the incident reporting system on 13 occasions in quarter 1. These incidents are reported when staff identify and escalate that there is a potential for safe staffing to be compromised, either due to a lack of available staff or an increase in patient activity and acuity levels. In order to enhance the understanding around the reasons for this, in July 2022, safe staffing red flags that are raised within the BirthRate+ system have been reported and are presented to the Trusts Executive Team on a monthly basis. This data provides further assurance of the reporting of safe staffing concerns from quarter 2 onwards.

2.8.4 There are ongoing challenges with both recruitment and retention of the midwifery workforce, with a regional comparison of NHS Digital data showing no improvement in the position for the Trusts locally since the last quarterly report. The service have a rolling midwife advert to enable ongoing recruitment. During quarter 1 there has been an overall reduction in substantive WTE midwives by 2.32 WTE (from 116.2 WTE at the end of quarter 4 to 113.88 WTE at end of quarter 1), this has been driven mainly by Band 6 staff leaving. This reduction has been offset by an increase in the use of bank shifts within the service, which has grown by 3.39 WTE (from 3.08 WTE at end of quarter 4 to 6.47 WTE at end of quarter 1).

2.8.5 As mentioned above recruitment into the current registered midwifery vacancies is on-going using a rolling monthly bespoke advert to attract external registered midwives to the Trust. There has been a recent appointment of 7 WTE midwives who will take up their positions across the service throughout October 2022.

2.8.6 A review of the current core midwifery posts within the Trusts Maternity Unit has been undertaken; relevant staff have now been interviewed and recruited in all clinical areas. The development of the job description for a Retention, Recruitment and Pastoral Midwife has been completed and the role it to be advertised during quarter 2, this role will provide support to staff in new roles and liaise with the university to develop and support newly qualified midwifery staff. Additional roles, including a Digital Midwife and Infant Feeding Lead Midwife have been approved for advertisement and recruitment.

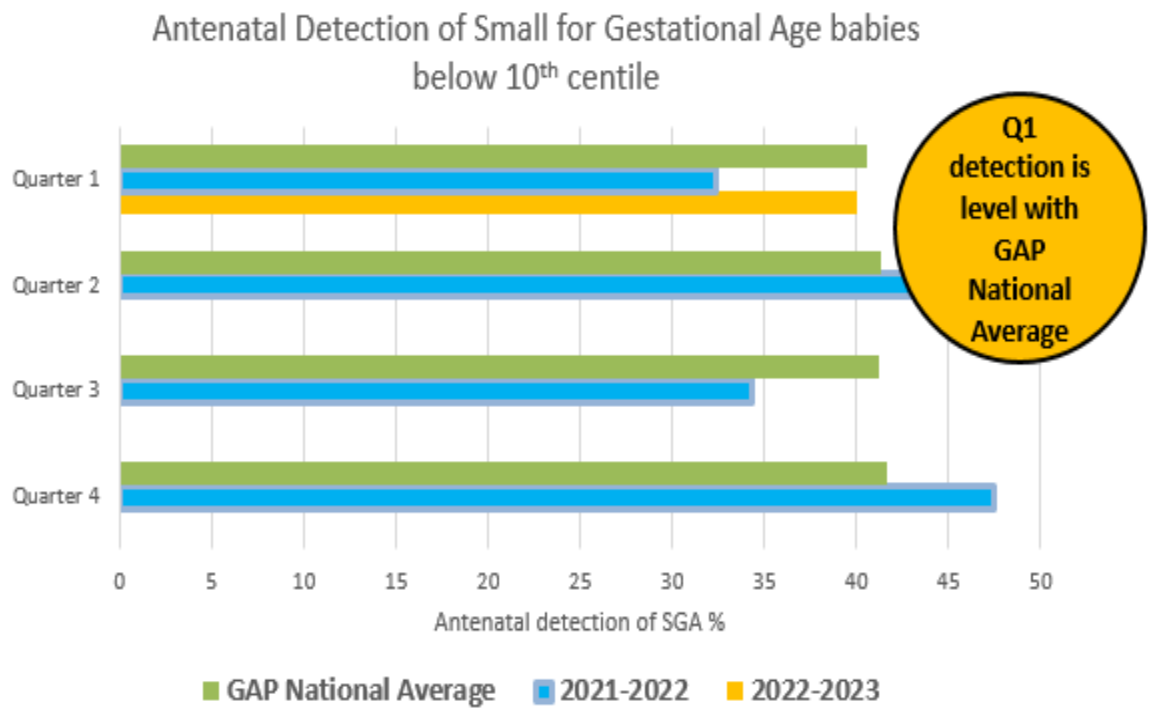
2.9 MSA6: Can you demonstrate compliance with all elements of the Saving Babies' Lives V2?

2.9.1 There are five elements in the Saving Babies Lives care bundle. These are smoking cessation, risk assessment and surveillance for babies at risk of growth restriction, raising awareness of reduced fetal movements, effective monitoring of fetal wellbeing in labour and reducing preterm births. The Trust has ongoing projects to establish and monitor all five elements; details of these are provided below. There are several aspects to all five elements and currently the Trust is fully compliant with four of these. The Trust at this time cannot provide one aspect of the surveillance for babies at risk of growth restriction, details of the actions in place are summarised below.

2.9.2 There is a high background rate of smoking in the population served by the Trusts maternity services. There is a well established smoking cessation programme with the maternity services which starts at the first contact, promoted and supported following the dating scan, any admissions and every contact. Carbon Monoxide monitoring is in place for antenatal visits. As mentioned in point 2.5.2 above, there had been issues identified with the data submission relating to smoking in pregnancy, this has now been addressed. During quarter 1, the department registered as part of a national trial on Smoking, Nicotine and Pregnancy (SNAP3) looking at how to reduce smoking in pregnancy and have already been successful in recruiting patients into the trial.

2.9.3 At the first contact at the start of pregnancy, a booking form is completed; this includes a risk assessment tool to aid in the detection of pregnancies at risk of fetal growth restriction. If this assessment identifies a mother as being at increased risk, then additional growth surveillance scans are planned. The department for some time has used personalised growth charts and this support quarterly monitoring of the detection of small babies. Detection of severe growth restriction offers the opportunity to discuss and offer early delivery to reduce the risk of intrauterine fetal death.

The chart below shows the overall detection rates of small babies within the Trust by quarter since April 2021. In quarter 1, 4% of babies born in the Trust were below the 3rd centile for their birthweight; and 1.84% of babies born after 38 weeks of pregnancy were less than the 3rd centile for weight. This means their birthweight was in the lowest 3% of all babies born after 38 weeks.



2.9.4 To support overall assessments of fetal growth all women with a BMI that is greater than 35 are offered serial growth scans to assess growth from 32 weeks of gestation in line with national recommendations. The department has been working with the Trusts Ultrasonography team to further enhance the detection of babies at risk of growth restriction. During quarter 1, the service has continued to focus on the recommendation to undertake Uterine Doppler studies by 24 weeks of pregnancy for women with high-risk pregnancies. To support compliance with this recommendation the service has established a quality improvement project to increase the provision of this service; additional training opportunities are being offered to support this and the impact will be assessed over coming months. It is anticipated that training will be completed by the end of quarter 2 and the Uterine Doppler studies in place during quarter 3.

2.9.5 As mentioned earlier in the report, the Trust has undertaken some focused work to ensure women are provided with information about when, how and who to contact if they are concerned about their baby's movements. Following this quality improvement project to raise awareness and standardise assessment, there is on-going monitoring to ensure high compliance is sustained. There will be a further audit, to assess the impact of the project, undertaken in quarter 2 and the results of the evaluation will be outlined in future reports.

2.9.6 The Maternity Department has a Lead Fetal Wellbeing Midwife, Obstetrician and a Clinical Educator, who work collaboratively to support education and assessments of fetal monitoring with all of the maternity staff. The team support weekly CTG case review sessions to support learning and offer 1:1 training opportunities. The Maternity services also have a well-established multidisciplinary mandatory training programme, which includes practical and theoretical training on assessment of fetal wellbeing, escalation and situational awareness; this is also supported by the use if simulation training.

2.9.7 The Maternity Service have a specialist preterm birth prevention clinics at both sites, lead obstetricians and a specialist midwife run these jointly. The team are also working collaboratively with other maternity units to develop regional guidelines and pathways of care. There are risk

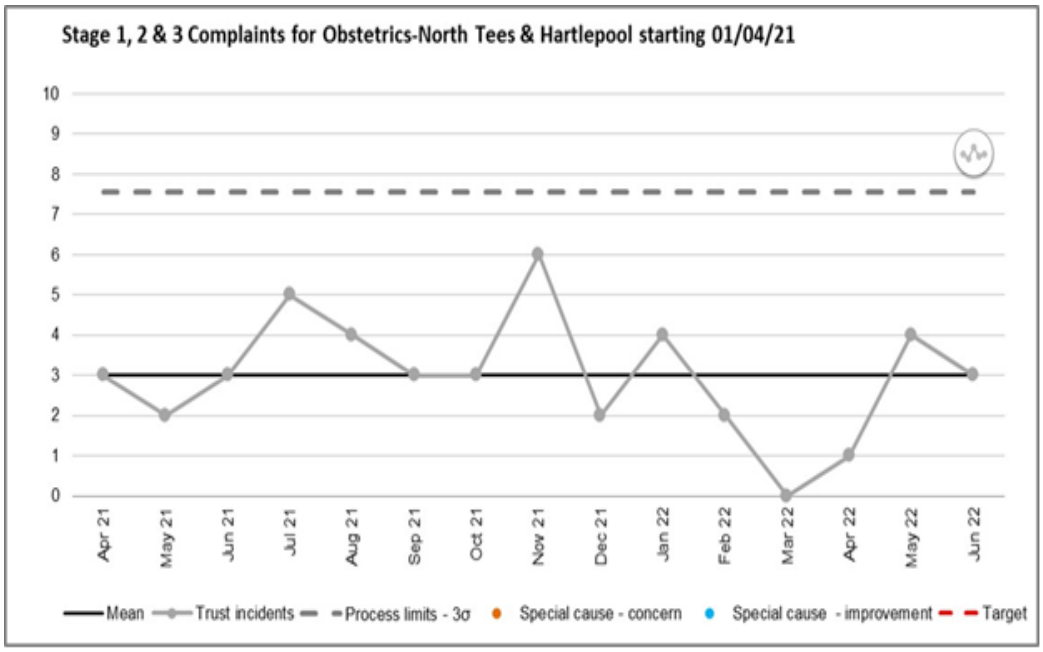
assessment tools that are used to assist in identifying pregnancies at risk of a preterm birth; this helps patients understand the need to access early interventions to reduce the risk. There is a regional quality improvement programme to support monitoring of the preterm optimisation indicators and to aid planning.

2.10 MSA7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

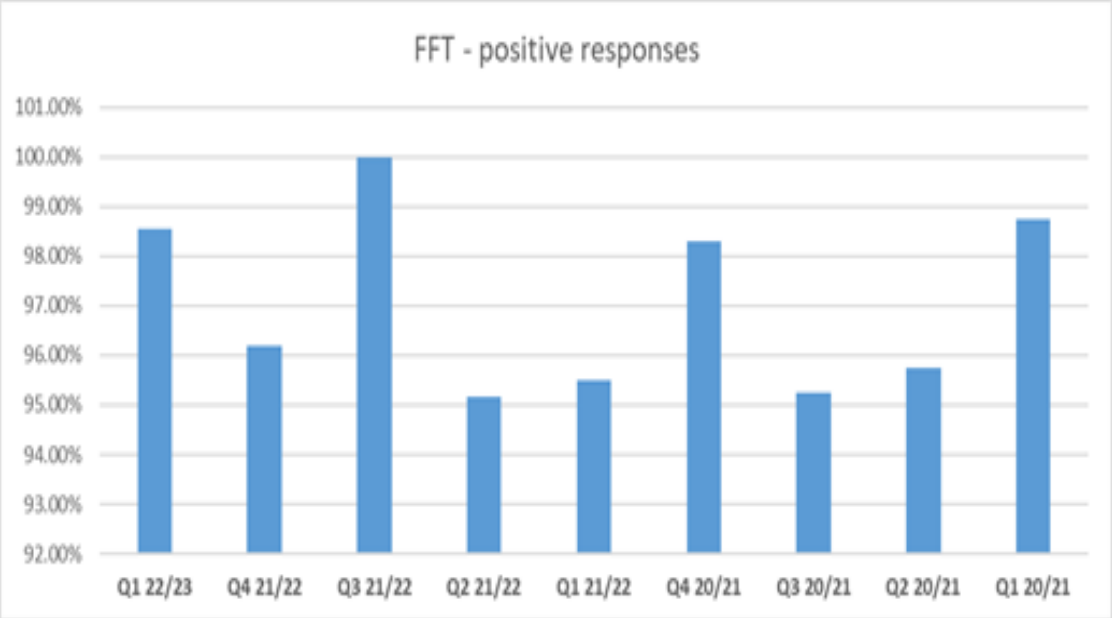
2.10.1 The Maternity services are compliant with this requirement and have a variety of methods by which patients can provide feedback about their care, there are established Trust processes for monitoring compliments and complaints; there is also the Maternity Inpatient Survey. The information obtained from the Maternity Survey has been reviewed and the details have been used to develop an improvement plan. The chair and vice chairs of the Trusts Maternity Voices Partnership were appointed during quarter 1 and have been assisting the service in progressing with the coproduction of information and also service development. In quarter 1, the Maternity Voices Partnership members have attended the Maternity Improvement Group to identify how they can support the service to improve patient care. They have also given invaluable advice around the development and review of patient information leaflets, in particular a leaflet to improve understanding of what happens when a baby is identified as having an anomaly during an ultrasound scan.

2.10.2 The Maternity service has received 74 compliments during quarter 1; 68 of these were related to the care provided. The staff are encouraged to record any compliments and complete a “Greatix” using the Trusts reporting system. Overall feedback is provided to staff individually as needed, through patient safety meetings and other departmental meetings.

2.10.3 The Maternity service has received 8 complaints during quarter 1. The majority of these were related to communication and documentation issues, and most were managed through local resolution directly with the patient or family involved. The SPC chart below shows the number of complaints received by the services each month since April 2021.



2.10.4 The Maternity services also receive feedback through the Friends and Family Test (FFT). The current response rate is low, with 138 returns in quarter 1, despite relaunching this feedback route following Covid, the number of returns remains relatively stable. The chart below shows the rates of positive responses since April 2020, during quarter 1 98% of those who responded gave positive feedback in care.



2.11 MSA8: Can you evidence that the local training plan is in place to ensure all six core modules of the Core Competency Framework will be included over the next 3 years?

2.11.1 The Maternity services have a well-established multidisciplinary (MDT) mandatory training programme covering training in the management of obstetric emergency skills. The training programme is regularly reviewed and updated to reflect changes in national requirements, learning from incidents and to align with the Core Competency Framework.

2.11.2 Multiprofessional simulation training for managing obstetric emergencies are run across a range of locations in the Trust, and additional simulation-training sessions on Labour Ward and in the Obstetric theatre have been scheduled to improve training opportunities for not only maternity staff but also other professionals who support the provision of care to women. The training utilises feedback from incidents to ensure learning is shared widely across the multiprofessional team. The clinical educators from maternity, paediatrics and theatres have developed a joint improvement plan to ensure ease of access to theatre and neonatal staff in the MDT emergency obstetrics skills drills.

2.11.3 The service has established a process to support improved monitoring of training compliance; this helps support early escalation to the services Senior Management Team if there is any identification of a potential delay in meeting required training targets.

2.11.4 Work is ongoing to review our training programme against the Core Competency Framework to identify any gaps and produce an action plan to address if needed. There are no current or emerging issues that would prevent the service from achieving overall compliance in the next 3 years.

2.12 MSA9: *Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?*

2.12.1 The Maternity and Neonatal Safety Champions Group is well established. It meets bi-monthly and enables a clear communication pathway from ward to Board and escalation opportunities, in relation the safety and quality improvement. The Chief Nurse is the Board level Maternity Safety Champion and there is a named Non-Executive Director as the Maternity Board Champion. The Trust is compliant with the requirement.

2.12.2 The Board Champions undertake monthly walk abouts in the clinical areas to gain direct feedback from patients and staff; there is direct feedback to the relevant team in relation to any learning obtained from the walkabout. Currently, because of discussion on a Maternity Board champion's walk about, the service are reviewing how mothers can be supported when their baby requires transfer to another trust for on-going care. The Trusts neonatal charity "Leo's" is looking into how they may support this.

2.12.3 During quarter 1, the Trusts revised Continuity of Carer plans were shared with the Board Champions and presented at the Patient Safety and Quality Standards Committee. The Rowan Team facilitates the current Continuity of Carer pathway and were recently announced regional winners in the Nursing and Midwifery category and shortlisted for the National Parliamentary Award.

2.12.4 A midwife has been appointed to the role of Quality Improvement Lead during quarter 1, this role will help the coordination of the quality improvement work as part of the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). The role will also link with the regional activity and reflects the whole teams' engagement with regional MatNeoSIP events.

2.13 MSA10: Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

- **Reporting of all outstanding qualifying cases to NHS Resolution EN scheme**
- **Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB*)***

2.13.1 During quarter 1, two cases met the criteria for Serious Incident investigation and both have been notified to the HSIB maternity review process and NHS Resolution, as a result the Trust is compliant with this requirement. The families have been informed and involved in the HSIB investigation process as well as the Trusts internal investigation processes.

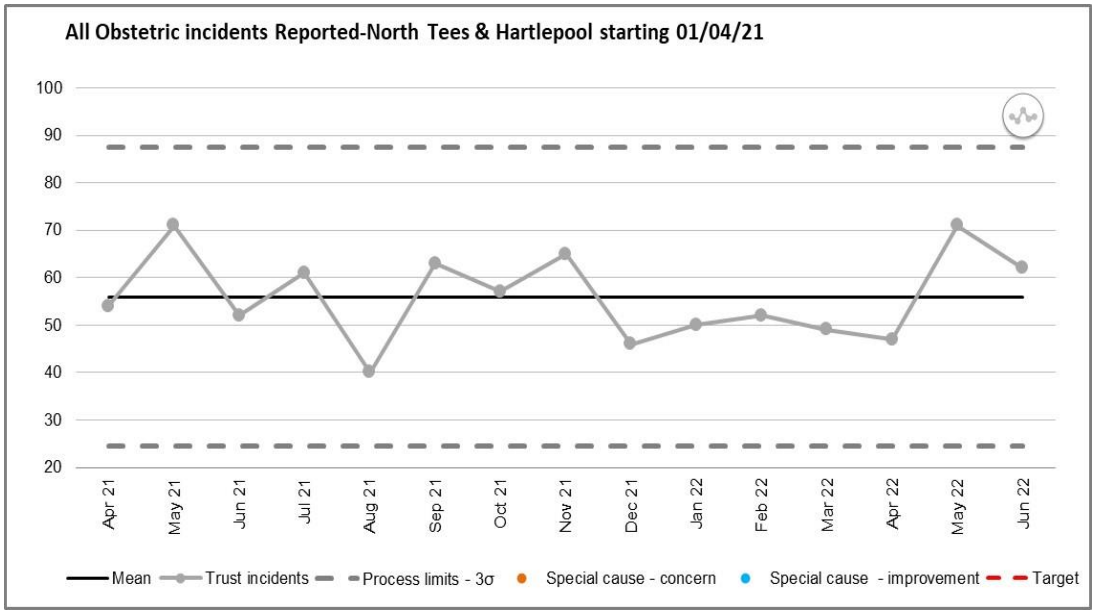
2.13.2 HSIB conducts independent investigations of patient safety concerns in NHS-funded care across England. From 1 April 2018, HSIB have been responsible for all NHS patient safety investigations of maternity incidents, which meet criteria for the Each Baby Counts programme (Royal College of Obstetricians and Gynaecologists, 2015), and maternal deaths (excluding suicide). The purpose of this programme is to achieve learning and improvement in maternity services, and to identify common themes that offer opportunity for local or national system-wide change.

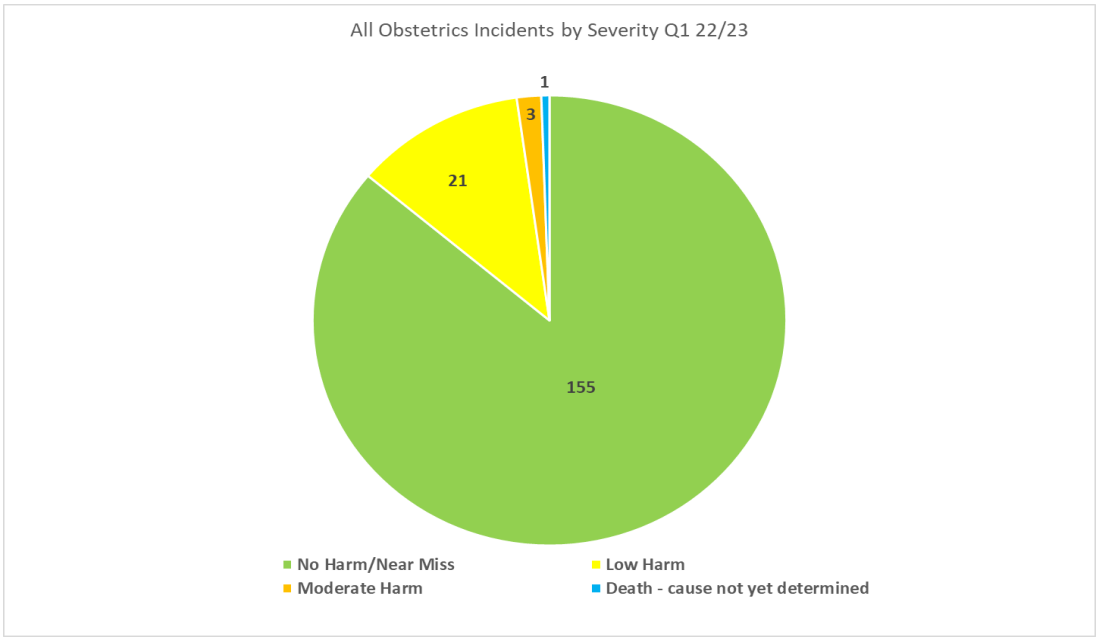
2.13.3 A HSIB report on learning may take around 6 months to be shared with the Trust. A local case review is undertaken to identify any areas for immediate action and learning. As a result of the local learning, the procurement process has been reviewed as described in the PMRT section 2.4.6 earlier in the report. The learning in the second case relates to interpretation of fetal

wellbeing. The immediate lessons learnt have been shared with staff. A full case review for further learning will be undertaken and an improvement plan developed when both the local and HSIB reports have been completed.

2.13.4 The Trust Maternity service and Board Safety Champions meet with the regional HSIB team on a quarterly basis. The purpose of these meetings is to review cases, provide an opportunity for additional support and to share feedback in relation to active cases and national themes.

2.13.5 There were 180 incidents reported by staff in the maternity service during quarter 1; the SPC chart below shows the overall incident reporting, in the Maternity services, by month since April 2021.





2.13.6 There were 19 incidents reported relating to term admissions to the SCBU; all cases are reviewed by a joint maternity and neonatal team as described in the MSA3 above.

2.13.7 There were thirteen post-partum haemorrhages (PPH) of over 1.5 litres reported in quarter 1, this is a reduction compared to the previous quarter. The 13 cases represent 2.17% of all births this quarter, which is in line with the national rate (2-3%). A PPH is a blood loss following delivery and can occur after any birth. The occurrence of PPH is an emergency and prompt management is required. All cases are reported and reviewed through the weekly multidisciplinary Patient Safety meetings to ensure the PPH protocol was followed and to identify any learning for sharing more widely in the department. All staff participate in both planned and ad hoc simulation training to ensure they have the skills to recognise and manage such an emergency. An audit has been commenced monthly to examine the management of post-partum haemorrhage and compliance with management guidelines, the learning from this audit helps the service modify the MDT PPH simulation training.

2.13.8 Thirteen incidents were reported relating to third and fourth degree perineal tears; this is a slight increase from the previous quarter. These are complex tears associated with childbirth, overall, the incidence in the UK, is 2.9%. An increase in the number of incidents occurring does not necessarily indicate a reduction in the quality of care as in part, this may reflect an improvement in the early detection and reporting of complex tears. There is an active quality improvement project (Obstetric Anal Sphincter Injury, OASI2) in place to embed an OASI Care Bundle to reduce the occurrence; this also supports early detection and appropriate management when they do occur.

2.13.9 As mentioned earlier in the report there were thirteen incidents related to staffing and when the staffing escalation plan was implemented to ensure safe staffing in high risk clinical areas.

3. Ockenden, Immediate and Essential Actions

3.1 The interim Ockenden report was published in December 2020 and identified seven Immediate and Essential Actions (IEAs) to be implemented nationally. There is some overlap with the maternity safety actions in the MIS.

3.2 In quarter 1, there was a site visit undertaken by the Regional and LMNS teams as part of a national plan to assess and support implementation of the seven IEAs in all Maternity units. The Trusts self-assessment identified full compliance with five and partial compliance with two of the seven IEAs. The Trust submitted data and evidence to the regional team prior to the visit. The visit format was multiple meetings with senior leaders and front line staff. A formal feedback report is anticipated in quarter 2 following completion of all of the site visits in the region.

3.3 IEA1:Enhanced Safety

The maternity team submit and present monthly Maternity Perinatal Quality Surveillance Reports at the Patient Safety and Quality Standards Committee. The serious incidents are also shared at this committee and there is a LMNS process to share serious incident reports within the region. All cases that qualify have been notified to HSIB and the Trust is assessed as being compliant.

3.4 IEA2:Listening to Women and Families

There is an Executive Director with specific maternity service responsibility and there is named Non-Executive Director to support the Board maternity champion. Prior to the site visit the Trust had been assessed as partially compliant due to not having an active Maternity Voices

Partnership (MVP). However, during quarter, there was successful recruitment to the MVP and with this progress was made to achieve full compliance.

3.5 IEA3:Staff Training and Working Together

Consultant led, multidisciplinary maternity ward rounds are undertaken twice daily, seven days a week in line with the required standard. The multidisciplinary, multiprofessional mandatory training programme is well established and there is a planned training schedule. Any finances received for maternity safety improvement is ring fenced to be used for that purpose. The Trust has been assessed as compliant.

3.6 IEA4:Managing Complex Pregnancies

All women with complex pregnancies have a named consultant, there are specialist clinics available to support management of complex pregnancies and there is engagement in the maternal medicine network. The Trust has been assessed as compliant.

3.7 IEA5:Risk Assessment Throughout Pregnancy

There is a detailed risk assessment undertaken for all women at the first contact visit. Following this, at each antenatal contact there is a process in place to prompt the reassessment of risk and discuss if the risk affects discussion on the intended place of birth. Auditing to assess compliance has been undertaken and the Trust has been assessed as compliant.

3.8 IEA6:Monitoring Fetal Wellbeing

There is a Lead Fetal Wellbeing Midwife and lead Obstetrician to oversee the training provision and support for learning around fetal monitoring assessments. There is a combination of multidisciplinary teaching sessions, case reviews for learning and 1:1 training. The Trust has been assessed as compliant.

3.9 IEA7:Informed Consent

The requirement is for pathways of care to be clearly written and posted on the Trust website. There is some maternity service information currently on the Trust website, however not all pathways of care, as a result of this the Trust is assessed as being partially compliant. There is a plan in place to review the Trust maternity website and an aim to coproduce this with the MVP members.

3.10 In addition to the seven IEAs, the visiting team reviewed the Maternity services workforce and guideline processes. A high level initial feedback summary was provided by the visiting team, this included many positives for the service identified such as a positive culture, effective maternity champions and Non-executive Director, good training and information displays, smoking cessation service, preconception service and staff wellbeing support.

3.11 There were also improvement ideas shared by the visiting team, which include investing in the Governance team, increase the number of Specialist Midwives in the service, Co-production work with the MVP and investment in an end-to-end maternity digital system. Several of these initiatives are in progress within the service currently.

3.12 During quarter 1, the Senior Midwifery Advisor, recruited by the Trust, commenced in post on a fixed term basis to give leadership and professional advice, in the absence of the Head of Midwifery and Deputy Head of Midwifery who are both currently away from the service. A risk has

been raised, on the Trust Risk Register, to ensure the necessary management and Executive Team support is in place. The Senior Midwifery Advisor has worked alongside the Service and the Trust Professional leads to develop a midwifery workforce plan, as part of the overall Obstetrics and Gynaecology workforce plan. The plan to have a BirthRate+ midwifery staffing establishment review in quarter 2 will further inform the workforce review plan.

3.13 In quarter 1, an initial self-assessment was undertaken by the department, in relation to the 15 additional IEAs identified in the Ockenden 2022 Report. Many of the recommendations are for LMNS or national level action; however, the Trust has identified partial compliance with all of the 15 actions. The 15 IEAs are summarised below, there are multiple recommendations aligned with each of these.

1. WORKFORCE PLANNING AND SUSTAINABILITY
2. SAFE STAFFING
3. ESCALATION AND ACCOUNTABILITY
4. CLINICAL LEADERSHIP
5. CLINICAL GOVERNANCE INCIDENT INVESTIGATION AND COMPLAINTS
6. LEARNING FROM MATERNAL DEATHS
7. MULTIDISCIPLINARY TRAINING
8. COMPLEX ANTENATAL CARE
9. PRETERM BIRTH
10. LABOUR AND BIRTH
11. OBSTETRIC ANAESTHESIA
12. POSTNATAL CARE
13. BEREAVEMENT CARE
14. NEONATAL CARE
15. SUPPORTING FAMILIES

4. Key areas of improvement during quarter 1

- The development of the Maternity Improvement Group to enable the Care Group Senior Team to have oversight and support quality / safety developments and improvement plans.
- The recruitment to the Maternity Voices Partnership Chair and Vice Chair roles will enable development of coproduction in maternity services.
- There has been additional senior midwifery leadership and professional support provided by the Senior Midwifery Advisor who commenced with the service in quarter 1.
- The positive feedback and support received from the Regional and LMNS team undertaking an assessment of the Trusts progress against the Ockenden 2020 seven IEAs.
- The improved process for monitoring progress with achieving on the actions required for MIS and Ockenden, with project planners supported by the Trust Project Management Information Office and the development of the training database.

5. Conclusion /Summary

5.1 This report provides an overview of the safety improvements, achieved and ongoing in quarter 1 in relation to Trusts Maternity services. The report demonstrates the significant amount of work being undertaken by the service to ensure safety is maintained, the highest quality of care continues to be delivered, and that opportunities for learning and improvement are embedded.

5.2 The report demonstrates clear pathways of communication between the staff in the maternity service, the Senior Management Team within the Care Group and the Board level Executive and Non-Executive Maternity Safety Champions.

5.3 The report identifies progress against both the MIS and the Ockenden IEAs, with plans in place to work towards compliance with all measures over the coming months. It is important to note that several national enquires are due to be published and are expected to result in further recommendations for implementation. As a result, there is a need to ensure a continued robust project structure is in place to prioritise and complete actions in the required timescales. To comply with the national recommendations, the department of Obstetrics and Gynaecology will require additional investment to enable safety and quality improvements across the service.

5.4 The report provides assurance that there is ongoing improvement across areas including culture and leadership, workforce review, recruitment and retention, recruitment of the MVP chair and the creation of automated training dashboards.

5.5 The report also highlights the challenges in the service currently and provides details of the risks identified by the service to ensure management and Executive Team awareness of issues and support needed to overcome the challenges.

6. Recommendations

6.1 The Board of Directors are asked to note the significant work being undertaken by the maternity services to deliver on the improvements required to achieve the MIS standards and the actions following publication of the recommendations from the key national enquiries and reports.

6.2 The Board are asked to note the significant work being undertaken in relation to leadership and culture across all areas of the service and the plans in place to maintain stability ensuring safety and quality are at the centre of care delivery.

6.3 The Board are asked to be aware of the impact upon the current workforce in relation to the national reports and the requirements for additional resources for further improvement, including additional workforce.

6.4 The Board are asked to note that the Maternity services are continuing to monitor for any emerging risk and manage the risks identified in this report, the service are providing updates in relation to progress against these to the Executive team, and also Patient Safety and Quality Standards committee each month

6.5 The Maternity services regularly support Executive and Non-Executive visits to clinical areas, if any Board members wish to visit the areas then this can be arranged.

Lindsey Robertson
Chief Nurse
Director of Patient Safety and Quality

Board of Directors

Title of report:	Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation								
Date:	22 September 2022								
Prepared by:	Emma Roberts, Associate Director of Nursing and Professional Workforce								
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality								
Purpose of the report	This report provides an annual update position on the preparation, support and monitoring compliance for Registered Nurses and Allied Health Professionals (AHP) to revalidate in line with their regulatory body (NMC/HCPC).								
Action required:	Approve		Assurance	x	Discuss		Information	x	
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing our People	x	Transforming our Services	x	Health and Wellbeing		
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x

Executive Summary and the key issues for consideration/ decision:

The NMC and HCPC advise that revalidation is the responsibility of the registrant and that it is the role of employers to provide support for registrants who wish to revalidate. All registrants are required to meet a number of minimum standards during the three years preceding the date of their application for renewal.

Any individuals who fail to meet revalidation standards are not legally able to work in the UK within the profession.

The Head of Nursing Education and Placements and the Heads of Nursing and Midwifery for the Care Groups are identified as the operational leads for Nursing, Maternity and Nursing Associate revalidation. The Heads of Services are identified as the operational leads for Allied Health Professional revalidation. The operational leads for revalidation within the Trust act on behalf of the Chief Nurse/Director of Patient Safety and Quality. The Electronic Staff Record (ESR) process generates emails to all registrants and their managers in advance of revalidation being due.

The Trusts nursing and revalidation policy is in place and the BI team run a monthly report to highlight all staff who are due to revalidate. This report is shared with the Deputy Chief Nurse, Heads of Nursing/Midwifery and workforce business partners. The BI report allows for robust monitoring and oversight of the registered nursing and midwifery staff within each of the care groups in terms of their revalidation status and dates.

Whilst this process is well established for Nursing and Midwifery revalidation and there is assurance of full compliance, the current process for HCPC registrants relies heavily on the registrant and their manager escalating and taking appropriate action to ensure all revalidate as required.

Plans are already in place to expand this monthly report to include all registered AHP staff in addition to the Nursing and Midwifery staff.	
Risk has been placed on the risk register regarding not having robust trust wide system for HCPC revalidation to ensure alignment with Nursing and Midwifery revalidation.	
	The Board of Directors are asked to note the content of the report and the processes in place to ensure a robust system of support for the Nursing, Midwifery, Nursing Associate and Allied Health Professional revalidation process within the Trust.

North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

22 September 2022

Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation

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

1 Introduction

Revalidation is the process by which all registered Nurses, Midwives, Nursing Associates and Allied Health Professions maintain their registration with the Nursing and Midwifery Council (NMC) and the Heath and Care professions council (HCPC) in the UK.

The NMC and HCPC advise that revalidation is the responsibility of the registrant and that it is the role of employers to provide support for registrants who wish to revalidate. All registrants are required to meet a number of minimum standards during the three years preceding the date of their application for renewal.

2 Preparation and support for registrants

In order to revalidate with the NMC all Nurses, Midwives and Nursing Associates must demonstrate that in the preceding three years they have achieved 450 practice hours within the scope of their role, evidence of 35 hours of Continuous Professional Development (CPD), completed five pieces of written reflective accounts and evidence of five records of feedback on their performance. This is supported by a reflective discussion with another registrant and written confirmation of the evidence collected.

For Allied Health Professionals to revalidate with the HCPC the registrant must complete an online declaration confirming the following:

- That they continue to meet the HCPC Standards of proficiency for safe and effective practice
- That they have not had any change relating to their good character, that there has been no health changes that would impact upon safe practice.
- That they continue to meet the HCPC's standards for continuing professional development.

Any individuals who fail to meet revalidation standards are not legally able to work in the United Kingdom within the profession. The Head of Nursing Education and Placements and the Heads of Nursing and Midwifery for Healthy Lives, Responsive Care and Collaborative Care Groups are identified as the operational leads for Nursing, Maternity and Nursing Associate revalidation and the Heads of Services are identified as the operational leads for Allied Health Professional revalidation.

The operational leads for revalidation within the Trust act on behalf of the Chief Nurse/Director of Patient Safety and Quality. Any individual queries from registrants relating to revalidation are supported by the Head of Nursing Education and Placements and by the Care Group Heads of Nursing, Midwifery and Services.

3 Monitoring compliance

Nursing and midwifery registration and revalidation is recorded in the Trust's Electronic Staff Records system (ESR) which automatically notifies line managers when their registrants are due to revalidate at 12, 6 and 4 months prior to revalidation taking place. The NMC and HCPC also reminds staff via their recorded email address when their revalidation is due.

The Trusts nursing and revalidation policy is in place and the BI team now run a monthly report to highlight all staff who are due to revalidate. This report is shared with the Deputy Chief Nurse, Heads of Nursing/Midwifery, workforce business partners, workforce advisor – resourcing & quality and employee relations manager. The BI report allows for robust monitoring and oversight of the registered nursing and midwifery staff within each of the care groups in terms of their revalidation status and dates.

If a registrant fails to renew their registration or to revalidate, an alert is flagged centrally and to the Employee relations manager. This process is well established to provide escalation to the Care Group Head of Nursing/Midwifery and the appropriate Senior Clinical Matron/Professional. Professional registration issues are then escalated to the Deputy Chief Nurse / Chief Nurse by the Care Group Head of Nursing. There are plans to expand this report to include all registered AHP staff.

4 Recommendation

The Board are asked to note the content of the report and the processes in place to ensure a robust system of support for the Nursing, Midwifery, Nursing Associate and Allied Health Professional revalidation process within the Trust.

Lindsey Robertson
Chief Nurse / Director of Patient Safety and Quality

Board of Directors

Title of report:	Appraisal and Revalidation, Report of the Medical Director										
Date:	22 September 2022										
Prepared by:	Dr Basant Chaudhury / Alison Cavanagh										
Executive Sponsor:	Dr Deepak Dwarakanath										
Purpose of the report	Update on doctors appraisals and revalidation										
Action required:	Approve		Assurance		Discuss		Information	X			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People		Transforming our Services	X	Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led		

Executive Summary and the key issues for consideration/ decision:

The report is presented to the Trust Board for assurance that the statutory functions of Appraisal / Revalidation processes are being appropriately discharged.

The report provides a summary of Medical Appraisal and Revalidation activity within the Trust in the period 1st April 2021 to 31st March 2022.

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

The prescribed format of this report has been retained for continuity but it should be noted the information is presented against the backdrop of the Covid – 19 pandemic which marke affected the ability to deliver appraisal and revalidation.

Committees/groups where this item has been discussed	Ps & Qs Medical Directors & Deputy Responsible officers meeting Medical Appraiser Update sessions
Recommendation	The Board of Directors are asked to note the content of the report.

North Tees and Hartlepool NHS Foundation Trust

Revalidation and Appraisal

Report of the Medical Director

1st April 2021 – 31st March 2022

1. Summary

Medical Revalidation was introduced in December 2012 and is now well established within the Trust. The Medical Director (Responsible Officer) has delegated the role to the Deputy Responsible Officer. The RO has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date and that there be no concerns about their conduct and practice.

The report provides a summary of Medical Appraisal and Revalidation activity within the Trust in the period 1st April 2021 to 31st March 2022. It includes information on the number of doctors that the Trust has on its GMC designated body.

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to. Updates on the progress regarding medical appraisal and revalidation development plans will be included in the quarterly, HR and Educational Board Report as well as the Non-Executive Directors report when required

The report seeks to assure the Board that the Trust is compliant with requirements of Medical Revalidation.

2. Background

Designated Bodies have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officers Regulations and it is expected that their Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;

- Checking there are effective systems in place for monitoring the conduct and performance of their doctors;

- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.

The Trust also acts as the Designated Body (DB) for both the Butterwick Hospice Care and Alice House Hospice, Hartlepool the Medical Director.

3. Governance Arrangements

Now that revalidation is well underway for doctors starting their second cycle there is a need for ROs to be able to provide assurance to patients and the public that appropriate systems and processes are in place to ensure that every licences medical practitioner connected to the Trust as their Designated Body (DB) is safe to practice

4. Medical Appraisals Performance Data

As at 31st March 2022 the Trust had a prescribed connection with 295 doctors and the breakdown of appraisals are as table below.

Directorate	Number to be Appraised	Number Appraised for 2021/22	Current number of outstanding appraisals	Reason for outstanding appraisals
A&E	21	15	6	1 sickness, 1 maternity, 4 appraisals outstanding due to work commitments
Anaesthetics	56	56	0	
Palliative Care	5	4	1	1 extension personal circumstances
In Hospital Care	66	56	10	10 appraisals outstanding due to work commitments
Obstetrics & Gynaecology	21	17	4	4 appraisals outstanding due to work commitments
Orthopaedics	35	32	3	3 outstanding appraisals due to work commitments
Paediatrics	25	19	6	1 long term sickness - 1 appraisal extension - 4 outstanding due to work commitments
Pathology	8	7	1	1 sickness
Radiology	20	18	2	2 appraisals outstanding due to work commitments
Surgery	38	31	7	7 appraisals outstanding due to work commitments
Totals	**295**	**255**	**40**	

Appraisal compliance period for 2020 – 2021 was 86.44%. We currently have 5 doctors on long term sick. The 35 doctors who did not complete an appraisal within the appraisal year was due to winter pressures / working commitments. All of the 35 doctors with outstanding appraisals were contacted and personalised action plan to assist them to get back on track with their appraisal they were offered a six week extension to complete their appraisal we have 2 outstanding appraisals from 2021/2022.

5. Appraisers

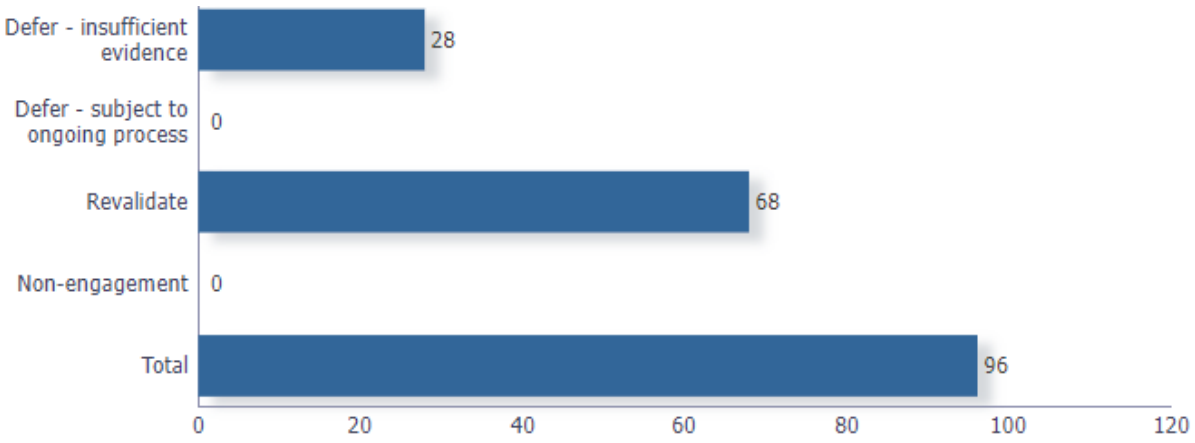
As at 31st March there are 58 active appraisers within the Trust, all of whom have undertaken appraisal for revalidation training. This training is a one day training event held annually to maintain a ratio of 1:5 of appraisers to the connected doctors. All trained appraisers are asked to have annual refresher training.

The objectives of the Training include:

- Be familiar with the Trusts appraisal policy and process.
- Be up-to-date with the requirements of the GMC
- Understand the role of the appraisal in the revalidation process, based on the most current information from the GMC and NHS England
- Maintain the skills required to conduct an effective appraisal interview

6. Revalidation

During the period 1st April 2021 to 31st March 2022 there were 68 revalidation recommendations made to the GMC by the Trust.



North Tees and Hartlepool NHS Foundation Trust has a much lower deferral rate that the average for England and we are committed to reducing the deferral rate further.

For most of our deferral recommendations, the reason was due to incomplete 360 feedback by the deadline for recommendation, either from patient or colleagues. 360 feedback will be completed in year three of the revalidation cycle to reduce our deferral rate.

All recommendation were made before the doctors due date.

7. Access, Security and Confidentiality

The Appraisal Policy confirms that only the MD, Deputy RO and Revalidation Administrator have access to the appraisal documentation. All data is stored securely and in accordance with Data Protection legislation and must not contain any patient identifiable data.

8. Improvements

- Continued work has been undertaken to address the issues highlighted in a gap analysis, including the updated version of a QA checklist prior to the doctors revalidation
- Close monitoring of appraiser attendance at annual update sessions.
- New annual appraiser training
- Updated Medical appraisal document, the documents is under constant review to reflect any changes that may be required in line with guidance from the GMC
- New Medical Appraisal / Revalidation Policy

9. Developments Required / Next Step

- Quality improvement activity to be more emphasised on the appraisal document and will be added to the appraiser update sessions
- Review of allocation of appraisers to ensure we have an even spread of numbers
- Improvement on communication on doctors coming from training into a fixed term contract / MTI doctors employed by the trust are currently not included on the monthly starter's lists.

10. Conclusion

The Revalidation Team, led by Dr Basant Chaudhury, Deputy Responsible Officer, and supported by Mrs Alison Cavanagh has continued to make significant progress during 2021/2022 in ensuring the Trust is meeting the requirements of Revalidation. The team requires continued support of the trustees, executive board, HR and Medical Education Directorate to continue to achieve and maintain high standards in appraisal and revalidation of doctors.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

Title	Foundation Trust Governance Update								
Date	22 September 2022								
Prepared by	Sarah Hutt, Company Secretary								
Executive Sponsor	Hilton Heslop, Associate Director of Corporate Affairs and Strategy								
Purpose of the report	The report provides an overview for the Board of Directors of three draft Governance documents published by NHS England that will sit under a revised Provider Licence. The documents reflect the passing of the Health and Care Act 2022, updating governance arrangements where relevant.								
Action required	Approve		Assurance	x	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		Caring		Effective		Responsive		Well Led x

Executive Summary and the key issues for consideration/ decision

NHS England (NHSE) has published three draft Governance documents that will sit under a revised Provider Licence which is currently in development and will apply to all foundation trusts. The documents were sent out to providers as part of a national consultation, which closed on 8 July 2022. Each document has been summarised within the main report with key highlights as follows:

Draft Code of governance

The draft Code of Governance sets out the framework for corporate governance of trusts to ensure that decision-making is effective, risk is managed, and the right outcomes are delivered. With an emphasis on system working and place-based partnerships, the draft guidance details best practice under Board leadership and purpose; division of responsibilities; composition, succession and evaluation; audit, risk and internal control; and.

In general, the provisions set out in the draft Code of Governance are broadly in line with the legislation contained in the Health and Care Act 2022 which was passed on 1 July and does not change the statutory role, responsibilities and liabilities of provider trust boards of directors. However, there are some key themes included in the draft changes which include:

- A new focus on requirements related to system working following the Health and Care Act 2022;
- Inclusion of the board's role in assessing and monitoring the culture of the organisation, including the wellbeing of its workforce
- A focus on addressing health inequalities, and on equality, diversity and inclusion among board members but also training for those undertaking director-level recruitment
- Potential for greater involvement for NHSE in recruitment and appointment processes at Trust level.

Draft System working and collaboration: **The role of foundation trust councils of governors** (Addendum to Your Statutory Duties – reference guide for NHS foundation trust

governors)

This addendum adds to existing guidance for Governors and seeks to place the legal duties of Council of Governors into the context of system working. This addendum only applies to a council of governors' role within its own foundation trust's governance and includes updated requirements set out in the 2006 Act in respect of legal duties, holding NEDs to account and representing the interests of members and the public and approving significant transactions, mergers, acquisitions or dissolutions.

It is important to note that there are no changes to the statutory duties for councils of governors as set out in the 2006 Act. This draft addendum outlines the role of the ICP and ICB and the trusts will be judged against their contribution to the objectives of the ICS.

One key change that has developed since the 2006 Act is that a council of governors should have consideration for how a trust board makes decisions with regard to the 'triple aim' duty for better health and wellbeing for everyone, and that failure to collaborate effectively with partners to co-design and deliver plans may be treated as a breach of licence conditions.

Draft guidance on good governance and collaboration

The draft guidance sets out what NHSE expects from trusts in terms of collaboration and the good governance they need in place to support it. It reflects the expectation that trusts will be judged against their contribution to ICS objectives and that providers collaborate with partners to agree shared objectives through integrated care partnerships (ICPs) and to collaborate on the delivery of plans through system and place-based arrangements, and provider collaboratives.

Much of the guidance contained in the draft document around collaboration is straightforward and therefore holds no surprises for the trust, for example, 'effective participation within system and place-based partnerships and provider collaboratives will be necessary'. In *'How we expect providers to collaborate with system partners'* the guidance points to three key areas:

- Providers will engage consistently in shared planning and decision-making;
- Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place; and
- Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other forum.

Next steps

Once all the guidance is published, a full analysis and assessment of the requirements will be undertaken in order to confirm compliance or to identify any areas where action is required.

Implementation of required actions across all code provisions within the NHS Code of Governance will be undertaken and included in the Board's annual declaration against the Code, which will be formally approved as part of the Trust's Annual Report and Accounts.

How this report impacts on current risks or highlights new risks
There are no immediate issues or concerns for the trust with regard to the detail set out in the documents. The full analysis and assessment against the guidance will determine any areas of non-compliance, with action plans developed to address.

Committees/groups where this item has been discussed	Executive Team
Recommendation	The Board of Directors is asked to note the content of the report and the work that will be progressed to ensure the Trust is fully compliant once the guidance has been published.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

22 September 2022

Foundation Trust Governance Update

Report of the Associate Director of Corporate Affairs and Strategy

1 Introduction

1.1 NHS England (NHSE) has published three draft Governance documents that will sit under a revised Provider Licence which is currently in development and will apply to all foundation trusts. The documents reflect the passing of the Health and Care Act 2022, updating governance arrangements where relevant.

2 Consultation

2.1 The documents were sent out to providers as part of a national consultation, which closed on 8 July 2022. The full consultation documents can be found at the following links:
https://www.england.nhs.uk/wp-content/uploads/2022/05/B0439-draft-code-of-governance-for-nhs-provider-trusts.pdf
https://www.england.nhs.uk/wp-content/uploads/2022/05/B0440-draft-addendum-to-your-statutory-duties.pdf
https://www.england.nhs.uk/wp-content/uploads/2022/05/B0562-draft-guidance-on-good-governance-and-collaboration.pdf

Each document has been summarised below.

3 The Documents

3.1 Draft Code of governance

3.1.1 The draft Code of Governance sets out the framework for corporate governance of trusts to ensure that decision-making is effective, risk is managed, and the right outcomes are delivered.

3.1.2 With an emphasis on system working and place-based partnerships, the draft guidance details best practice under the following provisions:

- **Board leadership and purpose** – the guidance states that board of directors should develop and articulate a clear vision and values for the trust with due regard to the triple aim duty of better health and wellbeing for everyone, better quality services, and the sustainable use of resources. There is now also specific reference to the trust's role in reducing health inequalities, assessing and monitoring culture and investing in, rewarding and promoting the wellbeing of the workforce.

  Incorporated within the requirements is for the board of directors to assess the trust's contribution to the objectives of the Integrated Care Partnership and Integrated Care Board and the trust's role within the system and place-based partnerships. In addressing these points, the Corporate Strategy since 2020 has featured these elements and will be further strengthened in our refreshed strategy from the autumn;

- **Division of responsibilities** – this section sets out the role of the Chair and the

need for clear division between the leadership of the board and executive leadership of the trust's operations. It references the responsibility of the Chair with regards to Board, Committees, Council of Governors etc and as well as the business of governance, the Chair should promote a culture of honesty, openness, trust and debate ensuring the effective contribution of Non-Executive and Executive Directors, and that the trust's chair is responsible for ensuring that the board and council work together effectively.

The provisions in this section remain largely unchanged from the previous code, however, the appointment and removal of the Company Secretary becomes a matter for the board as a whole, rather than the Chair and Chief Executive jointly;

- **Composition, succession and evaluation** – based on the principle that board appointments follow a rigorous and transparent procedure with an effective succession plan made solely in the public interest following Nolan principles. This section/provision sets out the governance and relevant statutory requirements for board appointments/removal and focuses on appointments and succession plans based on merit and promote diversity of gender, social and ethnic backgrounds.

  There is a new requirement for the board to have published plans on the composition and diversity of the board, as well as inclusion within annual board evaluation. The work planned for phase 2 in relation to Equality, Diversity and Inclusion will reflect this. Annual reporting on the work of the Nominations Committee includes the new provision to describe the trust's policy on diversity and inclusion. Directors and Governors involved in recruitment should receive training in equality, diversity and inclusion.

  The inclusion of the expectation to involve NHSE in advertising and on selection panels is new, though there is the "and/or" option of having a representative from a relevant ICB on panels. There is a new provision for trusts to set a lower threshold for a council of governors vote to remove a governor from the council.
  In addition, Governors should be provided with information on plans, decisions and delivery that directly affect the organiation and its patients;

  - **Audit, risk and internal control –** this section/provision sets out the necessary and relevant statutory requirements with regard to audit and contains no new information other than the senior independent director should not chair the Audit Committee. Chris Macklin is currently the Committee Chair and is a senior independent NED. As soon as interviews for permanent NEDs takes place the position of senior independent NED will transfer to another NED to allow Chris to continue as Audit Committee chair. There are no additional requirements linked to system-wide or place-based working under this provision. The Council of Governors role in appointing the auditor is not mentioned, though it remains their statutory duty;

- **Remuneration** – this section/provision sets out the requirement for a formal and transparent procedure for developing policy on executive remuneration and for fixing remuneration packages of individual directors. The provision details the requirements of the Remuneration Committee but there are no material changes.

3.1.3 In general, the provisions set out in the draft Code of Governance are broadly in line with the legislation contained in the Health and Care Act 2022 which was passed on 1 July and does not change the statutory role, responsibilities and liabilities of provider trust boards of directors. However, there are some key themes included in the draft changes which include:

- A new focus on requirements related to system working following the Health and Care Act 2022;
- Inclusion of the board's role in assessing and monitoring the culture of the organisation, including the wellbeing of its workforce
- A focus on addressing health inequalities, and on equality, diversity and inclusion among board members but also training for those undertaking director-level recruitment
- Potential for greater involvement for NHSE in recruitment and appointment processes at Trust level

3.1.4 Trust's must comply with the provisions of the code within their Annual Report on a comply or explain basis. The Trust has complied with all of the provisions listed at Section 3 within the 2021-22 Annual Report as examined and verified by our external and internal auditors.

3.1.5 The first point of compliance is that trusts, board of directors and Governors should always ensure that they are meeting the specific governance requirements set out the provider licence. The Trust has reviewed the self-certification of the provider licence and can be assured that it meets the requirements of licence conditions of FT4. This, however, does not take into account any outcomes, recommendations or enforcement actions that may or may not fall out of the NHSE/I formal review of governance.

3.2 Draft System working and collaboration: **The role of foundation trust councils of governors** (Addendum to Your Statutory Duties – reference guide for NHS foundation trust governors)

3.2.1 This addendum adds to existing guidance for Governors and seeks to place the legal duties of Council of Governors into the context of system working. It addresses holding the non-executive directors (NEDs) to account for the performance of the board, representing the interests of trust members and the public, and approving or not, significant transactions, mergers, acquisitions, separations or dissolutions. This addendum only applies to a council of governors' role within its own foundation trust's governance and includes updated requirements set out in the 2006 Act in respect of legal duties, holding NEDs to account and representing the interests of members and the public and approving significant transactions, mergers, acquisitions or dissolutions.

3.2.2 It is important to note that there are no changes to the statutory duties for councils of governors as set out in the 2006 Act. This draft addendum outlines the role of the ICP and ICB and the trusts will be judged against their contribution to the objectives of the ICS.

3.2.3 In addition, the draft guidance provides updated considerations for governors linked to the broader benefit of the ICS i.e. significant transactions may not immediately benefit the individual trust but providing there is an expected benefit to the population of the wider ICS then there is evidence that the interests of the public are being appropriately considered.

3.2.4 Whilst there are no changes to the role of councils of governors, the governing body will need to consider the consequences of decisions on other partners within the system. Assurance around accountability is based the performance of the board but this does not mean that governors should question every decision. Councils of governors are recommended to follow key areas of enquiry and provide appropriate challenge on board performance in a considered manner and, only in extreme cases, liaise with NHSE on potential breaches.

3.2.5 One key change that has developed since the 2006 Act is that a council of governors should have consideration for how a trust board makes decisions with regard to the 'triple aim' duty for better health and wellbeing for everyone, and that failure to collaborate effectively with partners to co-design and deliver plans may be treated as a breach of licence conditions.

3.3 Draft guidance on good governance and collaboration

3.3.1 The draft guidance sets out what NHSE expects from trusts in terms of collaboration and the good governance they need in place to support it. It reflects the expectation that trusts will be judged against their contribution to ICS objectives and that providers collaborate with partners to agree shared objectives through integrated care partnerships (ICPs) and to collaborate on the delivery of plans through system and place-based arrangements, and provider collaboratives.

3.3.2 The guidance talks about removing legal barriers to collaboration and to make it easier for trusts to use their knowledge and expertise for effective service planning at a place level by establishing an ICP as a statutory join committee of the ICB with NHS and local government as equal partners to develop an integrated care strategy and address the specifics with the Joint Strategic Needs Assessment (JSNA).

3.3.3 Much of the guidance contained in the draft document around collaboration is straightforward and therefore holds no surprises for the trust, for example, 'effective participation within system and place-based partnerships and provider collaboratives will be necessary'. However, as the implementation of place-based planning and delivery gets closer there is still areas that require clarification.

3.3.4 In *'How we expect providers to collaborate with system partners'* the guidance points to three key areas:

- Providers will engage consistently in shared planning and decision-making;
- Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place; and
- Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other forum.

3.3.5 Providers, and therefore trusts, will need to clearly define and agree the geographic boundaries of place with the ICB whilst, and in the case of the Trust, work simultaneously within a ICP/Tees Valley and local Trust footprint (Hartlepool/Stockton) that meets the needs of the population and the wider system needs.

3.3.6 The guidance provides three scenarios that illustrate ways in which providers can collaborate effectively culminating in a list of bullet points that reflect the expected vision and values of collaborative working and these scenarios are largely descriptive of the way in which the trust already works with partners.

3.3.7 The guidance document also sets out five characteristics of governance arrangements to support effective collaboration and includes key lines of enquiry that, when used by NHSE in discussion with an ICB are likely to indicate whether or not a provider is acting in line with this guidance and the obligations within, but state that 'it should not be used as a compliance checklist'.

3.3.8 There are no immediate issues or concerns for the trust with regard to the detail set

out in the documents.

4. Next steps

4.1 Once all the guidance is published, a full analysis and assessment of the requirements will be undertaken in order to confirm compliance or to identify any areas where action is required.

4.2 Implementation of required actions across all code provisions within the NHS Code of Governance will be undertaken and included in the Board's annual declaration against the Code, which will be formally approved as part of the Trust's Annual Report and Accounts.

5. Recommendation

The Board of Directors is asked to note the content of the report and the work that will be progressed to ensure the Trust is fully compliant once the guidance has been published.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Review of Trust Constitution										
Date:	22 September 2022										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Executive Sponsor:	Hilton Heslop, Associate Director of Corporate Affairs and Strategy										
Purpose of the report	The purpose of the report is to present proposed amendments to the Trust's Constitution to ensure it remains fit for purpose, is aligned to best practice and complies with requirements proposed within the NHS Code of Governance specifically in relation to Governor terms of service.										
Action required:	Approve	x	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:

NHS England issued a draft Code of Governance for NHS Providers, which was out for consultation until 8 July 2022. This will replace the existing NHS Foundation Trust Code of Governance, last updated in 2014 and the expectation is this guidance will be published imminently.

The guidance advises of some changes to existing provisions as well as the addition of new guidance, which will mean that review is required of trust processes and procedures to ensure it is fully compliant with requirements. This will involve a review of the Trust Constitution to ensure any provisions are appropriately included, with a working group of the Council of Governors convened to progress in line with previous practice.

Prior to this work being taken forward and in light of the Governor elections due to commence on 3 October 2022, it is noted that one provision has been reviewed due to the impact on this process. The current Constitution was changed in August 2019 to allow Governors the option to stand for election beyond 9 years, subject to satisfactory performance, which in part was due to the inability to attract candidates to some constituencies and would allow those already in the seat to stand again. The current wording is as follows:

11.3 Following completion of six years service, an elected governor may state their intention to be considered for re-election to the chair, Lead Governor and Company Secretary subject to satisfactory performance, and every three years thereafter.

The existing NHS Foundation Trust Code of Governance is silent in terms of maximum number of terms which can be served by a Governor. However, within the draft Code of Governance for NHS Providers, it is proposed that no more than three consecutive terms (9 years maximum) are served to ensure that objectivity and independence can be retained, similar to provisions that will be strengthened for Non-Executive Directors. The new requirement is identified in the following provision:

'Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.'

The provisions of the code is offered as best practice and good governance, although it does not represent mandatory guidance, however, the Trust is required to 'comply or explain' on an annual basis with the requirements as part of the annual reporting process. Therefore, it is recommended the Trust adheres to the guidance on this provision and others which may require change upon review unless there is a justifiable reason for departure from the provisions.

In line with the proposals the revised wording for the Constitution would be as follows:

11.3 Following completion of six years service, an elected governor may state their intention to be considered for re-election to the chair, Lead Governor and Company Secretary subject to satisfactory performance, for a further three years up to a maximum of nine years.

The Council of Governors will discuss the changes to the constitution at a Development Session on 28 September.

It is recognised that Governors play an important role in the organisation, making sure the views of patients, carers and the communities served by the Trust are heard at the highest level in the decision-making process. In acknowledgement of the commitment and contribution of Governors in undertaking their role, consideration will be given by the Trust as to ways to recognise long service.

How this report impacts on current risks or highlights new risks:
Non-compliance with the provisions within the Code of Governance may impact on audit review and approval as part of the annual reporting process and/or form part of a wider regulatory assessment on adherence to the provider licence.

Committees/groups where this item has been discussed	Council of Governors (Verbal)
Recommendation	The Board of Directors is asked to approve the proposed changes to the Trust's Constitution as detailed.

North Tees and Hartlepool
NHS Foundation Trust

Equality and diversity

Annual Report 2021-2022

Contents

1. Introduction

I am delighted to present the Equality, Diversity and Inclusion Annual Report (2021/22) for North Tees and Hartlepool NHS Foundation Trust.

Our actions to improve staff experience in relation to EDI align with the Trust's wider organisational strategic goals, specifically 'Valuing our People'. They also support our commitments to the NHS People Plan and the People Promise: 'We are compassionate and inclusive'.

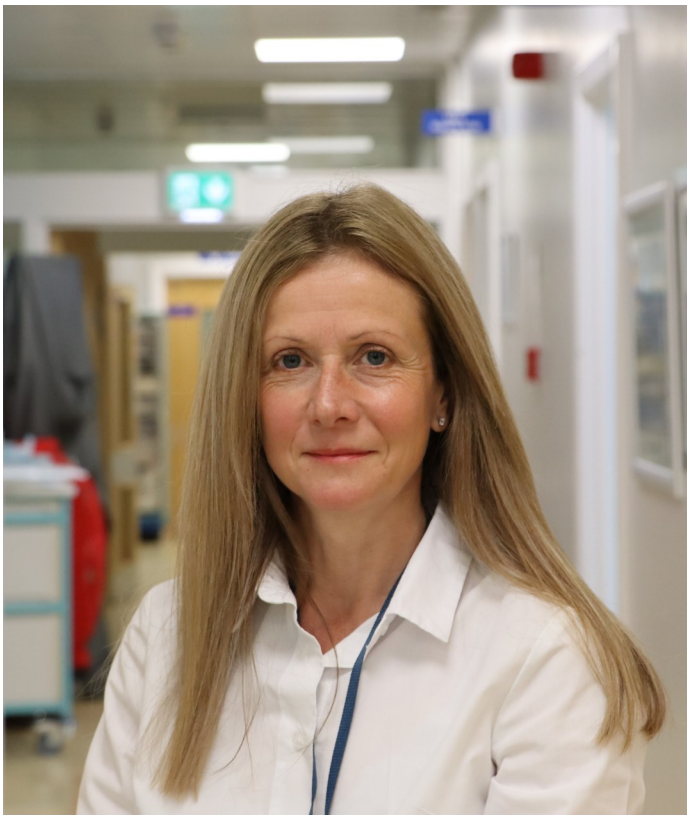
As a public sector body, we are governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to our equality duties. The purpose of this report is to demonstrate the Trust's compliance with the Public Sector Equality Duty by publishing information on an annual basis. It summarises the workforce equality monitoring data for the period 1 April 2021 to 31 March 2022. This report offers an opportunity to reflect on our commitment to equality, diversity and inclusion, celebrating our successes and highlighting the key pieces of work we have achieved throughout the year.

Our aim is to make a positive difference for our colleagues and also the patients we care for and we believe that everybody in the Trust has a role to play in fostering a culture of inclusion and belonging and tackling inequality.

We believe that all protected characteristics are of equal importance, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Understanding the lived experiences of our colleagues is vitally important to us so that we can see where we need to make improvements and ensure that we provide a supportive and inclusive workplace for everyone. Our staff networks are run by our staff and bring together people from across the organisation to improve equality of experience in our Trust.

Our commitment is to provide the best healthcare for everyone in our population. We are dedicated to making North Tees and Hartlepool NHS Foundation Trust a great place to work by creating a culture of compassion and inclusivity, with the health and wellbeing of our staff at the heart of all we do.



Dr Susy Cook
Interim Chief People Officer

2. Strategic Overview

North Tees and Hartlepool NHS Foundation Trust is a Care Quality Commission (CQC) 'Good' rated organisation. Based in the North East of England, we support the health and care needs of over 400,000 people across our region in Stockton, Hartlepool and parts of County Durham.

The Trust is committed to Equality, Diversity and Inclusion (EDI) in all aspects of the services we deliver and the employment of our staff. Our aim is to continue to look after each other and foster a culture of inclusion and belonging, as well as developing actions to grow our workforce, train our people, and work together differently to deliver patient care.

Our customer services charter is developed in conjunction with our staff. Our vision and values promote a human rights based approach, which serves as a constant reminder that the patient is placed at the very heart of all that we do.

This is reflected through our core values of CARE: Collaborative, Aspirational, Respect and Empathy.

Equality, diversity and inclusion flows through all our values, but is particularly embodied within "Respect".

Whilst equality, diversity and inclusion is threaded across all structures and services in our Trust, we have a formal governance route which ensures that an overarching strategic and operational function is in place to provide assurance on our progress.

The People Committee ensures that the Trust strives to achieve best practice across all of our services in a fair and equitable manner, ranging from employment practices through to service delivery and redesign.

We also have networks aimed at engaging with colleagues who identify with the protected characteristics of: ethnic minorities, disabilities/long -term conditions, LGBTQ+, Women and Older Workers.

The Trust is represented at an ICS level through membership of the regional Equality, Diversity and Human Rights Group, where representatives from local Trusts meet to share ideas and promote best practice. The Trust is also part of the Tees Valley EDI Network, which includes representation from wider services including police, fire, education and local authorities. Both networks seek to adopt a system wide approach to the implementation of local and national equality and diversity practices.

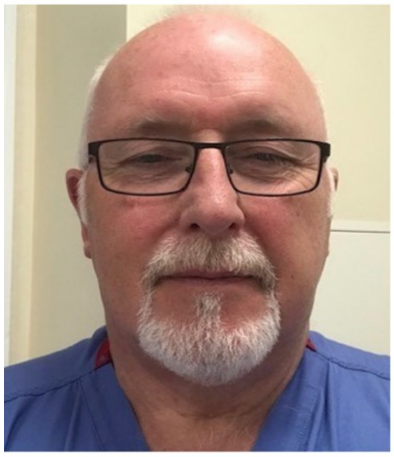
The Trust holds Disability Confident employer status, which recognises our commitment to removing inequality and ensuring fairness and equity in relation to recruitment and employment processes. This is reflected further within our workforce policies and practices, all of which are assessed from an equality perspective and adopt the principles of Just Culture.

Our Equality, Diversity and Inclusion Champions/Network Chairs

Michelle Taylor
Workforce lead

Elizabeth Morrell
Employee Relations

Nicola Hogarth
Employee Relations



Michael Swinbourne
Age (Older) Network Chair

Kristopher Bell
Ability Network Chair

Matthew Andersen
LGBT+ Network Chair

Sushil Munakhya
BAME Network Chair

Shooey Dar
Multi-faith Network Chair

Samantha Eaton
Women's Network Chair

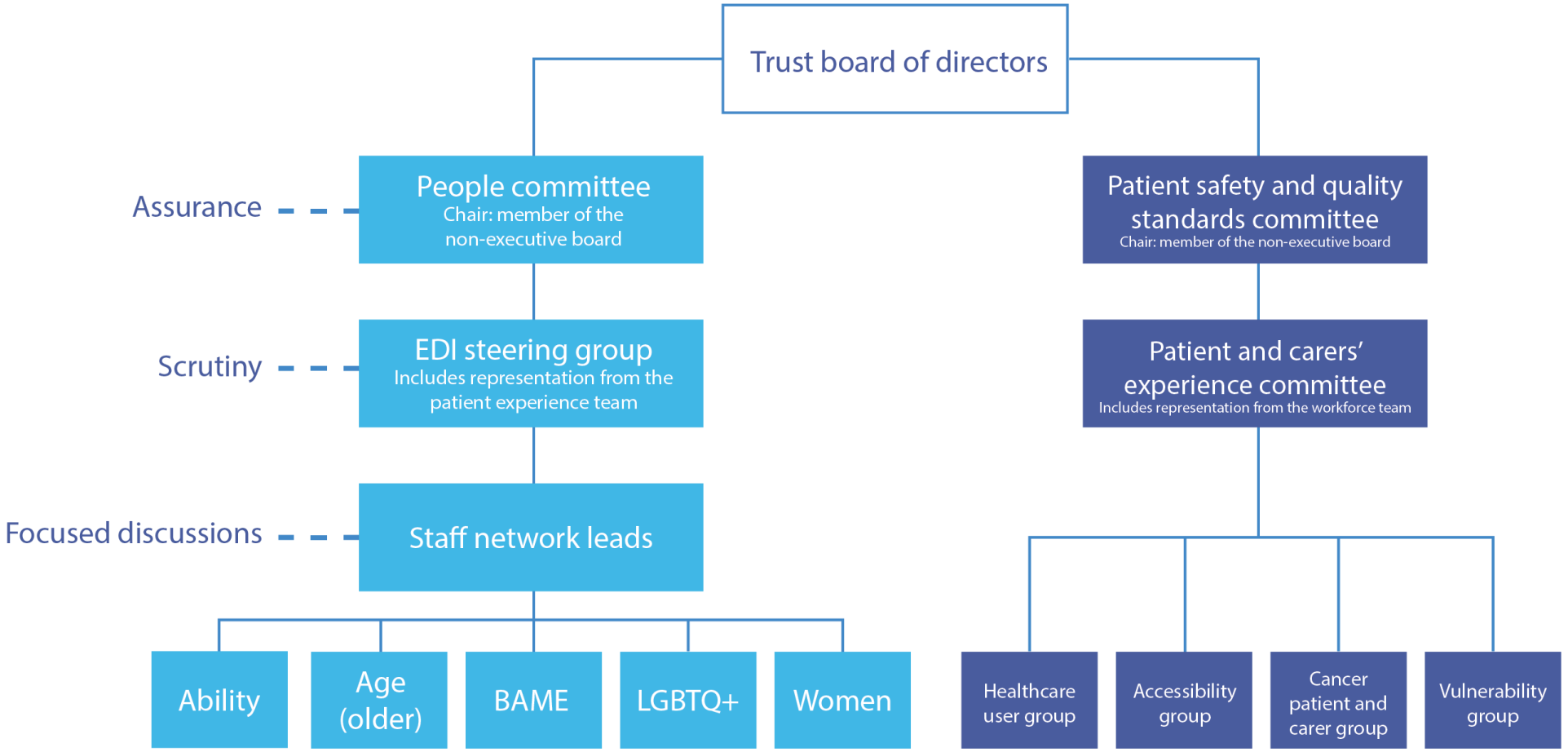
3. Inclusive Leadership

Equality, diversity and inclusion is threaded across the organisation and is key to delivering the Trust's Workforce Strategy and our organisational objective of 'Valuing our People'.

Our ambition is to build an EDI governance structure that inspires ED&I practice from Board to Ward, and we have a number of non-executive led committees who meet on a regular basis to provide assurance to our Trust Board.

The Trust's EDI governance structure is shown below and is built on the principle of inclusive leadership and inclusion. It includes an EDI Steering Group that reports to the People Committee, and a Patient and Carer's Experience Committee that reports to Patient Safety and Quality Standards (Ps & Qs) Committee.

The EDI Committee receives reports from the Staff Diversity Networks and the Ps & Qs Committee receives reports from the Healthcare User Group, the Accessibility Group, the Cancer Patient & Carer Group and Vulnerability Group.


Trust board of directors
Assurance
People committee
Chair: member of the non-executive board
Patient safety and quality standards committee
Chair: member of the non-executive board
Scrutiny
EDI steering group
Includes representation from the patient experience team
Patient and carers' experience committee
Includes representation from the workforce team
Focused discussions
Staff network leads
Ability
Age (older)
BAME
LGBTQ+
Women
Healthcare user group
Accessibility group
Cancer patient and carer group
Vulnerability group

4. We are the NHS: People Plan

Published in July 2020 by NHS England and NHS Improvement, the NHS People Plan's aim is to have more people, working differently, in a compassionate and inclusive culture within the NHS.

- To achieve its ambitions, the NHS People Plan sets out specific actions within six areas:
- Responding to new challenges and opportunities
- Belonging in the NHS
- Growing for the future
- Looking after our people
- New ways of working and delivering care
- Supporting our people now and for the long term

The plan also includes Our People Promise, which outlines behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone.

Our kind, and inclusive culture underlines how we operate. We want all of our people to feel like they belong, and that North Tees and Hartlepool NHS Foundation Trust is a great place to work towards a better future.

5. Staff Networks

At North Tees and Hartlepool NHS Foundation Trust, we are proud of our strong reputation within the Equality, Diversity and Inclusion (EDI) agenda and we are committed to creating a more diverse and inclusive culture, where our staff can come to work in a supportive working environment, which is strengthened by a framework of comprehensive workforce policies.

It is important that, as a caring and compassionate employer, we understand how it feels to work for this Trust and particularly, how an individual's lived experience may be influenced by one or more protected characteristic(s) and to allow our leadership teams to learn about the real impact of policy and practice.

One way of understanding this is through the development of staff networks and we have developed networks for each of the following groups:

- Black and Minority Ethnicity (BAME)
- Lesbian, Gay, Bi-sexual and Transgender (LGBT+)
- Disability
- Age (Older)
- Multi-faith
- Women

It is intended that our networks will offer a place for staff to come together, share experiences and facilitate learning and development. Networks can also assist in the shaping and delivery of organisational strategy and policy, working with us to improve staff experience on specific issues relating to each network. By adopting a collective approach, we will ensure greater equity and impact, which is underpinned by a strong commitment to listen, understand, support and improve the experience of our staff, acknowledging the different needs of protected characteristics.

We recognise that some individuals may identify with more than one characteristic and therefore it is both right and important that our networks allow the opportunity for intersectionality. To this aim, we aim to bring together all networks on an annual basis, and we have scheduled quarterly meetings for the network chairs as a means of peer support and to discuss any shared objectives/actions.

6. Public Sector Equality Duty (PSED)

The principles of equality and diversity have been incorporated throughout the Trust, with inclusion of EDI considerations within business plans, ensuring that equality impact assessments are completed to a consistent standard, and that these are considered when implementing new and amended services, and workforce practices and policies.

As a Trust, we continue to seek to:

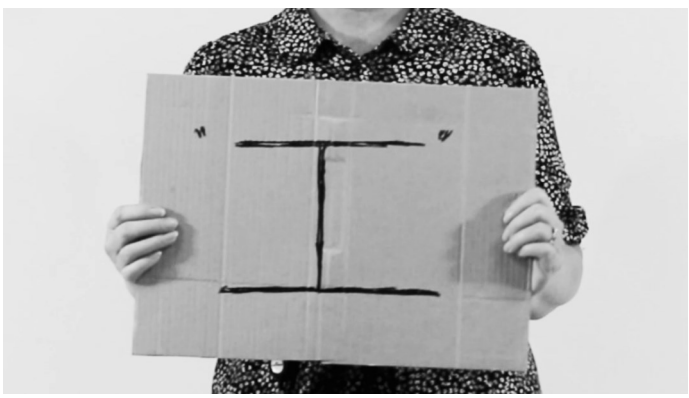
- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups
- Seek to improve existing practices, embed new initiatives and enhance our equality and diversity activity

We are continuing to work towards achieving the objectives identified in line with the specific duties of PSED.

Our current objectives are:

- To engage with our patients, the local community and various stakeholders, in line with the requirements of EDS2, to ensure the effective provision of services.
- To enable our staff to work alongside patients and carers to determine realistic, reasonable adjustments to deliver safe, effective care to people with literacy problems, learning difficulties and dementia.
- To promote equality, diversity and inclusion across the trust.
- To explore and reduce the discrimination experienced by our staff, as identified by the NHS annual staff survey, through the development of proactive measures and support mechanisms to be implemented trust-wide.

We will be reviewing our equality objectives for 2022/23, ensuring that focus is given on issues that are of particular importance to the organisation, based on feedback from our stakeholders.



7. Equality Delivery System 2

The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. A refreshed EDS (known as EDS2) was made available in November 2013.

The main purpose of the EDS2 is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

We have worked closely with our stakeholders, both internal and external to the Trust, in relation to the implementation of the Equality Delivery System (EDS2).

EDS2 enables us to provide focus for areas requiring further attention, to ensure all identified equality issues are addressed for all protected characteristics, as recognised by the Equality Act 2010.

EDS is currently transitioning from EDS2 to EDS 2022, and it is intended that the focus will be on collaboration and delivery of the EDS as a system to tackle health inequalities and this is included in plans for future EDI ICS activities. This will include an element of peer review which will need to be factored into the process for each organisation, requiring engagement with relevant patient groups, voluntary care organisations, community groups, trade union representatives, staff networks, and FTSU representatives.

The review of EDS 2022 dovetails with our wider work in relation to the organisational EDI agenda.

8. Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 and seeks to tackle one particular aspect of equality – the consistently less favourable treatment of those who identify themselves as Black, Asian or from a Minority Ethnic background.

National research shows that those individuals who are from a Black, Asian or Minority Ethnic background are:

- less likely to be appointed for jobs once shortlisted
- less likely to be selected for training and development programmes
- more likely to experience harassment, bullying or abuse
- more likely to be disciplined and dismissed

The WRES consists of nine metrics which consider the fairness of how BAME staff are treated. Trusts must report on the metrics annually and implement an action plan to address any disparities highlighted by the information, in an attempt to try and close the gap between the experiences of BAME staff as compared to White staff.

The Trust's WRES report for 2021 is available on our website and can be found on: www.nth.nhs.uk/about/equality-diversity

A summary of the results for 2021 is shown in the table. The baseline data has been extracted and calculated to determine a response to each of the nine WRES indicators.

WRES indicator			2017	2018	2019	2020	2021
1	Percentage of BME staff	Overall	9%	10%	11%	11%	**11%**
		VSM	0%	0%	0%	0%	**0%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		0.74	0.58	0.86	0.99	**3.24**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.33	0.9	0.76	0.69	**0.93**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development compared to BME staff		0.6	0.89	0.67	0.77	**1.16**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	39.1%	36%	37.5%	42.3%	**28.1%**
		White	26.6%	29.2%	26.9%	28%	**24.8%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	20%	28%	31.3%	33.8%	**29.2%**
		White	19.8%	22.5%	18.3%	18.4%	**20.4%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	89.9%	80%	85.7%	77.4%	**82.4%**
		White	90.8%	94%	91.4%	90.2%	**88.9%**
8	Percentage of staff personally experiencing discrimination at work from a manager, team leader or other colleagues	BME	15.9%	14%	8.5%	11.7%	**14.6%**
		White	5.1%	5%	4.4%	4.3%	**5.1%**
9	BME Board membership		7.1%	6.7%	6.7%	5.3%	**5.6%**

9. Workforce Disability Equality Standard

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

The WDES first came into force on 1 April 2019 as part of the NHS Standard Contract and consists of ten specific metrics which consider the fairness of how disabled staff feel they are treated by the organisation. NHS Organisations are required to report on the metrics annually and the information obtained is used to implement local action plans to address any disparities in the metrics and to demonstrate progress against the indicators of disability equality.

The Trust's WDES report for 2021 is available on our website and can be found here: www.nth.nhs.uk/about/equality-diversity

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table. The baseline data has been extracted and calculated to determine a response to each of the ten WDES indicators.

WDES indicator			2019	2020	2021
1	Percentage of staff with a disability or long term health condition	Overall	2%		**2%**
		Non-clinical	2%	2%	**2%**
		Clinical	2%	2%	**2%**
2	The relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff		1.64%	1.34%	**0.94%**
3	The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff		0	0	**0**
4	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	With	35.4%	35.5%	**29.6%**
		Without	26.7%	27.8%	**24.1%**
5	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	With	16.3%	14.2%	**18.3%**
		Without	5.8%	7.3%	**7.5%**
6	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	With	33.7%	21.5%	**23.4%**
		Without	12.4%	14.7%	**13.8%**
7	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	With	51.2%	45.9%	**54.3%**
		Without	52.9%	46.3%	**47.3%**
8	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	With	84.4%	83.3%	**80.9%**
		Without	92.1%	90.3%	**90%**
9	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	With	43.8%	35.7%	**39%**
		Without	19.2%	24%	**24.9%**
10	Percentage of staff satisfied with the extent to which their organisation values their work	With	36.7%	40.7%	**36.9%**
		Without	53.4%	54.1%	**53.3%**
11	Percentage of staff with a long lasting health condition or illness saying their employer has made adequare adjustment(s) to enable them to carry out their work	With	66.7%	77.4%	**74.2%**
12	Staff engagement score (0-10)	With	6.5	6.7	**6.7**
		Without	7.2	7.3	**7.3**
		Overall	7.1	7.2	**7.1**
13	Disabled/LTC Board membership		0%	0%	**0%**

10. Gender Pay Gap

The gender pay gap report is intended to show the difference in the average pay between all men and women in a workforce. The report we have published demonstrates our compliance with statutory reporting requirements and analyses the figures in more detail to understand the reasons why the pay gap exists. Most importantly, it highlights the good practice which exists within the organisation and sets out the actions we intend to take to reduce the gender pay gap for future years.

North Tees and Hartlepool NHS Foundation Trust unequivocally supports fair representation across all levels of the organisation, irrespective of gender. Our approach to pay is based on the principles of consistency, fairness and transparency, which supports the fair treatment and reward of all staff.

Our gender pay gap report as of 31 March 2021 (the snap shot date) shows the Trust has an average pay gap of 36.73%, and a median pay gap of 24.73%. A further breakdown of results shows that the average pay gap is slightly higher amongst the non-medical workforce in comparison to medical staffing. This is because the proportion of male senior managers employed by the Trust is higher than the number of female senior managers. It is therefore reasonable to conclude that male workers earn a higher rate of average pay than female workers. The median pay gap is also higher amongst the non-medical workforce compared to medical staff.

Male		
Female	£16.04	£14.58
Difference	£9.31	£4.79
Pay Gap %	36.73%	24.73%

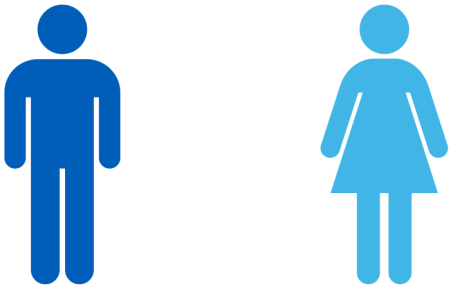
The mean gender pay gap for the Trust shows that female staff are paid 36.73% less than male staff. The median gender pay gap for the Trust shows that female staff are paid 24.73% less than male staff.

Gender	Average hourly rate (mean)	Median hourly rate (median)
Male	£11,051.06	£7,068.75
Female	£8,621.16	£6,032.04
Difference	£2,429.90	£1,036.71
Pay Gap %	21.99%	14.67%

The Trust does not operate a bonus scheme, however consultant medical staff are eligible to apply for clinical excellence awards, which are considered to be a bonus payment and form part of the gender pay gap calculations. As our consultant medical workforce are predominantly male, the results show that male consultants earn a higher average rate of bonus pay (CEAs) than female consultants. The Trust's average Bonus Pay Gap for 2021 shows an increase of 4.99%, from 17% to 21.99%. The non-competitive process of awarding CEAs for 2020 has had a significant impact in this area. Where in previous years the gap had started to narrow with more female consultants applying and receiving an award, the fact that an additional 51 male consultants became award holders in 2020 as compared to an increase of only 25 female consultants has now caused the gap to widen.

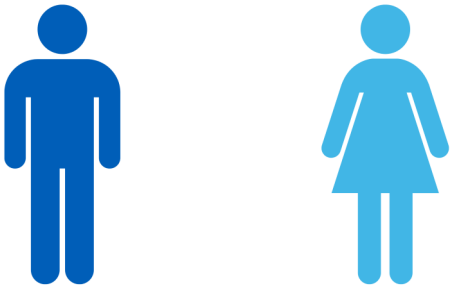
Pay Quartiles by Gender:

Lower Quartile



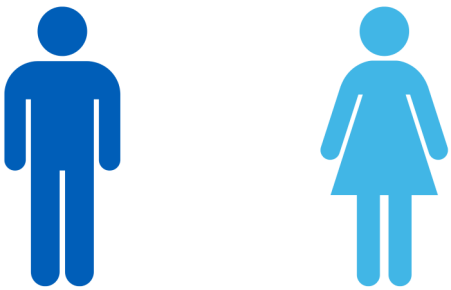
9.83% 90.17%

Lower Middle Quartile



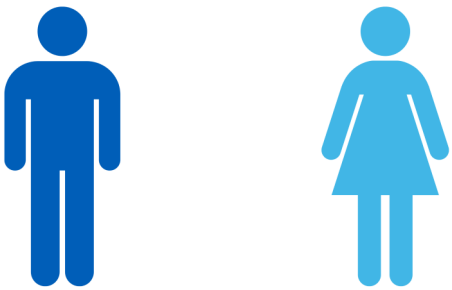
11.23% 88.77%

Upper Middle Quartile



11.49% 88.51%

Upper Quartile



29.98% 71.02%

The data above shows the male to female split of our workforce for each quartile.

The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.

The information indicates that women occupy 71.2% of the highest paid jobs within the Trust and 89.3% of the lowest paid jobs. This is the fundamental reason behind the Trust's overall gender pay gap.

11. Staff Survey

The national staff survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experience across the NHS.

2021 was one of the most testing years we have ever faced as a health service and the world health pandemic has impacted on many of our colleagues, both on a personal and a professional level.

All employees were invited to participate in the survey and the personal characteristics of the respondents are reported as similar to the overall profile of our workforce.

We achieved a response rate of 54%, where 2410 of our colleagues took the time to tell us about their experiences of working for the Trust. The results showed that for 9/10 themes, the Trust scored higher than the regional average.

Equality, Diversity and Inclusion Responses

For the first time in 2021, the questions were aligned to the NHS People Promise to track progress against the ambition to make the NHS the workplace where we all want to be by 2024.

"We are compassionate and inclusive" is assessed by examining four specific areas relating to culture, leadership, equality/diversity and inclusion. The Trust scored higher than the national average in all four areas – a positive development which reflects the organisation's commitment to the People Promise.

The responses to these areas can be examined at a more detailed level to further understand staff experience.

Compassionate Culture

89.1% of colleagues feel that their role makes a difference to patients/service users, and 80% of colleagues believe that care of patients/service users is the Trust's top priority. 77.1% of colleagues reported that the Trust acts on concerns raised by patients/service users. 61.4% of staff would recommend the Trust as a place to work and 69.5% would be happy with the standard of care provided to a friend or relative.

All questions within this section were reported as higher than the national average.

Compassionate Leadership

66.1% of colleagues stated that their immediate manager works with them to come to an understanding of problems, with 69.4% of colleagues reporting that their immediate manager is interested in listening to them when describing the challenges they face. 68.6% of colleagues believe that their immediate managers cares about their concerns and 65.8% believe that their immediate manager takes effective action to help them with any problems they face.

All questions within this section were reported as higher than the national average.

Diversity and Equality

It is pleasing to report that 62.6% of our colleagues believe the Trust acts fairly with regard to career progression/promotion – an increase of 2.1% from the previous year (2020).

4.1% of colleagues reported that they have personally experienced discrimination from patients/service users (a reduction of 2.8% from 2020) and 6.3% of colleagues have reported that they have experienced discrimination from a manager/team leader or other colleagues.

72% of colleagues think that the Trust respects individual differences. This was a new question for 2021.

The responses to all four questions within this section are above the national average and, with exception of experience of discrimination from a manager/colleague, all scores have improved since 2020. Our work in relation to the delivery of people practices training for all managers and supervisors includes the principles of Just Culture and is expected to have a positive impact in this area.

Inclusion

69.4% of colleagues reported that they feel valued by their team and 65.2% feel a strong attachment to their team.

71% of colleagues stated that the people they work with are understanding and kind to one another and 71.9% stated that the people they work with are polite and treat each other with respect.

All four questions are new for 2021 and as with all other sections in this category, are above the national average.

You said, we did

These are the actions which we identified as being important in response to the 2020 staff survey, and which we believe have directly contributed to our high scores for 2021:

- Provision of unconscious bias training
- Introduction of Civility Training
- Development of our Staff Networks
- Refreshed our Practical Skills Training for Managers
- Introduced 'Stay interviews' to ensure we retain staff
- Included Talent Management in appraisal training
- Enhanced our flexible working offer to staff
- Creation of a staff support hub
- Launch of RESPECT campaign to empower staff to voice any concerns
- Delivered training on Mental Health First Aid
- Creation of our Rainbow Rooms for staff to relax in
- Introduced the Customer Care Charter
- Launch of 100 leaders focussing on change in the organisation
- QI Leads located in each Care Group
- Provided opportunities such as difficult conversations, leadership training and apprenticeships

Staff Support

Responses to the staff survey are anonymous therefore it is not possible for us to directly address any concerns raised through the survey on an individual basis. However, we continue to ensure that all staff are informed of the numerous options in place where they are able to raise concerns in confidence, and this includes details of the various support systems that are available for staff to access.

There are both formal and informal measures to assist staff who may be experiencing any form of discrimination, bullying or harassment. In addition to our Workforce policies for raising a request for resolution or raising concerns of bullying and harassment, there are also additional routes for staff to seek support. This includes direct access to and support from the Trust's Freedom to Speak Up Guardian and Champions; referral to our internal mediation service, and; self-referral to occupational health support which includes access to counselling services.

We are keen to ensure that staff feel empowered to raise concerns and that, as a responsive employer, we clearly communicate the cultures and values we expect from our employees, including those in relation to behaviour and attitude and ensuring these are instilled within all staff at all times.

NHS North Tees and Hartlepool NHS Foundation Trust

We found that 92% of you feel that **you are trusted** everyday in doing your job.

NHS North Tees and Hartlepool NHS Foundation Trust

You rated us 7.4 out of 10 for **compassion and inclusivity**.

12. Equality, Diversity and Inclusion Review

If The Trust commissioned an external consultancy to undertake a review of our Equality, Diversity and Inclusion practices and people processes and this programme of work commenced during quarter 3, 2021/22.

The decision was taken to undertake the review in two phases. The EDI phase one review covered 10 key areas, with 24 recommendations identified. An agreed action plan was developed and agreed with the external consultancy to drive the activity for phase two of the review.

An event took place on 30 May 2022, where a number of key individuals from across the Trust were invited to meet with the external consultancy and commence the preparations for phase two.

A workforce summit was held on 20 June 2022 to launch the next stage of the review.

Representatives from across the Trust's senior management team were invited to share their thoughts, ideas and priorities in relation to:

- Supporting the Health and Wellbeing of our workforce
- Inclusive recruitment practices to drive representation of our local communities
- Identifying initiatives to address shortage occupations

The event was a huge success and generated a significant amount of information and suggested areas of focus.

The key areas of activity have been considered and an agreed action plan for 2022/23 has been developed.

13. Equality, Diversity and Inclusion in Practice

Equality and diversity is about inclusion, respect and removing barriers, whether this be in relation to the health care services we provide, or the employment of our staff.

There are numerous ways in which this is illustrated throughout the organisation, through specific initiatives as well as in everyday practices. The following section of the report highlights some examples of good practice and the case studies which reflect this.

Raising awareness of disabilities in the workplace

Staff from an active networking group are leading the charge to change people's views of disabled people in the workplace, especially those dealing with hidden disabilities. The Trust's Disability Staff Network launched a series of videos of group members talking about the issues they tackle every day.

The short but moving testimonials include staff talking candidly about dealing with mental health, autism, myalgic encephalomyelitis (ME) and multiple sclerosis. One video interviewee is pharmacy support worker Nic Samuels.

Nic, who suffers from bouts of serious depression, says in her video: "People don't understand that when that black cloud starts and you just get that black cloud in your head. There's nothing you can do and you just feel so ill.

"It's horrendous, this feeling of pain in your mind." You've got no logic or rationale. Your brain just will not function, it's just full of lowness and it's the most horrendous feeling in the world."

Nic advises her colleagues dealing with similar issues to ask for help, commenting: "Anybody that's suffered from it should feel they can get support from the Trust, because I have. You feel so much better when you have been and spoken to someone."

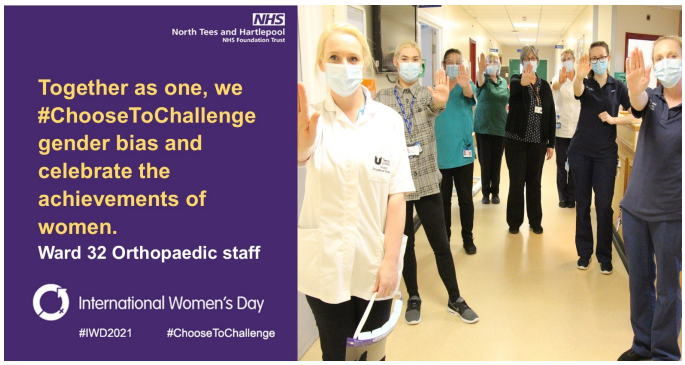
Trust Chooses to Challenge

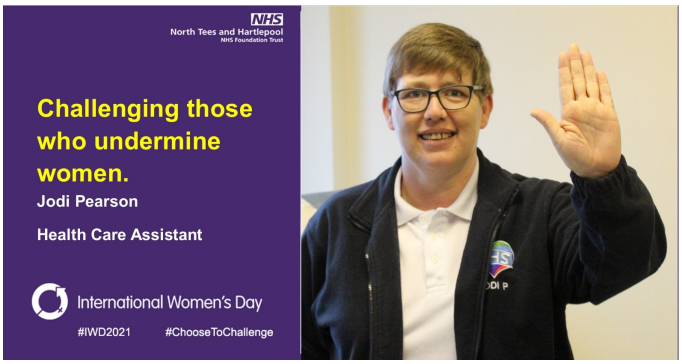
The theme of International Women's Day was Choose to Challenge.

A challenged world is an alert world. Individually, we are all responsible for our own thoughts and actions – all day, every day. We can all choose to challenge and call out gender bias and inequality.

We can all choose to seek out and celebrate women's achievements. Collectively, we can all help create an inclusive world.

Throughout International Women's Day, the Trust posted a series of social media posts featuring staff proclaiming their commitment to the ideals of International Women's Day.





Raising awareness of disabilities in the workplace

We were thrilled to welcome this year's cohort of Project Choice interns who are placed within various departments across North Tees and Hartlepool NHS Foundation Trust. The students undergo a range of placements gaining experience in different roles including portering, ward hostess, chef and domestic assistant.

Project choice is a programme that supports internships at the Trust for young people aged 16 to 25 with learning disabilities, learning difficulties and/or autism.

These placements are a fantastic opportunity for young people to gain the vital experience and skills they need to be employment ready. The programme provides interns with three 12-week placements throughout the academic year and the journey offers the individual the chance to gain valuable work experience, developing their knowledge and skills and building confidence along the way.

Mayor of Stockton and nurse join BAME appeal

The Mayor of Stockton-on-Tees Councillor Mohammed Javed and Nurse Millie Magadlela joined the Trust's campaign to record video appeals to the diverse ethnic groups within our local communities, about the importance of having the COVID-19 vaccine.

Members of the BAME community are at a higher risk of serious illness from COVID-19 and the Trust recognised that there was a low uptake of the vaccination within the BAME community. This prompted us to record and release a series of video appeals by our BAME colleagues and this included speaking in native languages as a direct appeal to those who may not speak English.

Councillor Javed and Millie were themselves seriously ill with the virus, with both making local headlines after being applauded out of intensive care after lifesaving treatment saw them spend time on ventilators.

On his video appeal, Councillor Mohammed Javed commented: "I urge people to please have the vaccine. It's safe. Don't listen to the fake news and the fake social media. It is safe to have the vaccine."

"I've had my COVID vaccine and I'm really happy and proud to have had it because I know I'm going to be safe. I'm protecting myself, my family, my colleagues and the public at large", says Millie on her video.

Hypnobirthing service relaunched for local mums-to-be

We are once again offering expectant mothers the opportunity to give birth in more comfort thanks to our refurbished hypnobirthing service.

Serenity HypnoBirthing aims to reduce pain and create a calmer, more peaceful childbirth experience by teaching women breathing techniques, relaxation exercises and a safe form of self-hypnosis. Mums-to-be can sign up to a five-week HypnoBirthing course for just £90, which includes a book and a CD of relaxation exercises. Serenity HypnoBirthing is unlike 'stage' hypnotherapy and is a meditative process of enhancing breathing and relaxation techniques to self-manage the body's reactions to the birth process.

It aims to help reduce the pain naturally, although even if painkillers are still required, women will have a calmer, more relaxed birth with Serenity HypnoBirthing.

“It’s not a new chapter, it’s a new book”

“It’s not a new chapter, it’s a new book” is the message from Matthew Andersen, a transgender man as he approached what he calls his first ‘manniversary’.

The 30-year-old clinical coder came out as transgender to his family, friends and colleagues two years ago. Matthew, who does not like to publically refer to his birth name, was confident in the support he would receive from those in his life, especially his Trust colleagues.

Matthew took part in a filmed interview as part of Pride month and told us: “I didn’t even realise I was a man. All of my life I thought I was female. I was a bit of a late bloomer, and I was 28 when I realised I was transgender.

“Looking back at my life and childhood, all the signs were there – I just didn’t piece them all together. When I came to the realisation that I was living in the wrong body it was a glass shattering moment. Very quickly it became unbearable. It felt wrong, but at the time I felt there was nothing I could do about it. When I look at photos of myself pre-transition, I recognise that person but it’s not me”.

“My physical transition began when I started testosterone. That brought about the physical changes. I started that about a year ago. I’m having a party for it – I call it my ‘manniversary’! Pre-transition is like a prequel, this is my life now. It’s not a new chapter, it’s a new book. It’s the start of my story.”

Matthew was supported by his family, colleagues and the Trust during his transition. Stuart Harper-Reynolds, Trust adult safeguarding nurse and chair of the Trust’s LGBTQ+ staff network was the first person Matthew confided in about his realisation he was trans.

Pride in the NHS Week

To mark Pride in the NHS week, our LGBTQ+ staff network held an event inviting Trust colleagues to pledge to be an ally to our LGBTQ+ patients and members of staff.

Hundreds of staff came forward to sign their pledge and receive an NHS rainbow badge as a visual display to show their pride in being an LGBTQ+ ally.

The Trust also released a video of Stuart Harper-Reynolds, adult safeguarding nurse and chair of our LGBTQ+ staff network, highlighting the importance of the staff network.

Reducing the Risk of Discrimination - Cultural Ambassador Programme

The Trust was delighted to become part of the Royal College of Nursing (RCN) Cultural Ambassador Programme in 2021.

The aim of the programme is to ensure that staff from BAME backgrounds are treated fairly and in a consistent manner when facing potential disciplinary action from their employer. Cultural ambassadors are trained to identify and challenge discrimination and cultural bias and use these skills in their role by acting as a neutral observer within disciplinary processes, formal investigations and grievance hearings involving staff from BAME backgrounds.

Through the implementation of the Workforce Race Equality Scheme (WRES) at a national level, we are aware of the evidence which exists which shows that BAME staff in the NHS are over-represented in such processes, and this means that they are therefore more likely to receive a formal sanction, as compared to White colleagues.

We currently have five individuals who have attended formal training to become a Cultural Ambassador for the Trust. Their role is to ask questions that others may not have considered, and they are therefore able to encourage important and thorough deliberations which can prevent cases from progressing to unnecessary formal stages.

Celebrating the vital role of overseas workers in healthcare

The Trust employs staff who come from more than 50 countries across the globe.

These staff work in a range of areas – including doctors, nurses, healthcare support workers, therapy, non-clinical staff, and many more!

The Trust highlighted the vital contribution that our global workforce makes to the organisation.
Dr Deepak Dwarakanath, medical director, said:

“Without overseas workers and the outstanding role they play at this organisation, we simply couldn’t provide the same level of care to our patients. We are proud to have such a diverse range of staff from more than a quarter of the world’s countries – all playing a critical role here at this Trust. These are people who want to make a real difference to the health of people in our local communities and bring a wealth of skills and knowledge with them to do that. This is an opportunity for us to acknowledge the fantastic part that these staff play.”

The Trust has staff from countries across Europe such as Romania and Ukraine as well as from countries further away including the Philippines, India, Malaysia, Afghanistan and Nigeria.

Martha Nandago moved from her homeland in Uganda to Stockton nearly 20 years ago. She works as a staff nurse in the orthopaedic outpatient departments at the University Hospital of North Tees and the University Hospital of Hartlepool.

She said: “I love working at this organisation and am passionate about making a difference to the lives of our community.

“I live in Stockton – it’s where three of my four children were born. It’s my community and my home.

“This is a fantastic place to work and to live – we have staff from all over the world bringing so many skills to their roles.”

New staff ID badges helping remove the barrier facemasks create with patients

The palliative care team have created new ID badges to show the face behind the mask.

The #AndILookLikeThis campaign – first launched by staff at Chesterfield Royal Hospital NHS Foundation Trust – is in response to the impact personal protective equipment (PPE) has had since the COVID-19 outbreak.

John Sheridan, Macmillan lead nurse for end of life care, said: "So much of the care we give is about the personal relationship we have with our patients. "A smile, a reassuring touch, and showing that we care can mean so much to them and to their relatives. When you can't see half of someone's face, it creates a real challenge.

"So, when we saw the social media coverage from Chesterfield about their idea, we loved it. "Ever since we have first used the badges, we have had so much fantastic feedback. It shows to patients who we are — they can see from our badge what we look like behind the facemask. We are now calling on all of our staff to join us in wearing the badges."

Chinese New Year COVID appeal

Leung Yu Wu, a pharmacist based at the University Hospital of North Tees, lent his voice to a series of filmed videos on behalf of the NHS appeal for members of the UK's Chinese community to celebrate the Year of the Tiger in safety and to get the COVID-19 vaccine.

Leung, 40, is originally from Hong Kong and has lived in the UK for 16 years. He lives in Newcastle with his wife Mia and their two children, a son aged three and a one-year old daughter.

An experienced pharmacist who has worked at the Trust since 2009, recorded appeals in Mandarin, Cantonese and English, Leung said:

"Chinese New Year is a time of family celebration and fun. I'm a pharmacist and I know the vaccine is safe and effective. I've had it and I would recommend it to any of my family and patients. Please, protect yourselves and loved ones and begin the Year of the Tiger vaccinated and safe from COVID-19."

World AIDs Day

The Trust marked World Aids Day on 1 December 2021 by inviting a representative from the Terence Higgins Trust to speak to members of the LGBTQ+ staff network and dispel the myths surrounding HIV and AIDS. Anthony Young attended the network and delivered a moving and thought provoking presentation.

Stigma and discrimination can be a daily issue for people living with HIV. A recent national stigma survey showed that 13 per cent report avoiding visiting the GP because they feared being treated differently and 21 per cent of gay men living with HIV report they have been discriminated against in

Improving care for people with a learning disability

The safeguarding team is supporting new ‘diamond pathways’ to deliver high quality, reasonably adjusted care for people with a learning disability.

The new standards, developed by the North East and Cumbria Learning Disability Network and Access to Acute Network, are about planned admission, emergency admission and discharge which are then underpinned by a core set of values and principles.

As part of Learning Disability Week, the safeguarding team visited clinical areas to highlight the new standards and deliver information and free goodies. Carley Ogden, nurse advisor for adult safeguarding and learning disability, said: “These new standards will provide the standard of care that people with a learning disability require and to which they are entitled.

“The aim of the pathway and workforce education package is to help people with a learning disability by improving communication, experiences of health care, quality of life for people with a learning disability, promoting seamless care and reducing premature mortality.”

The team also used the week to raise awareness of hospital passports – a document for patients with information about them and their health needs.

14. Looking ahead to 2022/23

We have many plans for the year ahead and our focus will be to implement the priority actions resulting from the Trust-wide review of our EDI practices. These actions will be taken forward as part of phase two of the programme and they will be governed in such a way that the effect and impact will be embedded to allow for sustained progress to be made with the Trust ED&I approach.

Our activities will be themed across the four key strands of:

- Development
- Governance/Risk
- Groups and Committees
- Strategy

The agreed action plan for 2022/23 includes timescales for delivery. The plan is structured around the short-term priorities (3 to 6 months) and those to be taken forward in the longer term (6-12 months).

There are eleven project areas covering the following headings:

Short term:

- Work with workforce colleagues to integrate ED&I policy and practice within existing OD and people strategy, policy and practice
- Equality Impact Assessment Training
- Trust Board development
- ED&I Governance Framework
- Managing difficult situations and having difficult conversations
- Staff Networks development

Long term:

- Positive action programme and leadership development
- Reciprocal mentoring programme
- Develop capacity to link ED&I and health inequalities, quality agenda and continuous improvement
- Integrated ED&I focused learning development offer
- ED&I annual conference

15. Contacts for Further Information

If you would like any further information about Equality, Diversity and Inclusion within North Tees and Hartlepool NHS Foundation Trust, please contact our Workforce Equality and Diversity lead:

Michelle Taylor, Head of Workforce
University Hospital of North Tees
Tel: 01642 624025

Feedback
We actively seek feedback on our annual reports from stakeholders and service users so that we can continue to meet our commitment to improve service delivery. We would welcome any feedback and comments on this document which should be directed to:

The Employee Relations Team
University Hospital of North Tees
Hardwick Road
Stockton on Tees
TS19 8PE

Or by email at nicola.hogarth1@nhs.net

The information contained within this report is also available in alternative formats, which can be obtained by contacting, Cordelia Wilson, Clinical Governance Lead on 01642 383576 or via email on cordelia.wilson@nhs.net

16. Workforce Equality Factsheets

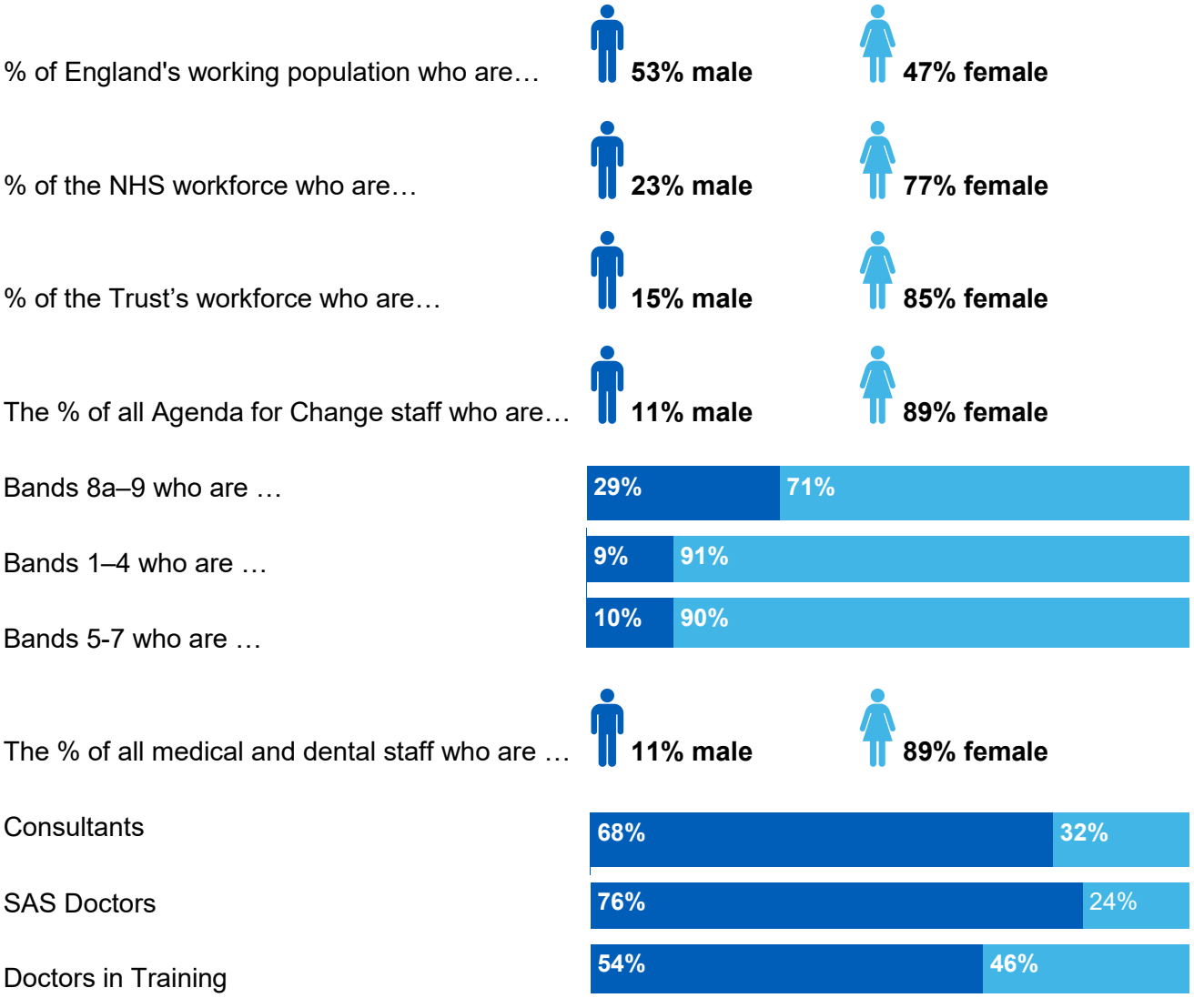
As of 31 March 2022, there were 4,700 members of staff employed by the Trust.

This section outlines the profile of the workforce of the Trust in relation to each protected characteristic, for the period 1 April 2021 to 31 March 2022.

Of the total staff employed by the Trust, 2,487 employees (53%) work on a full time basis and 2,213 employees (47%) work part time.

Section 1 - Gender

The Trust employs 4,020 female members of staff and 680 male members of staff.



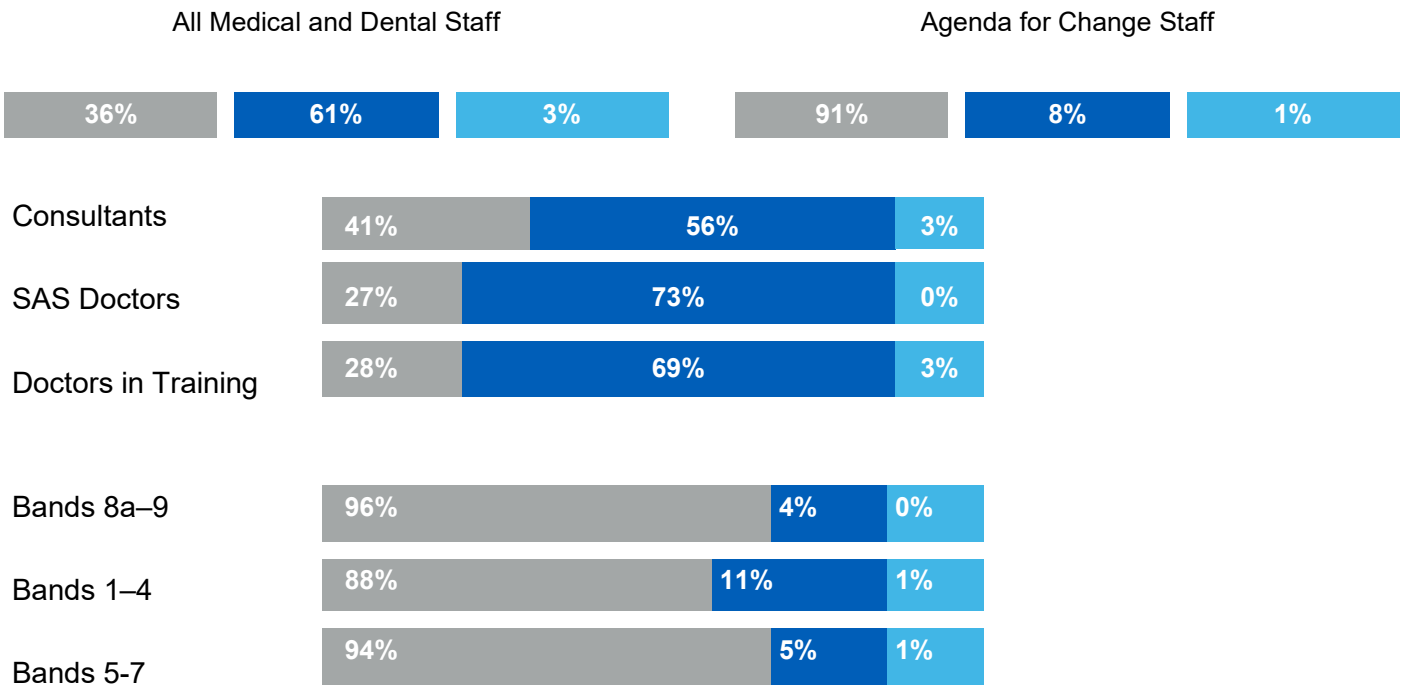
Section 2 – Ethnicity

The Trust employs 4,109 White employees and 536 BAME employees. A further 55 employees have chosen not to declare their ethnicity.

% Ethnic breakdown of England s working population	
White	86%
Black or Black British	3%
Asian or Asian British	7%
Mixed	1%
Chinese	1%
Any other ethnic group	1%
Not stated/unknown	0%

% Ethnic breakdown of the NHS Workforce	
White	76%
Black or Black British	6%
Asian or Asian British	9%
Mixed	2%
Chinese	1%
Any other ethnic group	2%
Not stated/unknown	5%

% Ethnic breakdown of the Trust s Workforce	
White	87%
Black or Black British	1%
Asian or Asian British	7%
Mixed	1%
Chinese	0%
Any other ethnic group	2%
Not stated/unknown	1%



Section 3 - Age

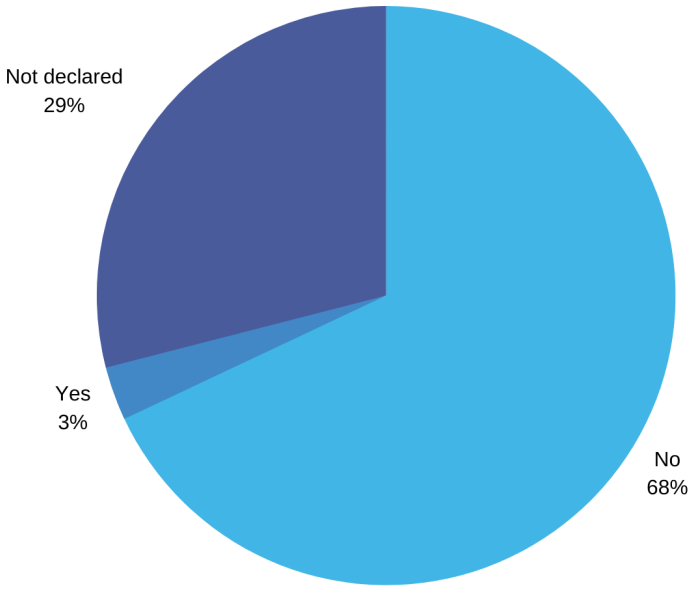
Of the 4,700 individuals employed by the Trust, the majority of staff are aged 56 to 60, closely followed by age 51 to 55 and then 46 to 50.

Age breakdown of England s working population		Age breakdown of the NHS Workforce		Age breakdown of the Trust s Workforce	
Under 25	12%	Under 25	6%	Under 25	6%
25 to 34	23%	25 to 34	23%	25 to 34	23%
35 to 44	22%	35 to 44	24%	35 to 44	24%
45 to 54	21%	45 to 54	28%	45 to 54	25%
55 to 64	18%	55 to 64	18%	55 to 64	21%
65 and over	4%	65 and over	2%	65 and over	2%

Section 4 - disability

Our data indicates that the majority of our employees (68%) have declared that they do not have a disability, as compared to 3% of employees who have declared that they do have a disability.

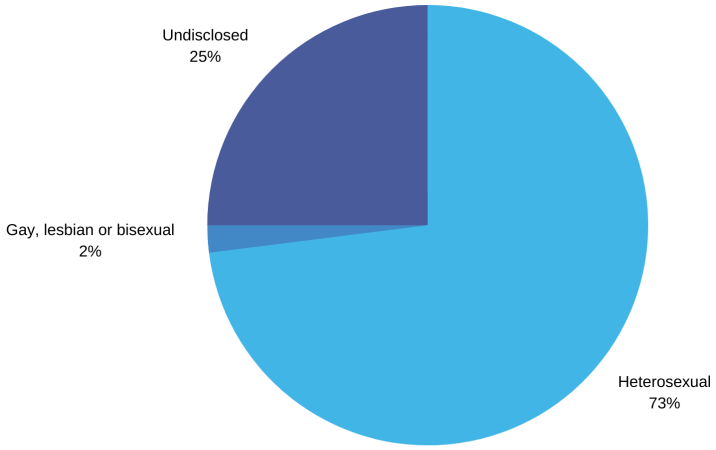
The information we hold relating to staff and disability continues to improve as there has been a reduction in the number of staff who have not declared their disability status from 36% in 2019/20 to 34% in 2020/21 to 29% in 2021/22.



Section 5 - Sexual Orientation

75% of our employees have declared their sexual orientation, whereas 25% have chosen not to declare their status. The number of staff choosing not to declare their status has reduced by 3% since 2020/21.

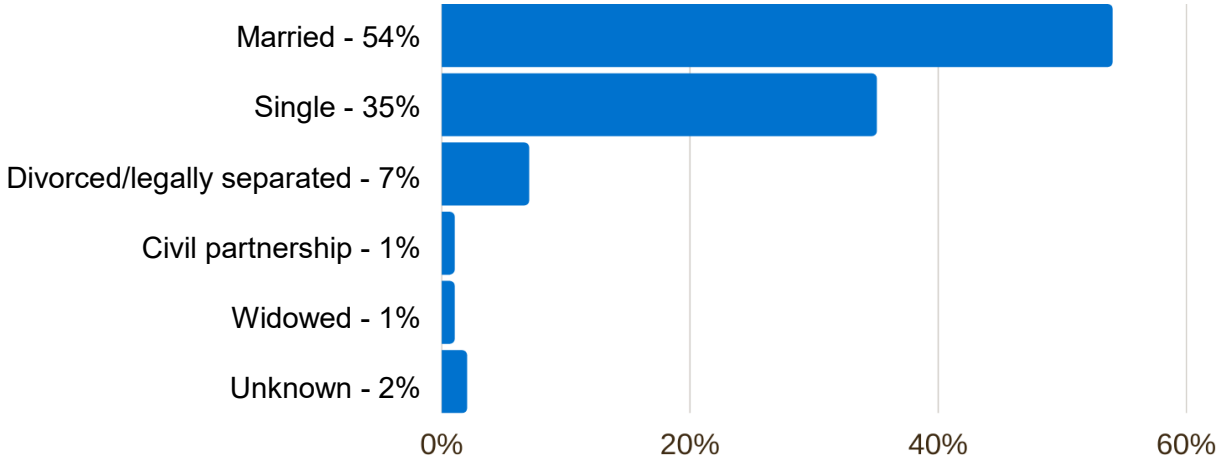
Of those employees who have chosen to declare their status, 73% of our employees have declared their sexuality as heterosexual, with a further 2% employees who have declared their status as gay, lesbian or bisexual.



Section 6 - Marital Status

Our data indicates that the majority of our employees (68%) have declared that they do not have a disability, as compared to 3% of employees who have declared that they do have a disability.

The information we hold relating to staff and disability continues to improve as there has been a reduction in the number of staff who have not declared their disability status from 36% in 2019/20



Section 7 - Religion and Belief

45% of our employees have recorded their religion as Christian, whereas 30% of staff have chosen not to declare their religion and 12% of staff have declared that they are Atheist.

Religion or belief	Number of employees
Christianity	2,135
Not declared	1,389
Atheist	554
Other	455
Islam	84

Religion or belief	Number of employees
Hinduism	60
Buddhism	15
Jainism	3
Sikhism	3
Judaism	2

Section 8 - Pregnancy and Maternity

5.1% of our staff (240 employees) have taken maternity/adoption or paternity leave in the last year.

Section 9 - Gender Reassignment

At present we are not able to report on this equality strand as these details are not captured on the standard documents/application forms that are used to gather personal details.

However, any member of staff currently undergoing gender reassignment is supported throughout their transition by their manager and an employee relations advisor, in relation to employment matters and workplace considerations.

North Tees and Hartlepool NHS Foundation Trust

Hardwick Road, Stockton on Tees, TS19 8PE

www.nth.nhs.uk

Board of Directors

Title of Report:	NTH Solutions Estates and Facilities Annual Report 2021 - 2022										
Date:	22 September 2022										
Prepared by:	Sharon Mee (Assistant Director Governance, Compliance & Company Secretary)										
Executive Sponsor:	Graham Walton, Chair & Mike Worden, Managing Director (North Tees & Hartlepool Solutions LLP Chair)										
Purpose of the report	Throughout 2021/22, the key function of NT&HS LLP was to optimise the operational effectiveness of the services it provides, whilst ensuring compliance with key legislation and ensuring the services adapt to the changing requirements of the Trust. This report provides assurances that services are delivered in a safe environment, employing safe practices and ensuring the safety of staff, patients and visitors. As well as ensuring all the services are delivered in accordance with best value principles, are of appropriate quality, efficient and on time.										
Action required:	Approve		Assurance	X	Discuss	x	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First		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 Estates and Facilities Annual Report highlights what has been achieved for the year 21/22 with reference to:

- MSA – number of reds reported
- Premises Assurance
- Model Hospital
- Capital Programme and Design and Development Service
- Carbon Reduction and Sustainability
- Departmental Key Achievements
- Health and Safety
- Fire
- Waste

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

Not Applicable

Committees / groups where this item has been discussed	NTH Solutions Senior Management Team 13.07.2022 NTH Solutions Management Board 21.07.2022
Recommendation	For information.

Estates and Facilities Annual Report

FINANCIAL YEAR 2021 / 2022

Presented: 13/07/2022

Reporting period:	FY 2021/22
Agreed by:	Mike Worden: NTH Solutions Managing Director

Estates and facilities management in health and care

Executive Summary

This has been yet another exciting and challenging year, with North Tees and Hartlepool Solutions (NT&HS) LLP continuing to mature and grow whilst endeavouring to meet the requirements and demands of its client and the ever-changing requirements of society and the NHS.

Throughout 2021/22, the key function of NT&HS LLP was to optimise the operational effectiveness of the services it provides, whilst ensuring compliance with key legislation and ensuring the services adapt to the changing requirements of the Trust. This provides assurances to the Board of Directors that services are delivered in a safe environment, employing safe practices and ensuring the safety of staff, patients and visitors. As well as ensuring all the services are delivered in accordance with best value principles, are of appropriate quality, efficient and on time.

The following resignations and appointments were made to NT&HS LLP Management Board this year:

- Stuart Irvine, NT&H NHS FT Representative resigned on 1th July 2021 as a voting member.
- Barbara Bright NT&H NHS FT Representative was appointed on the 1st July 2021 as a voting member.
- Lynne Taylor, NT&H NHS FT Representative resigned on the 31st October 2021 as a voting member.
- Neil Atkinson, NT&H NHS FT Representative was appointed on 1st November 2021 as a voting member.
- Sarah Hutt, resigned as Company Secretary (non voting member) on the 30th September 2021.
- Mr Brian Dinsdale, resigned as Chair on the 31st December 2021.
- Mr Steve Hall, was appointed interim Chair on the 1st January 2022 and resigned on 6th February 2022.
- Mr Graham Walton was appointed Chair on the 7th February 2022.
- Sharon Mee, was appointed as Company Secretary (non voting member) on 10th February 2022.

The efficiency of the Estates & Facilities services are annually benchmarked against the Lord Carter developed 'Model Hospital' metrics; these continue to indicate that services are delivered in the lowest cost quartile, which indicates cost efficiency again estate.

The procurement department are responsible for all third-party spend on behalf of North Tees and Hartlepool NHS Foundation Trust with the following exclusion; All Pharmacy spend is managed via the Pharmacy department, either through their own dedicated buyer or via regional Pharmacy arrangements.

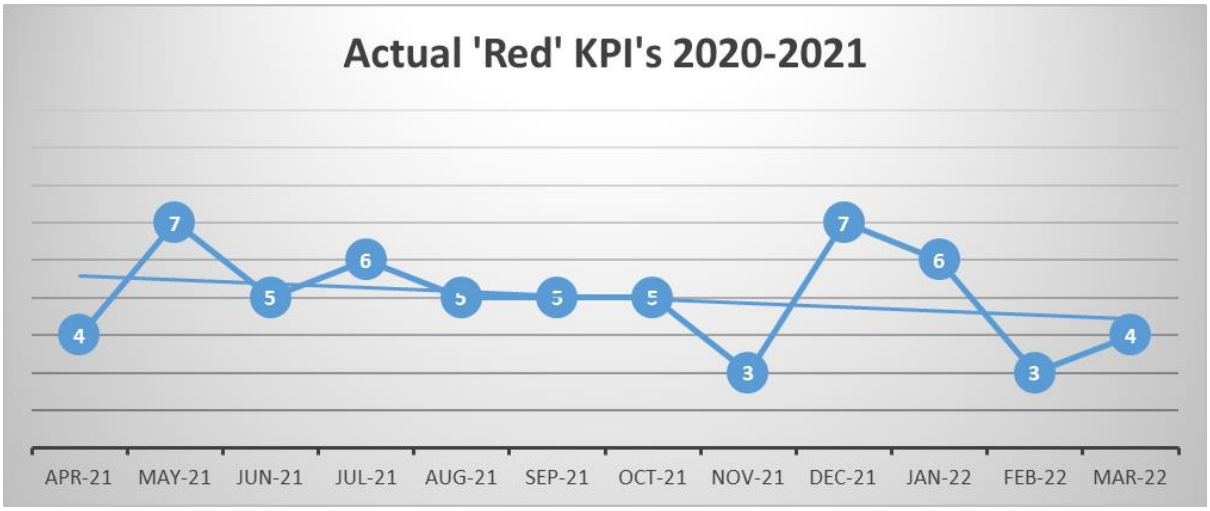
In addition, the Inventory Management Team provide a materials management service in a number of key areas within the Trust.

The businesses performance in delivering the Master Services Agreement (MSA) requirements is measured via Performance Indicators. A monthly report has been presented to the Trust MSA Operational Management Group which consists of a Performance and Assurance report which details the monthly Continuous Improvement Indicators (CII) and Key Performance Indicators (KPI) status and service failure notifications, implications and service pressure information. In addition deep dive reports are included if applicable when a performance indicator is of concern. An exception report is discussed at the Trust MSA Strategic Group at its quarterly meeting. The exception report details exceptions (primarily those performance indicators' which have shown a red target rating for the month).

The overall MSA contractual performance improved throughout the course of the year. Importantly, the graph below clearly demonstrates a downward trend of reduction in significant (red) KPI breaches throughout the course of the year representing a clear indication of continual improvement.

Four months of the year resulted in the red targets going above the trend line as follows:

- May 21 – clinical cleaning, physical assaults, catering income, sickness absence, electric demand, steam demand and procurement projects commenced against plan.
- July 21 – clinical cleaning, unwanted fire alarms, catering income, medical engineering routine repairs and cost of taxis.
- December 21 – unwanted fire signals, catering income, estates routine repairs, electric demand, steam demand and cost of shuttlebus.
- January 21 - catering income, sickness absence, estates routine repairs, electrical demand, steam demand and cost of taxis.



Out of a total of 95 Key Performance Indicators which are monitored by the Trust there have been 7 which have had 5 or more reds in a 12-month period:-

- Unwanted (False) Fire Alarm - NIL Brigade attendance (8);
- Catering income (10);
- Sickness Absence (12);
- Estates Repairs Routine Response Times <5 working days (7);
- Successful review of Total Electrical Demand – Monthly >2% reduction (6);
- Successful review of Total Steam Demand – Monthly >2% reduction (6);
- Cost of Taxis Service (5).

The performance achieved is excellent considering the many challenges, particularly whilst dealing with the Covid 19 pandemic, continuing to strive for growth and maintain compliance with relevant standards / legislation. In meeting these challenges the LLP has continued to play its part and achieved its aim through the dedication and hard work of all its staff.

Month	Number of Reportable KPI's Per Month	Green		Amber		Red		Not Applicable		Awiting Information		No target defined	
		KPI Count	% of Total	KPI Count	% of Total	KPI Count	% of Total	KPI Count	% of Total	KPI Count	% of Total	KPI Count	% of Total
Apr-21	95	65	68%	7	7%	4	4%	17	18%	1	1%	1	1%
May-21	95	62	65%	7	7%	7	7%	17	18%	1	1%	1	1%
Jun-21	95	65	68%	6	6%	5	5%	17	18%	1	1%	1	1%
Jul-21	95	66	70%	5	5%	6	6%	16	17%	1	1%	1	1%
Aug-21	95	70	80%	3	3%	5	5%	15	16%	1	1%	1	1%
Sep-21	95	66	69%	5	5%	5	5%	17	18%	1	1%	1	1%
Oct-21	95	65	68%	7	7%	5	5%	16	17%	1	1%	1	1%
Nov-21	95	69	73%	7	7%	3	3%	14	15%	1	1%	1	1%
Dec-21	95	66	70%	6	6%	7	7%	14	15%	1	1%	1	1%
Jan-22	95	67	71%	5	5%	6	6%	15	16%	1	1%	1	1%
Feb-22	95	66	70%	9	9%	3	3%	15	16%	1	1%	1	1%
Mar-22	95	67	71%	7	7%	4	4%	15	16%	1	1%	1	1%

Premises Assurance Model

The estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the NHS provides a safe, high quality and efficient estate. It is critical that none of these three elements are delivered at the expense of the other two. The objective is to deliver a financially sustainable NHS that takes quality and safety as its organising principle.

As part of this, assurance is needed that appropriate actions and investment are taking place. Assurance provides evidence and confidence for Boards and other interested parties that those actions needed to keep the NHS estate and facilities safe, effective, efficient and of high quality will actually occur.

In addition to supporting this NHS constitution right, the main benefits of the NHS PAM are to:

- Allow NHS funded providers of healthcare (NHS providers) to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe.
- Provide a consistent basis to measure compliance against legislation and guidance, across the whole NHS.
- Prioritise investment decisions to raise standards in the most advantageous way.

As the LLP is a subsidiary of North Tees & Hartlepool NHS foundation Trust and is supplying Estates and Facilities Services under a Master Services Agreement to the Trust it is appropriate for the LLP to carry out this assessment.

The NHS PAM is held and maintained by the NHS England and NHS Improvement, NHS Estates team. A user group made up of NHS trusts, regional colleagues and the Care Quality Commission (CQC) and other users oversees changes to the NHS PAM. Changes and updates to the NHS PAM will be approved by this group and implemented such that they will minimise problems for the NHS.

The PAM Self-Assessment Questions are grouped into five Domains, which are broken down into individual self-assessment questions and further sub-questions known as prompt questions. The six domains are:

- Safety (Hard and Soft)
- Patient Experience
- Efficiency
- Effectiveness

- Organisational Governance

The first four domains cover the main areas where estates and facilities impact on safety and efficiency. The organisational governance domain acts as an overview of how the other four domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the domains are reported to the NHS boards and embedded within internal governance processes to ensure actions are taken where required.

Findings

The PAM has been produced for the financial year 2021/22 and includes a self assessment to better understand the efficiency, effectiveness and level of safety with which the LLP manages their estate and how that links to patient experience. It also includes the 2022/23 corporate action plan see Appendix 1.

- 47 of the self-assessment questions, have increased in their rating this year, in comparison to the previous year;
- 17 self-assessment questions have decreased in their rating this year, the reason for the decrease and the actions required to increase the ratings are detailed in the action plan;
- 42 actions are detailed in the action plan which require evidence to support them in order to raise the scoring (See Appendix 1);
- The overall ratings following the assessment were categories as:
  - Outstanding = 25
  - Good = 239
  - Requires minimal improvement = 23
  - Requires moderate improvement = 14
  - Inadequate = 0
  - Not Applicable = 34

Areas in which the Trust Obtained a Rating of Outstanding

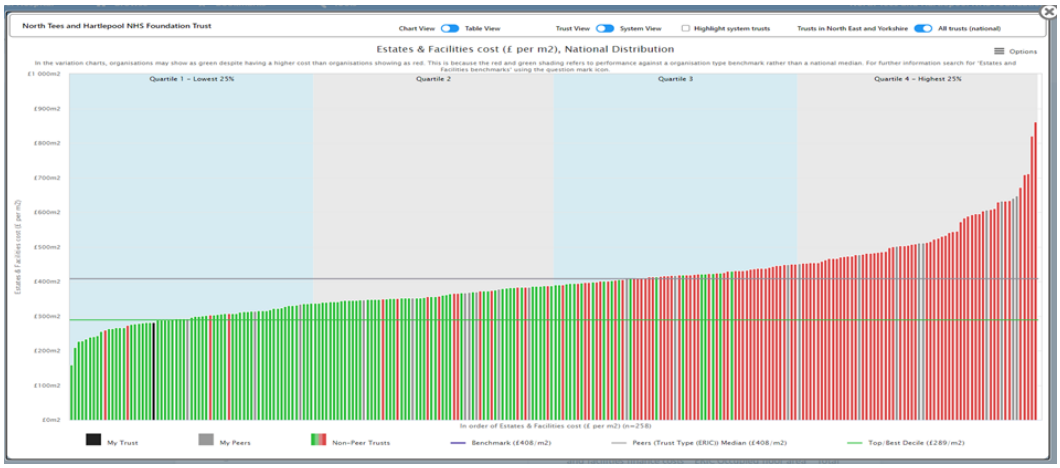
No Domain received a complete average score of outstanding. Some self-assessment questions within certain domains did receive an average score of outstanding, these were:

- Safety Hard (SH4) Health and Safety x 3
- Safety Hard (SH5) Asbestos x 5
- Safety Hard (SH6) Medical Gas Systems x 3
- Safety Hard (SH8) Water Safety Systems x 3
- Safety Hard (SH11) Ventilation, Air Conditioning & Refrigeration Systems x 2
- Safety Soft (SS1) Catering x 2
- Safety Soft (SS2) Decontamination x 5
- Governance (G3) - Professional Advice x 2

Model Hospital Metrics Estates & Facilities

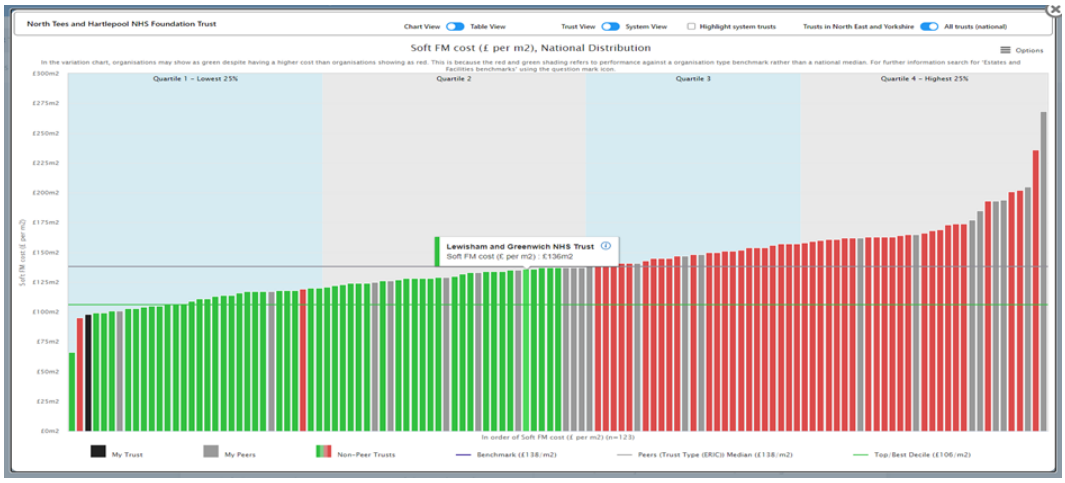
ERIC Return 2020/21 -1st Lowest Cost from 23 (Peers) Medium Sized Acute Trusts Nationally: NHS Digital published the Model Hospital benchmarks for all Estates and Facilities services for each Trust nationally in October 2020. This is populated from 2020/21 Estates Return Information Collection (ERIC) information that was submitted by the LLP on behalf of the Trust in June 2021.

After analysis of the results, North Tees and Hartlepool NHS Foundation Trust is within the lowest quartile (good) for all Trusts (which includes community hospitals and ambulance Trusts) and are ranked as 23rd place nationally out of 258 Trusts compared to last year which was 50th out of 223 for the estates and facilities services that are provided by the LLP. This is a significant indicator demonstrating that the LLP is delivering good value for money for the Trust.



The Trust performs very well in terms of estates and facilities cost per square metre – it is in the lowest 25% quartile for total occupied floor area in operational use. The Trust value with regard to running costs of the total occupied floor area is £282m^2 compared to its peer median of £335m^2 and benchmark value £408m^2 this gives an indication of cost efficiency against the estate.

This metric compares the hard FM running costs to the occupied floor area and provides an indication of the cost efficiency of the hard FM function of the estate. The higher the cost per unit area, the lower the cost efficiency. Hard FM costs make up one component of the total running costs which is made up of three parts: hard FM, soft and financing costs. Changes to this metric can be the result of movements in either of these elements year-on-year. The Trust value with regard to Hard FM Costs is £60m^2 compared to its peer median of £88m^2 and benchmark value £102m^2 this gives an indication of cost efficiency against the estate.



This metric compares the soft FM running costs to the occupied floor area and provides an indication of the cost efficiency of the soft FM function of the estate. The higher the cost per unit of the areas the lower the cost efficiency. Soft FM costs make up one component of the total running costs which is made up of three parts: hard FM, soft and financing costs. Changes to this metric can be the result of movements in either of these elements year-on-year. The Trust value with regard to Soft FM Costs is £98m^2 compared to its peer median of £117m^2 and benchmark value £138 m^2 this gives an indication of cost efficiency against the estate.

The LLP has continued to provide a safe, patient-centred, efficient and effective estate, with a record of achievement and a culture that strives for and delivers continuous improvement.

Benchmarking undertaken nationally on behalf of Lord Carter against all other small/medium size Trusts provides assurance that our Estate and Facilities services was placed in the 25% quartile nationally in the NHSI Model Hospital Report and 1st Lowest Cost from 22 Medium Sized Acute Trusts Nationally for estates and facilities services meaning the service the Trust receives is one of the most cost efficient and safe estates and facilities service in the UK.

Capital Programme and Design and Development Service

Capital Programme Performance 2021/22: The long-term estates strategy continues to be to rationalise the existing old estate to centralising into core buildings and the disposal of surplus estate or to attract business developments which utilise the existing surplus estate. At all times ensuring the estate is maintained in a safe condition while achieving performance standards and patient expectations. The NHS Improvement Compliance Framework requires that a minimum of 85% and a maximum of 115% of the original capital allocation should be spent on a monthly basis. Only goods and services that have been received or invoiced may be counted as expenditure.

At the end of Q4 21/22, expenditure (invoices and accruals) was £29,867,259, against a budget of £31,891,000, which is 93.7 % of the Trust's planned spend for the year.

Increasing Backlog Maintenance Position: During the FY 2021/22 capital programme, and taking maturing risk into account, the Trust's backlog maintenance costs across the whole estate increased by £14m, from £35.2m to a revised total of £49.2m. Critical infrastructure risk backlog maintenance increased from £6m to £19.7m. This is significantly due to the aging estate particularly on the North Tees site.

Theatre 1 Refurbishment and Future Proofing UHNT: Theatre 1 refurbishment has been planned with Care Group 3 in Q1 to minimise disruption to theatre services. Theatre 1 refurbishment is a high priority from a backlog maintenance point of view as the theatre plant is shared by theatre 1, 2 & 3. Any faults or downtime on this end of life plant risks affecting 3 theatres. The scope of the refurbishment works includes a dedicated ventilation plant for theatre 1 (reducing the above risk), installation of IPS / UPS to improve patient safety and future proofing enabling works to facilitate the theatre becoming an integrated theatre in the future. The design and procurement of the plant has now been completed with the majority of work was completed in Q4. The outstanding element is the new air handling unit which will not be installed and commissioned until early June 22 (due to supply chain issues).

A successful TIF bid has allowed integration to be added to the theatre refurbishment project to improve patient outcomes. Work commenced on site in January 2022 and is anticipated to be completed by the end of June 22.

Operating Theatre Light Replacement UHH/UHNT: The operating theatre lights within Theatres 2, 3 and 7 (UHH) and Theatre 10 (UHNT) are at end of life and in need of replacement. 4 LED operating lights were ordered and were delivered by 31st March. This was funded by underspend in other backlog areas and totalled £84k + vat.

Lift Replacement UHH: Replacement of the 3 ageing lifts in the acute block at UHH. The first lift was completed in Q4 FY21/22 with work continuing in relation to the remaining 2 lifts into Q1 and Q2 22/23.

Roofing Repairs UHH: A multi-year programme continues to progress, awarded to Group Tegula Ltd following a mini-competition in FY20/21. The contract value is capped at £2m, and includes flexibility to address the high risks roofs and other roofs in dilapidated conditions. The project relates to the roof replacement of Hartlepool Main Ward Block. The project was split into two phases to ensure continuity of resources and prevent costly demobilising at the end of March and remobilisation in FY22/23;

Phase 1 - £170,000 - Commenced in February and was completed by 31st March 2022.

Phase 2 - £497,588 and extra £10k contingency for market fluctuations. Overall cost £507,588 and started 1st April 2022 with completion in a couple of months.

An additional £30k contingency is in place to cover any unknowns. There will also be the removal and refitting of roof antennas to factor in which will be around £15k.

Total proposed spend is £553K spread over FY21/22 and FY22/23. Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

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

The final report is being reviewed currently but initial findings have identified work that is required to be carried out in the short term (FY22/23) and as follows:

North & South Wings

There are signs of carbonation behind a large number of concrete panels. This is due to the failure of the mastic sealants thus allowing water to ingress. There is a strong possibility that this will affect the vertical & horizontal fixings of the panels. The required works are the removal and replacement of all the existing mastic to prevent any further corrosion and carry out local repairs as needed. Some panels have significant cracks and need to be replaced. Mullions on the South Wing have previously been covered with sheeting without any remedial work being carried out and this will need to be rectified now.

In an area of the North Wing Basement, there are signs of cracking in the concrete structure which requires further investigation before a final report is issued. Testing is currently being carried with a further update to follow.

North Wing
Budget Cost: £500,000 (excl VAT)
Priority: 12 to 24 months

South Wing
Budget Cost: £930,000 (excl VAT)
Priority: 12 to 24 months

Tower Block

Above ground level there is evidence of cavity wall ties installed both during construction and also retrospectively. However, the wall ties are irregularly fitted and certainly not fitted in accordance with current BS regulations. Further calculations are being carried out on the North and South faces to establish if additional supports are needed to give support to the inner leaf (7.0 x 3.0 high) which is only visibly tied in at the left hand edge – nothing visible at top or bottom edges.

The outer and inner leaves are not cross bonded and there is no significant cavity between the two leaves. The retrospective ties are M10 Stainless Steel rod drilled and resin anchored into the ring beam and outer leaf (inner leaf is built from the top of the ring beam).

Budget Cost: £840,000 (excl VAT)
Priority: 6 to 12 months

Hospital Streets

There is evidence of the primary support steelwork starting to fail due to water ingress. There is also signs of corrosion to the primary pipework in the locations of the supports. Temporary solutions need to be installed before remedials can be addressed in the concrete, however, there is asbestos and lead

based paint present on both the pipework and walls. This will need removing first to allow the installation of temporary supports.

Once temporary supports are fitted and water ingress is stopped, a further option study would be required to decide on the best way to undertake the replacement of the primary pipework services and the method of connecting to the existing.

We expect to have the full survey report and recommended rectifications in Q1 of FY22/23 and any remedial work will be incorporated in the FY22/23 backlog maintenance plan, as a priority.

Budget Cost: £700,000 (excl VAT)
Priority: 6 to 12 months

Fire Door Replacement UHNT / UHH: The fire door replacement programme has begun with fire doors being repaired / replaced / upgraded due to operational damage and change of use over the life of the buildings. Fire doors have been replaced for high risk areas including Central Stores, Medical Records, Lung Health, main staircase and the main circulation corridors around the lower ground floor and ground floor. Additional funding has been brought forward in this high priority area and funded from underspend in other backlog areas.

The replacement works will continue on both sites into FY22/23. West Wing remains a high priority for FY22/23.

Fire Alarm Replacement UHH: The business case was approved in May 2020. Following an OJEU procurement tender, the project was awarded to TFS. The overall project cost is £1m, with £50K of spend in FY20/21 and the remaining spend in FY21/22. The installation is now 80% complete, with the majority of areas complete. The works has now extended into operational areas. The project team is working closely with the clinical teams to arrange access to clinical areas and using installation methods agreed with Infection Prevention and Control. The installation is planned to be completed by the end of Q1 FY22/23 with staff training and change over to follow.

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

The new CHP will ensure energy is provided consistently when required on site. The CHP will be a part of the sites future energy mix to deliver net zero carbon. The procurement stage has now been completed with Veolia being the successful bidder, the order has been placed and design and construction offsite has commenced.

The cost of the replacement CHP is £640K and is planned to payback in energy cost savings to the Trust in 4-5 years. The plant has a 10 year lifespan and is planned to be completed by Q2 of FY22/23.

Plate Heat Exchangers UHH: The ageing heating and hot water calorifiers will be replaced with modern energy efficient plate heat exchangers providing improved resilience and progress our path towards net zero carbon. This work was completed in March 2022.

Replacement Flooring UHNT: The works to replace the main entrance flooring have been completed. Works to replace fire doors and carry out redecoration will continue into FY22/23.

Patient Environment, Furniture and Equipment (PLACE): As approved by CRMG in February 80 high specification ultra-low beds including dynamic mattresses and digital pump packages (£257k) were purchased. This completes the bed replacement programme which has spanned 3 years. 300 Ward Bundle Packages were also approved and purchased which comprise over bed table, bedside locker and high back chair (£244k). Spend against Patient Environment, Furniture and Equipment (PLACE) was planned as a contingency to ensure that the backlog allocation for FY21/22 was fully utilised.

X-Ray Replacements: The 4 replacement x-rays for UHNT (x 2), Peterlee and UHH have been ordered with building enabling works due to be completed early in Q1 FY22/23.

AHU Replacement: Orders for the air handling units for Tower Block have been raised and the units have been delivered, installed and were commissioned by the end of March 22.

Other Estates Capital Developments

Community Diagnostic Hubs: Collaborative planning continues to deliver the Tees Valley element of the national plan to develop hub and spoke arrangements for diagnostic facilities outside of acute settings and within the community. Plans have been developed for the spokes at UHH, Stockton (Lawson Street) and Redcar (South Tees).

The spoke delivering additional MRI scanning capability became operational on the UHH site at the end of September with Respiratory and CT Scanning Services operational by the end of March 22. Works associated with Cardiology Services at Lawson Street were completed by the end of March 22.

An independent option appraisal was carried out by P+HS Architects to determine the location of the main hub (Stockton or Middlesbrough). The Waterfront development in Stockton is the recommended location and this will feed into the business case seeking capital funding approval.

The CDC Estates Project Group, which includes representatives from North Tees, CCG, NHS PS and South Tees supported the recommendation but have requested that the option appraisal is updated to include the provision of services at the Friarage. It is not anticipated this will change the recommendation.

PA Consulting appointed to support development of 22/23 business case for design and development of main hub.

Staff Recharge Hub Link Staircase From The Tees Dining Room (UHNT): As part of the 100 Leaders Challenge within the Trust and NTH Solutions, nominated candidates were asked to bring forward ideas to improve the estate for patients, visitor and staff. One of the early ideas that received significant support was to create a link from the Tees Dining room down to the staff recharge hub located on the floor below. This link would significantly improve access to the indoor and outdoor staff facilities within the recharge hub. The project is now completed.

Endoscopy Academy: This project is funded from a successful TIF bid that applied for external funding in October 21. The bid was approved by DofH in December 21 with the requirement to spend the money within the 21/22 FY. The money will fund a training endoscopy facility within the Endoscopy Department UHH used to train endoscopy staff from our Trust and potentially other Trust's in the Northern ICS.

The scope of works includes internal alterations within the Rutherford Morrison Endoscopy Unit that will create an endoscopy room and training room with appropriate audiovisual equipment to allow observation of operations for training purposes. Work commenced in Q4 and is planned for completion in Q1 FY 22/23.

As the design has developed a number of backlog maintenance issues have emerged associated with structural support, drains and electrical/mechanical infrastructure. This has required additional backlog funding (£200k) to be reallocated into the project. This has been funded from FY22/23 backlog allocation on other backlog areas.

There is still an agreed planned £100k pre commitment into FY22/23 from the original TIF allocation.

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

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

As part of this project CSSD also received funding for a low temperature steriliser and bespoke washer racks to support the decontamination/sterilisation of the Da Vinci Robotic Instrumentation.

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

The design work to achieve 1:100 drawing sign off for Phase 1 will be completed in Q1 FY22/23. 2 options were taken forward and will be costed to test against allocation and adjusted against inflation.

ICC Room: The current location of the RCC can only accommodate a small number of people. The space is used by the Clinical Site Manager, Bed Managers and the Transport Scheduler throughout the 24 hour period and at varying times others involved in capacity management and escalation. The function supports the resilience OPEL meetings and requires numerous other operational staff.

The new hub location is currently a redundant X-Ray storeroom. The space has been re-designed to provide a 10-person open plan office, as well as a 2-person office and a 1-person office. This involves the installation of new electrical and data services, new ventilation throughout (heating and cooling), upgraded sanitary ware, new ceilings and lighting, renewed flooring, appropriate IT facilities and improved disabled access.

The trust employed P&HS architects to carry out the design work and RPS to act as an engineering consultant. The room became operational w/c 18th April 22.

Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against an initial allocation of £3m and an additional allocation of £0.4m, a total of £3.4m. Of this, £3,354,063.40 has been ordered and receipted to date.

There are no outstanding items on the MER for 2022/23. Everything requested has been ordered and received or vested. This includes the following:

Patient Monitors Ward 23 Neonatal vital signs monitoring
Patient Monitors for Rutherford Morrison UHH & Endoscopy UHNT vital signs monitoring
Upper Limb Stack for surgical procedures on upper limbs
Zimmer Tourniquet System for surgery One Life Hartlepool Theatre
Luxmed Examination Light for Birthing centre UHH
Resuscitaires for Maternity for the care of new babies. They combines an effective warming therapy platform along with the components you need for clinical emergency and resuscitation
Endoscopes for Endoscopic surgery
Treadmill for heart function testing Cardiology
Operating Tables for UHH General surgery
Stryker Video Stack Upgrade to enable the system to be used for general surgery as well as breast surgery
Pencil Saw Surgical power tool system
TCI Infusion Pumps for pain management
Hoists for assisting with patient manual handling
Draeger Baby Incubators to closely control the environment of babies monitoring temperature oxygen and humidity
Nerve Simulator Modules for use with Mindray anaesthetic monitors during surgery
Trauma Chair suitable for bariatric patient handling for ITU
MRI Monitor essential for use in MRI environment to replace existing obsolete equipment
Sonosite Ultrasound Scanner for use in ITU to replace older machine that now falls short of the required image quality
SLE Transport Incubator to closely control the environment of babies in transport between departments monitoring temperature Oxygen and humidity
Surgical Headlights worn by surgeons to illuminate the site of surgery from their point of view
Topcon Optical Screening System to Peterlee hospital used for diabetic eye screening
Glidescope Monitors for ITU and Theatres used to assist in intubating a patient and correctly positioning the tube
CSM Patient Monitors for Pre-assessment units on both UHNT and UHH sites
Exercise Treadmill and CASE System PC for Cardiology assessment unit
Anaesthetic Machines to complete the upgrade of anaesthetic workstations on both sites

Carbon Reduction and Sustainability

The initial period of the Carbon Management Programme was completed successfully in 2016 achieving carbon reductions of 20%. Since then, a further targeted reduction of 2% per year, has seen carbon reductions reach more than 30%. The past 2 years have been heavily influenced by the COVID-19 pandemic, but this year has seen a rise in the carbon footprint of 7.2% against FY2020/21. This has been as a result of:-

- Increased clinical activity across the Trust (during covid and the ongoing covid recovery).
- Increased heating demands due to windows having been opened to aid airflow throughout COVID.
- Significant capital investment to provide new ventilation plant and equipment for new clinical services (A&E, Respiratory Support Unit and the third CT scanner being significant elements),

- In addition, the introduction and utilisation of 52 electric vehicle charging points across the 3 main sites, which now accounts for 2.5% of Trust's electrical load.

Over the past 2 years, a further £580k of Trust capital has been spent on LED lighting and upgrades to the building management system and air conditioning to improve energy efficiency and reduce the carbon impact with a return on investment of 3 years. Further funding has seen more energy efficient lifts and air-handling units installed as part of the capital investment in backlog maintenance.

On-site solar panels generating "Green" Electricity" on the UHNT site have generated over 686,000 kWh's of green and free electricity. This is enough to power over 190 homes for 1 year. This has also saved the Trust circa £102,000 off its electricity bill to date.

NTH Solutions is working with Veolia Environmental Services on a feasibility study with the potential to significantly reduce the carbon footprint. The aim is to seek funding through the government's Public Service Decarbonisation Scheme (PSDS) and where possible seek Trust capital. The full report is due in July, but a high level investment summary has been presented to identify some early measures.

The Trust Green Plan was also developed and approved at Trust Board in 2021, as part of the wider ICS strategic drive to net zero carbon. This has rightly raised the bar for the annual carbon reduction target to 5%. In reality, the reductions are likely to be "step change" reductions as new renewable plant becomes operational and new technology solutions emerge rather than an a consistent annual 5% reduction.

Under the Climate Change Act 2008, the Government introduced the Carbon Reduction Commitment (CRC) – an additional tax burden for larger, 'energy heavy' organisations. The Trust was required to register as a participant for Phase 1 and paid costs of £140,000 in 2011/12. Due to CHP availability, the trust did not qualify for Phase 2, where costs would have risen to more than £200,000 per year.

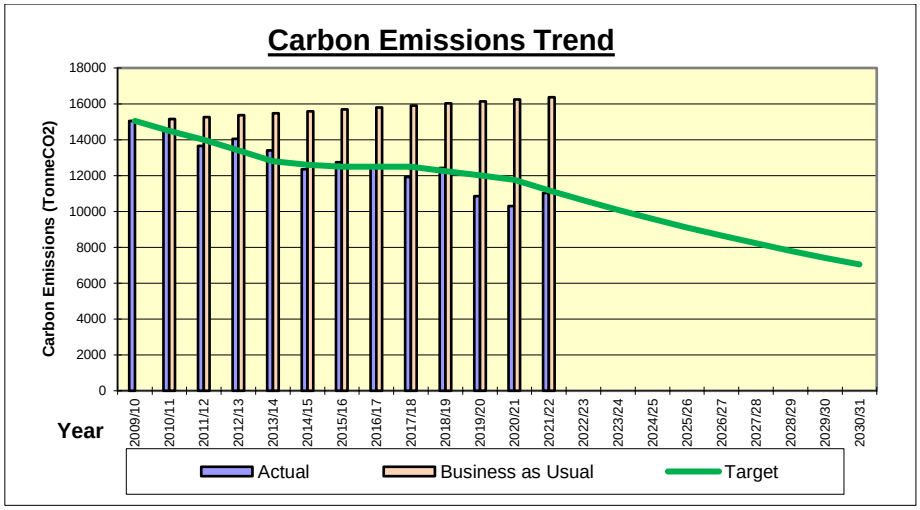
A further benefit of having the CHPs on each site is that the Trust is virtually exempt from Climate Change Levy (CCL), which has now increased to 0.465p/kWh. This has avoided over £265,000 of costs on the annual gas bill.

NTH Solutions spent £2.17M on Gas and Electric during FY2021/22 on behalf of the Trust. This is a significant increase (38%) on previous years and was greatly influenced by price increases in Oct 21 and then the Ukraine Conflict starting in Mar 22. The cost impact will continue to be felt into FY2022/23 and beyond.

Carbon Emissions (2021/22)

Notwithstanding all the good work and investment, the carbon footprint for FY2021/22 increased by 7.2% [using the 2010 benchmark system] to 11,034 TonnesCO_2e.

Nonetheless the trend in carbon reduction is still on target and, subject to approval, new schemes will help advance further reductions.



Key Achievements

During 2021/22, North Tees and Hartlepool Solutions LLP have achieved the following:

Catering:

- Work started on redesigning catering services, including work on an organisational change paper to support work to bring in-house all catering provision for patients, staff and visitors. Our aim is to deliver the best in nutrition and hydration for our patients through quality and choice whilst utilising fresh local produce. Our local produce initiative also supports our commitment to reducing our carbon footprint. We anticipate we will be able to complete this work by October 2021, and are working closely with nursing representatives and dieticians from a nutrition and hydration perspective although initially menus will not alter.

CSSD:

- The CSSD received investment this year when 3 of 4 Getinge sterilisers were upgraded with clean steam generators. This future proofed the service for the next 10 years. In preparation for the UHH upgrade the Automatic Endoscope Washers (AER's) and storage cabinets were replaced with "state of the art" equipment. This will ensure the Endoscope Decontamination Unit at UHH is fit to meet the challenges of the expected demand in endoscope re-processing.

- CSSD had its planned visit by the AE(D). She completed the JAG / IHEEM audit at North Tees. Following the completion of the upgrade at UHH the AE(D) returned in November to complete the JAG / IHEEM audit on this site. The North Tees endoscopy decontamination department is accredited to ISO 13485 and all processes were deemed satisfactory. The AE(D) confirmed that she had signed the relevant validation reports carried out on the currently installed equipment (MMM / Cantel machines).

Domestic & Linen Services

- Continued to support the Trust in provision of Domestic double running, awaiting decision on funding as this is giving a considerable cost pressure.

- For February, Linen and Laundry and Energy Collections - NTH Solutions received a request from NHSI/E to provide a response to a data collection request regarding Linen and Laundry and Energy Collection. The response for Energy Collection was issued to NHSI/E on the 22 February 2022 and the response for Linen and Laundry was issued on the 24 February 2022.

Estates

- Taking opportunities from our Utility purchasing strategy, we were able to optimise savings because of the significant dip in Gas pricing during 2020 as a direct result of the Wave 1 Lockdown. Many organisations would have purchased their gas and locked in prices – generally about 2p/kWh. We were able to take advantage of prices dropping as low as 0.8p/kWh. We continue to benefit from a healthy portfolio moving into 2021/22 and currently pay 1.85p/kWh. This has realised a cost avoidance of some £45,000 in 2020/21. Due to a number of issues at a national and international level, the price of natural gas is going up. We have been protected to some extent by the bulk-buying contract with INENCO that the Trust is within, where cheap gas was procured during Covid. We are now starting to see gas prices creep up to levels just prior to Covid and it is unknown at this time how long prices will continue to rise. This will likely be a continued risk over winter and until the end of this financial year. NTHS will continue to make all efforts to minimise this effect as we go through the winter.

- A 20% gas price increase for November and December was flagged by the provider (3.6 p/kWh); best advanced intelligence is that the price may then start to reduce. The cost of gas has increased significantly in recent months as reported nationally. This has been felt in the gas prices to the Trust – July 1.9p/kWh, August 2.3p/kWh, September 2.7p/kWh and 3.6p/kWh for October. The Trust has been protected against the worst of the changes by utilising a broad term procurement strategy, which locked in a proportion of the gas at prices ahead of the surge. The surge has still had an effect and best estimates are for the price to rise and then remain about 3.6p/kWh for November, December and January.

- The Capital Planning and Property Manager left the organisation to work for NHSI. We have completed an appointment process with just due diligence to be completed, hopefully to allow a new appointee to commence working early / mid-June 2021.

- 6 Facet survey completed by WS Atkin Group and Faithful and Gould for the North Tees site. (UHH site 6-facet survey is not due to take place until Financial Year 2022/23).

- Further, from having a limited incoming electrical demand, we were able to set our electric purchasing prices at a good price for the entire year; as such, we will be protected from a price surge in July 2020. Whilst the provider initially billed at the higher rate, we have fought our case and have been successful in obtaining a rebate for the difference i.e. £8,300.

- Storm Arwen caused significant damage to a number of trees, roofs and Covid cabin canopies across all hospital sites. The NTH Solutions Team escalated and called out

additional staff over the evening / night of 26 November to carry out work to ensure the Trust estates were kept safe. Works continued on the Saturday and Sunday to bounce back and ensure all services were operationally ready for the Monday morning.

- We were advised by NHSI/E that the prediction (while we remain fairly static with our waste, and have no current issues) is that there will be a significant increase in waste and therefore significant decrease in the amount of capacity available across the NHS for waste incineration. We responded to an NHSE/I request for information re our contingency plans and the plans as below (A-C).

    - Plan A – Our current collection is around 45 carts per collection twice per week (we are actually back down to pre-covid levels for clinical waste production although we did introduce more offensive waste, which could have distorted the figures). We have 120 x 770lt carts available for use on site plus we 12 x 1100lt carts from when HES went into liquidation. We could easily miss a collection or maybe two without this causing an issue. We would prioritise the incineration clinical waste to be removed first, so if we need to go to Plan C we would only store orange bag waste.

    - Plan B – Our Offensive and Non-Hazardous Pharmaceutical waste both go to our local Waste-to-Energy Incinerator operated by Suez (5 miles away from our site), which has 5 separate lines/incinerators, so we are not dependant on Clinical Waste capacity for these waste streams. Most of our sharps go to Sharpsmart, the Sharpsmart final disposal route is a TFS arrangement to Sweden so this stream is unaffected by the UK clinical waste capacity.

    - Plan C – We would bring in shipping containers if we had to store clinical waste as we did when HES went into liquidation, we could have containers within a couple of days.

Governance

- In previous years, each NHS Health Body has been asked to complete a self-assessment tool for the Premises Assurance Model (PAM). This year NHSE/NHSI developed an online reporting system and the results of the PAM for 2020/21 have to be uploaded into the system by the 23 July 2021. The LLP successfully uploaded the PAM 2020/21 results on the 21 July 2021.

- Kerry McLean (Information Governance) confirmed The DSP Toolkit for 2020/2021 has been submitted. NHS Digital were planning to release the 2021/2022 Toolkit on the 20 July 2021, work commence as soon as it was received.

- There was a failure to review the Reverse Service Level Agreement Specifications by the end of March 2022 as required by the Audit One outstanding recommendation due to the Trust requesting longer time to review. This work is still on-going.

- There was a failure to review the Master Services Agreement Specifications by the end of March 2022 as required by the Audit One outstanding recommendation due to:-

6.3.1 no review requested by the Trust on the main General Specification; and
6.3.2 the Trust requesting a 3-month pilot of the revised specifications prior to any formal agreement being confirmed.

Health and Safety

- Lean Approach West Wing Landing – Lean Approach West Wing Landing – We continue to have real problems with bed storage, this is directly as a result of creating the albeit fantastic facility in the rainbow room. However, this has compromised our bed storage facility. In turn unfortunately, this results in beds being stored in areas that aren't always appropriate and does increase the likelihood of beds being seen on landings etc. Due to the requirement of replacement beds being required in order to ensure the safe transfer of patients (when a bed breaks down); there will always be a requirement to keep approx. 20 spare beds. Request made to that ward staff be reminded of the process that when they push beds or other equipment onto landings, they ring the porters to make them aware. The portering team will endeavour to respond as soon as is operationally (dependent on patient moves). In addition, a general reminder for all that the responsibility for keeping landings and corridors free from clutter sits with everyone. We all have a responsibility to keep our areas clutter free, if we see it, we must deal with it.

- The Fire Safety Advisor left the LLP on 6th May. Elements such as the Fire risk assessment and Fire warden training was covered by the Health and Safety Team. Technical aspects and being covered by the Estates Team. CFB Risk Management Services (who supply our Authorising Engineer for Fire) was approached to request that they provide technical cover. Whilst we are waiting for a response from CFB, NTH Solutions have gone at financial risk and advertised a full time role as the 3 days per week funding from the Trust was not gaining any market / candidate interest. The Fire Safety Advisor post was advertised three times, due to the specialist aspects of the role and not being able to appoint. For 4 months, the Health and Safety Team have had no Fire Safety Advisor in place, which has caused considerable resource pressure. A new Fire Safety Advisor has been appointed and commenced employment in October 2021.

- An internal Legionella Audit was completed by NTHS Health and Safety Team. No major non-conformances found. Also, a full Legionella Risk Assessment review was completed of the Link Area at North Tees by consultant Alan Edwards (Authorising Engineer).

- 137 PK6 Observational health and safety inspections for individual areas covering general health and safety and the production of summary reports for the Health, Safety and Security Committee;

- 195 PK3 Fire safety inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 123 PK7 Waste compliance inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 21 Covid Environmental Safety risk assessments. Conducted by the team, initially in all areas then continued in communal areas across the hospital sites;

- 4 written Contractor Safety Inspections – not including visual inspections

- Audit for Containment level 3 pathogen processing in Pathology;
- 12 Union walkabout inspections, continuing monthly;
- Communication of 42 CAS alerts with collation of responses and sign off where applicable;
- Production and monitoring of bi-monthly non-clinical incident reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;
- Production and monitoring of bi-monthly risk reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;
- Production and monitoring quarterly safer sharps compliance reports for individual Care Groups and the Medical Devices Committee;
- 16 fire warden sessions were delivered and 71 staff trained.

Fire Safety

The Trust has a Service Level Agreement in place with an external Authorising Engineer (Fire) employed by Cleveland Fire Brigade Risk Management Services who acts as an independent professional adviser to the Trust & the LLP. The remit includes:

- assesses and makes recommendations for the appointment of authorised persons (Fire);
- monitors the performance of fire safety management;
- Provides an annual audit to the Board Level Director with fire safety responsibility as required by in Hospital Technical Memorandum (HTM) 05:01 Managing Healthcare Fire Safety who provides external fire safety assurance.

In the most recent annual report received, it was noted that further progress has been made across the North Tees & Hartlepool NHS Foundation Trust. The installation of the new fire alarm systems has progressed with the new system at University Hospital of North Tees becoming live. Further work is being carried out on compartmentation and a further compartmentation survey is to be commissioned during 2022.

The Trust continues to have a mixture of assets, some ageing and built to differing standards that were relevant at the time of build. There is a desire to provide modern facilities and challenges are faced with regard to upgrading existing facilities. The Fire Safety Advisor is consulted at an early stage of proposed new works and alterations. Where possible the Trust is striving to achieve standards as set out within HTM guides and where this is not possible, it aims to achieve a suitable compromise. This can prove challenging with ageing assets that do not fully comply with relevant HTM guides.

From the evidence assessed, it continues to be the case that fire safety is taken seriously by the Trust with appropriate actions taken when required. A number of recommendations from last year's report (June 2021) have been included on in a work plan, which sits with the Fire Safety Advisor and is scrutinised by the interim Fire Safety Manager.

Strategically there remains an effective management structure in place and responsibilities have been assigned appropriately together with appropriate governance arrangements. It is understood that, for Assurance and Governance purposes, Levi Buckley is the Trust Board member responsible for Fire. Mike Worden is the Managing Director of the LLP and reports all issues through the Master Service Agreement Strategic Group and Masters Service Agreement Operational Management Group meetings. Any issues are also reported via the Health, Safety and Security Committee meetings.

Overall, the standard of the strategies, policies and procedures reviewed were of a good quality, a number of which have been reviewed since the last report and are now published documents. Significant investment continues to be made and allocated to fire safety systems in times of stringent financial pressures. This demonstrates that the Trust takes the responsibility of keeping people safe from fire seriously and is of a high priority.

A Management of Fire Safety Policy is in place covering all properties within the Trust. The 'Fire Strategy University Hospital of North Tees' has been replicated for the University Hospital of Hartlepool. Both are useful documents. The documents are currently subject to a review.
Work continues to be carried out with regard to forward planning for reducing backlog maintenance with fire safety taking a significant role. This plan covers a five-year period and the Trust to date is in year 4. The replacement fire alarm system at University Hospital of Hartlepool is due to be commissioned in the summer of 2022.

None of the Trusts' properties are subject to any form of enforcement action by the respective Fire Authorities.

It is important that fire risk assessments (FRA's) (in the form of PK1's and PK3 inspections) are reviewed frequently. The current process indicates that all fire risk assessments will be reviewed annually. This process will need close monitoring to ensure that the outcomes meet the demand. The completion of PK1's by local managers needs to be re-invigorated and this has been noted and forms part of an action plan.

A live play evacuation exercise has been carried out with another scheduled for the very near future. The actions from previous reports have either been addressed or form part of a Fire Action Work Plan and are therefore not repeated within this report. The recommendations made within this report are intended to build on the work that is currently taking place within the Trust regarding matters relating to fire safety.

The following recommendations have been put forward in this report to assist in further developing the fire safety arrangements across North Tees and Hartlepool NHS Foundation Trust. Previous recommendations that form part of on-going action plans are not repeated. Recommendations were made that:-

- An audit of the process for conducting fire risk assessments (PK3's) is carried out with the Fire Safety Advisor to ensure that the current arrangements meet the requirements of the RR(FS)O.
- A system is put in place for the Fire Safety Advisor to audit the commercial premises within the hospitals to ensure a fire risk assessment has been carried out by the responsible person for each area.

- The revised Training Needs Analysis includes a programme of refresher training for Fire Wardens with a recommended time period of two yearly.

- As the Covid-19 situation eases, it is suggested that a programme of Level 2 fire drills is established that includes closer working between wards and departments to ensure that, should a fire occur, all staff are aware of what to do not only in their own area but in also neighbouring areas.

Portering:

- The Portering and Transport Manager retired and since April 14th will only work 3 days a week currently Monday, Tuesday and Wednesday. We implemented a structure review to accommodate the new change.

Security:

- Lost income from disabled parking fees which in the first quarter April 2021 to June 2021 equated to £17,620 lost income. This equates to 4,405 applicants who would have had to pay £4 each time to park their vehicle.

- There were a total of 859 incidents in the Abuse, Violent, Disruptive, Self Harming Behaviour category. A total of 163 (19%) physical assaults (malicious/unintentional) were committed on staff by patients or visitors during the year April 2021 to March 2022, compared to 141 the previous year, an increase of 16% per cent. Of the reported physical assaults 156 occurred within North Tees, 5 occurred at Hartlepool and 2 in the community.

- It should be noted the majority are non-intentional and are caused by the patient's medical condition. It is important to note that out of 163 assaults, it was necessary to involve the police with 24 incidents. 8 of these were in the malicious category and 16 in the unintentional category. The malicious unintentional were related to alcohol and drugs but the patients did not have capacity at this point.

Waste

A breakdown of all wastes created within the Trust from 2016 to date. It shows a slight increase in overall waste of only 0.3% in 2021/22. A decrease in clinical waste of 31% for 2021/22 compared to the previous year.

Period	Hazardous Clinical	Autoclave / waste to energy %	Pharm (Waste to energy)	Inert Landfill	Bulk Waste Transfer Station Potential Landfill	Waste to energy	Confidential	Metal	Cardboard	Mixed Recycling	Garden Waste	WEE	Furniture / Equipment	Total Waste	Total % Recycling
2016/17	378	76	0	0	64	819	275	12	51	0	0	39	0	1714	22%
2017/18	265	85	0	0	51	893	293	8	41	0	0	10	0	1646	21%
2018/19	182	78	0	0	23	859	275	10	44	0	0	6	0	1477	28%
2019/20	196	107	0	0	0	951	231	14	32	18	13	5	0	1567	23%
2020/21	284	124	0	0	51	681	175	20	49	28	13	10	0	1435	23%
2021/22	196	87	15	0	61	810	146	21	66	19	5	14	1	1440	21%

21% of waste produced was clinical whilst 79% was domestic/offensive. (It is difficult to quantify domestic/offensive split)

A decrease in clinical waste from 408 to 298 tonnes, as waste was directed from clinical to domestic/offensive due to reduction in Covid 19 patients.

Total Clinical Waste Disposal Costs 2021-2022 = £153,926.00 which equates to a 29.25% decrease £63,636.69 in costs from last year.

A decrease in overall recyclable waste of 2% for 2021 / 2022 compared to the previous year. The decrease is due to the reduction of confidential waste. (Although 31.11% of all domestic waste is recycled which is more than double the 14.8% figure of last year).

A decrease in clinical waste of 27% for 2021/2022 compared to the previous year, due to the Covid 19 patient reduction.

There is a decrease in confidential waste from 175 to 146 tonnes (29 tonnes or 17%), due to review of confidential waste bin activity on implementation of new confidential waste contract, as this stream is recycled the decrease does contribute to reduction of the overall recycling percentage. (It should be noted that confidential waste is not actually weighted but and industry average weight is used based on full bin weights). It is important to fully utilise the space in these containers. A review of confidential waste at the start of the new contract removed 10 bins from the weekly automatic list is these bin were not being filled.

Offensive waste is included with the domestic figures, it is mixed with the domestic for waste to energy incineration, so difficult to quantify. Offensive waste is non-hazardous healthcare waste EWC 18-01-04.

A new column has been added this year to signify the amount of waste reused, A nominal 1 tonne has been used this year (although more than 1 tonne has probably been reused), it is hoped in years to come this can be measured more accurately and show an increase.

Conclusion / Summary

The LLP has continued to provide a safe, patient-centred, efficient and effective estate, with a record of achievement and a culture that strives for and delivers continuous improvement. Benchmarking undertaken nationally on behalf of Lord Carter against all other small/medium size Trusts provides assurance that our Estate and Facilities services was ranked within the lowest quartile (good) for all Trusts (which includes community hospitals and ambulance Trusts) and are ranked as 23rd place nationally out of 258 Trusts compared to last year which was 50th out of 223 for the estates and facilities services that are provided by the LLP. This is a significant indicator demonstrating that the LLP is delivering good value for money for the Trust, meaning the service the Trust receives is one of the most cost efficient and safe estates and facilities service in the UK.

Recommendation

The Board is requested to receive this report and note the work undertaken in 2021/23 to support patient services across the Trust Estate.