North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 24 November 2022
at 10.30am

Boardroom
University Hospital of North Tees

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
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18 November 2022

Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 24 November 2022 at 10.30am** 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.	(10.30am)	Apologies for Absence	Chair
2.	(10.30am)	Declaration of Interest	Chair
3.	(10.30am)	Patient Story	L Robertson
4.	(10.50am)	Minutes of the meeting held on, 22 September 2022 **(enclosed)**	Chair
5.	(10.55am)	Minutes of the extra ordinary meeting held on, 6 October 2022 **(enclosed)**	Chair
6.	(11.00am)	Matters Arising and Action Log **(enclosed)**	Chair
	Items for Information		
7.	(11.05am)	Report of the Joint Chair **(enclosed)**	Chair
8.	(11.15am)	Joint Partnership Board Update (verbal) - Carnall Farrar update	S Hall
9.	(11.20am)	Report of the Chief Executive **(enclosed)**	J Gillon
	Performance Management		
10.	(11.35am)	Board Assurance Framework Quarter 2 Report 2022/23 **(enclosed)**	H Heslop

11. (11.45am)	Integrated Compliance and Performance Report **(enclosed)**	L Hunter, L Robertson, N Atkinson, S Cook

Strategic Management

12. (12 noon)	Capital Performance Report Quarter 2 Report 2022/23 **(enclosed)**	N Atkinson
13. (12.10pm)	Elective Recovery Update **(enclosed)**	L Buckley
14. (12.20pm)	Data Protection and Cyber Assurance Report **(enclosed)**	G Colquhoun
15. (12.30pm)	NHS Core Standards for Emergency Preparedness Resilience & Response – Compliance and Organisational Capabilities **(enclosed)**	L Buckley
16. (12.35pm)	Winter Resilience Plan 2022/23 **(enclosed)**	L Buckley

Governance

17. (12.45pm)	Care Quality Commission Update (verbal)	L Robertson
18. (12.55pm)	Learning from East Kent Maternity Services Report **(presentation)**	L Robertson
19. (1.05pm)	Learning from Deaths Report Q2: 2022/23 **(enclosed)**	D Dwarakanath
20. (1.15pm)	Guardian of Safe Working Hours Report **(enclosed)**	D Dwarakanath

Items to Receive

21. (1.25pm)	Board of Directors and Council of Governors Meeting Dates 2023 **(enclosed)**	
22. (1.25pm)	Any Other Business	Chair

Date of next meeting
(Thursday, 26 January 2023, Boardroom, University Hospital of North Tees)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing Our People

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

Transforming Our Services

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

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors held on Thursday, 22 September 2022 at 9.30am at the University Hospital of North Tees / Via Video Link

Present:

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

In Attendance:
Sarah Hutt, Company Secretary [note taker]

Via video link
Tony Horrocks, Lead Governor / Elected Governor for Stockton
Margaret Docherty, Elected Governor for Stockton
Pauline Robson, Elected Governor for Hartlepool
Emily Craigie, Reach plc

BoD/4871 Apologies for Absence / Welcome

There were no apologies for absence noted.

The Joint Chair welcomed everyone to the meeting.

BoD/4872 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/4873 Patient Story

The CN/DoPS&Q shared a story on behalf of a patient in respect of maternity care she had received at the Trust during pregnancy through to delivery. The patient felt well supported during the whole journey which had been a really positive experience, and thanked the individual members of staff who had been involved in her care.

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

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* voting member

BoD/4874 Minutes of the meeting held on, Thursday, 28 July 2022

Resolved: that, the minutes of the meeting held on, Thursday, 28 July 2022 be confirmed as an accurate record.

BoD/4875 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/4876 Report of the Joint Chair

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

- A meeting of the Joint Partnership Board (JPB) had been held the previous day attended by representatives from Carnall Farrar and the North East North Cumbria Integrated Care Board (NENC ICB) regarding the work being undertaken by Carnall Farrar to support both trusts in respect of future opportunities for collaboration.
- The report from NHS England (NHSE) following the governance review carried out earlier in the year had been received. The Board were collating a formal response.
- The report from the Care Quality Commission (CQC) following the inspections in May had been received and was published on 16 September. The Joint Chair placed on record thanks to all staff who had been involved, recognising the immense effort involved.
- As part of the programme of site and departmental visits for Governors, visits would include areas on the North Tees Hospital site. A visit to Peterlee Community Hospital and the X-Ray pathway had taken place in August, and a review of signage across the Hartlepool Hospital site with HealthWatch had recently taken place.
- The flu and Covid booster vaccination programme would be commencing shortly and members were encouraged to be vaccinated.
- The Vice Chair provided an update regarding the progress of the JPB, with the most recent meeting being well attended and productive. There had been positive engagement with the ICB and members from Carnall Farrar.
- As part of the work of the JPB the Trust had hosted a visit by South Tees Non-Executive Director colleagues at the University Hospital of Hartlepool providing an overview of services at the site, which had been well received. A reciprocal visit had taken place at the Friarage Hospital, which had also been positive and highlighted the recent investment made at the site.
- The fortnightly JPB Oversight Group continued to meet to maintain focus and delivery to support the JPB, which included engaging with wider partners and stakeholders as well as between the two trusts. A discussion ensued regarding positive messaging about the work for staff and wider stakeholders.
- Shining Stars, the Trust's celebratory event for staff as part of the reward and recognition programme was taking place on Friday, 4 November at Hardwick Hall. The event was funded through sponsorship and charitable funds. This year it was proposed to introduce a recognition award for Governors to reflect long service.

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

BoD/4877 Joint Partnership Board Update

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

BoD/4878 Report of the Chief Executive

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

- The Care Quality Commission (CQC) Report detailing the outcome of the focused inspection into maternity services and children and young people services, and the unannounced well led inspection was published on 16 September. The Trust had embarked on an improvement plan to sustain clinical services and clinical quality as well as to support staff post Covid. The governance structure across the organisation was also being strengthened.
- As of 21 September, the Trust was caring for 9 Covid-19 positive patients and there were no patients in ITU. Due to the low prevalence of Covid the wearing of face masks had been reduced to high risk areas only. The Trust would commence its Covid booster and flu vaccination programme during September.
- High demand for urgent and non urgent care was being experienced across the region including increased cancer referrals and elective care. The North East Ambulance Service (NEAS) remained under pressure and there remained a consistent focus to ensure timely handovers for patients and minimise the time ambulance crews were unavailable. An Urgent and Emergency Care Plan was issued nationally on 15 August 2022 and contained six key metrics to monitor performance. The Trust was implementing a new operational model to support operational sustainability with safe staffing a priority.
- As part of the Culture journey, the Trust was undertaking a culture survey supported by an external organisation Clever Together to listen to staff and gather their views with the information helping to further develop the wider cultural work. It was noted that the Reward and Recognition Survey recently undertaken had been the most responded to survey with great ideas generated.
- An EDI review had been undertaken as part of the Trust's commitment to the EDI agenda to provide a more motivating experience for staff. A number of staff networks around protected characteristics were now established.
- Research and Development remained active with 1,015 participants recruited to date across 25 specialties. Plans were being developed to offer PHD studentships for Nursing, Midwifery and Allied Health Partnerships at the University of Teesside.
- The North East North Cumbria Provider Collaborative Leadership Board met in August with discussions around non-surgical oncology, a regional clinical model for gynaecology oncology and winter preparedness.
- A final business case would be developed to support the proposed Community Diagnostic Centre on the Castlegate Campus site in Stockton for approval by the respective Boards of the Trust and South Tees Hospitals NHS Foundation Trust (South Tees) and the ICB prior to submission to NHS England. A partnership board had been developed with Stockton Borough Council to support the work programme.
- The Endoscopy Training Academy facility at the University Hospital of Hartlepool which had been developed jointly with South Tees would open officially on 7 October 2022.
- Therese Coffey had been appointed as the new Secretary of State for Health, and had announced greater access to primary care and moving the NHS towards a different opportunity, which was welcomed.
- Representatives from the Trust's Bowel Cancer Screening Team would be visiting Mauritius to support the establishment of a cancer screening programme.

FS sought to understand what communication plan the Trust had to ensure the positive achievements and developments were publicised. The CE explained that the Trust was active on social media regarding its work, however, it was also important to proactively engage with partners and staff about the accolades received for services.

CM highlighted in reference to increasing access to primary care, that the public were often unaware of the alternative pathways that were available, prompting discussion. The CE explained that it was important to understand perception of health services and social determinants and to work closely with community ambassadors and the at place work. It was noted in some areas of the population served the adult reading age was aged 9-12, therefore a review of the information provided was

required to ensure it was easily understood.

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.

BoD/4879 Board Assurance Framework 2022/23: Quarter 2 Interim Report

The ADoCA&S presented the Board Assurance Framework (BAF) Interim Report for Quarter 2 and highlighted the key points. The BAF comprised 12 risk domains with the principal risks consisting of 35 threats. A review of the Trust's risk appetite was being undertaken at a session later that day.

There were currently three principal risks that included a high risk rating with one or more threats:
Strategic Risk 1A – risk 6434 – linked to Procurement
Strategic Risk 1A – risk 6379 – Pathology workforce challenges
Strategic Risk 3C – risk 6188 – delivery of the CIP programme
Strategic Risk 3E – linked to completion of the Integrated Care Partnership (ICP) Clinical Services Strategy and progression of the Tees Valley and North Yorkshire Provider Collaborative.

The MD/DCE provided an updated regarding the workforce challenges in Pathology, highlighting this was a national issued with not enough trainees coming through. Interim arrangements were in place to support gaps.

Resolved: that, the Board Assurance Framework Interim Quarter 2: 2022/23 Report be noted and specifically the risks with a current risk rating of >15 (High).

BoD/4880 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 August 2022 including quality, workforce and finance. Operational and workforce pressures continued within the organisation and across the region affecting performance against key standards. The overall position for the majority of key standards was comparable to the regional and national position.

Highlights included:
Performance:

- Delivery of the cancer standards remained challenging with only three of the nine standards achieved in July. The 62 day standard reported at 63.77% against 62.2% regionally and 61% nationally. A continued focus remained to improve compliance and progress patients along pathways as quickly as possible;
- Continued achievement against the 28 day faster diagnosis standard was reported, with a significant improvement noted in July;
- The Trust continued to experience increased activity, requests for mutual aid and diverts across the system often with patients requiring admission. High bed occupancy was impacting on waiting times in the Emergency Department;
- NEAS reported the Trust at 53.3% of ambulance turnaround times within 30 minutes and an average ambulance handover turnaround time of 32 minutes, placing the Trust joint first in the region;
- An improving position against the two-hour urgent community response standard at 68.04%. the Trust remained on track to achieve standard of 70% by the end of Quarter 3;
- Performance against the Elective Recovery Plan continued with 49 patients waiting over 52 weeks in August and no patients waiting over 78 and 104 weeks. Patients with the longest waiting times were being offered appointments in September;
- There had been a drop in Diagnostics performance in August primarily due to staffing issues. Additional capacity had been put in place to reduce the number of patients waiting 6 weeks;
- The focus remained on Patient Initiated Follow Ups in Outpatients to contribute to the plan to reduce clinic review appointments. There had been a slight increase on the July position due

to a significant increase in activity and a reduction in the month's trajectory.

Quality and safety:

- HSMR and SHMI remained within the expected range, with HSMR reporting at 92.45 and SHMI at 95.89;
- Overall reduction in the number of complaints within Stages 1, 2 and 3, with communication remaining the top subject of complaint. There were a total of 394 compliments received in August;
- No falls leading to severe harm were reported. There was a reduction in the number of falls leading to moderate harm, these were being investigated and learning would be shared to implement training. The Falls Assurance Framework continued to capture learning;
- The Trust reported below the projected trajectory for three of the infection types. There were 8 cases of Clostridiodes difficile reported, a Period of Increased Incidence (PII) had been initiated on ward areas where there has been two positive cases in 28 days;
- The Trust received 1,349 Friends and Family Returns (FFT) in August, with all three reporting groups: Maternity, In patient and Emergency above the 75% standard. Maternity care reported at 100%.

Workforce

- Sickness absence had increased compared to the previous month at 6.80%, with 3.49% short term and 3.31% long term. There was an increase in Covid-19 related absence and the top reasons for sickness absence were respiratory conditions (including Covid), and anxiety/stress/depression. An action plan had been developed and was being presented at the People Committee during September;
- Mandatory Training compliance had decreased slightly to 90.31% in August, however, remained above the 90% standard;
- Staff turnover reported at 11.19%. The current trend remained positive and it was envisaged the various staff initiatives such as Scope for Growth and the leadership development programme would have a positive influence.

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 5, the Trust was reporting a surplus of £37k and a year to date surplus of £4.199m, both of which were ahead of plan;
- Total income at Month 5 was £31.512m;
- Pay expenditure was £21.350m and non-pay expenditure was £10.153m.

CM reported discussion had taken place at the Finance Committee earlier that week regarding delivery of the CIP target acknowledging that 2022/23 was a different year in respect of managing the non-recurrent aspect. The next Finance Committee would review delivery of the financial plan taking into account national changes.

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/4881 Care Quality Commission Update

The CN/DoPS&Q provided an update following the Care Quality Commission's (CQC) unannounced focused inspection of two core services, which culminated in a planned well led review. Disappointingly, the aggregated position was requires improvement. The Trust were provided the opportunity to respond to the draft report regarding factual accuracy and provide additional evidence. The final report was received on 12 September and was published by the CQC on 16 September.

The CN/DoPS&Q outlined the outcome of each of the five domains and highlighted that there no

enforcement actions had been placed on the Trust. There were 13 must do actions split across 5 trust wide, 5 in maternity services and 3 in children and young person services. The Trust had 28 days to respond to the must do actions. A discussion ensued, with the overall feeling of disappointment amongst members, particularly in relation to maternity services, having received wholly positive feedback from the visit to the Trust by the Ockenden Team and the notable improvements that had been made. It was noted that maternity services nationally were under pressure and it was felt the must do actions did not reflect the service being provided at the Trust.

The CE explained that the Trust was on an improvement journey of transformation. It was noted that the fundamental CQC standards measured in a different way to the Ockenden Review, which had commended the Trust on an open and transparent culture floor to board. Good information was displayed, good training was in place for staff and there were effective maternity champions in the organisation including Ann Baxter the Non-Executive lead.

Resolved: (i) that, the verbal update be noted; and
(ii) that, the aggregated position of requires improvement following the CQC inspection be noted; and
(iii) that, a formal thanks be placed on record to all the staff who were involved in the inspection process acknowledging the time and effort applied.

BoD/4882 Maternity Safety Report Quarter 1, 2022/23

The CN/DoPS&Q presented the Maternity Safety Report Quarter 1, 2022/23 and provided a detailed update of current progress in relation to quality and safety improvements within Maternity Services including the Maternity Incentive Scheme: Maternity Safety Actions and the Ockenden Report: Immediate and Essential Actions. The board commended the positive work being undertaken and the progress made.

Resolved: (i) that, 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 be noted; and
(ii) that, 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 be noted; and
(iii) that, the Board 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; and
(iv) that, it be noted Maternity services continue to monitor for any emerging risk and manage the risks identified in this report, the service provide updates in relation to progress against these to the Executive team, and to the Patient Safety and Quality Standards Committee each month.

BoD/4883 Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation

The CN/DoPS&Q presented the Nursing, Midwifery, Nursing Associate and Allied Health Professions (AHP) Revalidation Report and highlighted key points. There were no issues reported. A well-established system was in place to monitor revalidation for registered nursing and midwifery staff, which was being expanded to include (AHP) staff.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the processes in place to ensure a robust system of support for Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation was noted.

BoD/4884 Responsible Officer's Medical Appraisal & Revalidation

The MD/DCE presented the Responsible Officer's Medical Appraisal and Revalidation Report for 2021/22. Doctors were required to revalidate every 5 years. Medical Appraisal information was broken down by speciality. There were 58 appraisers at present in the Trust. A brief discussion ensued.

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

BoD/4885 Foundation Trust Governance Update

The ADoCA&S outlined draft guidance published in May by NHS England, which included three documents: code of governance, system working and collaboration: the role of foundation trust Councils of Governors, and good governance and collaboration. Changes included more focus on system working and collaboration, more governor involvement in system working discussions, tackling health inequalities, monitoring culture in organisations, and greater focus on the EDI agenda.

Resolved: (i) that, the content of the report be noted, and
(ii) that, work would be progressed to ensure the Trust was compliant following publication of the guidance.

BoD/4886 Review of the Trust Constitution

The ADoCA&S presented proposed changes to the Trust Constitution, which would reflect the new Code of Governance for NHS Providers, currently in draft although was anticipated to be published imminently. The changes recommended for best practice that Governors should serve no more than three consecutive terms of office to a maximum of nine years to maintain independence and objectivity. Similar amendments would be made in respect of Non-Executive Director terms of office.

The current Constitution made provision for Governors to make an application to continue to beyond nine years to aid the constituent areas that were difficult to recruit to, prompting discussion. In order to discuss the changes further and consider mitigation for constituent areas with low turnout at elections a further a session was arranged with Governors on 28 September. An award to recognise Governors service was being considered as part of the Trust's reward and recognition programme.

Resolved: (i) that, the proposed changes to the Constitution in respect of Governors terms of office be approved by the Board of Directors, subject to further discussion with the Governors on 28 September 2022; and
(ii) that, the Council of Governors formally approve the proposed changes to the Constitution.

BoD/4887 Equality, Diversity & Inclusion Annual Report 2021/22

The ICPO presented the Equality Diversity and Inclusion Annual Report 2021/22 outlining key highlights and future plans.

Resolved: that the Equality, Diversity Annual Report 2021/22 be accepted.

BoD/4888 Estates and Facilities Annual Report 2021/22 (enclosed)

The DoF presented the Estates and Facilities Annual Report 2021/22 outlining key highlights.

Resolved: that, the Estates and Facilities Annual Report 2021/22 be accepted.

BoD/4889 Any Other Business

There was no any other business reported.

BoD/4890 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 24 November 2022 in the

Boardroom at the University Hospital of North Tees.

The meeting closed at 12.20pm.

Signed:  Date: 24 November 2022

North Tees and Hartlepool NHS Foundation Trust

Minutes of an Extra Ordinary meeting of the Board of Directors held in public on Thursday, 6 October 2022 at 3:30pm at the University Hospital of North Tees / Via MS Teams

Present -

Professor Derek Bell, Joint Chair* (Chair)	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	SH
Chris Macklin, Interim Non-Executive Director*	CM
Fay Scullion, Interim Non-Executive Director*	FS
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
Susy Cook, Interim Chief People Officer	ICPO
Linda Hunter, Interim Director of Performance and Planning	IDoP&P
Gillian Colquhoun, Interim Chief Information and Technology Officer	ICITO
Hilton Heslop, Associate Director of Corporate Affairs and Strategy	ADoCA&S
Ruth Dalton, Associate Director of Communications and Marketing *(virtual)*	ADoC&M
Ray Martin-Wells, Associate Director of Governance and Transformation	ADoG&T

In attendance: -

Sarah Hutt, Company Secretary (note taker)
Alan Foster, Former NENC ICS Executive Lead (attending in an informal capacity)
Rita Taylor, Former Non-Executive Director – NTHFT
Jonathan Erskine, Former Non-Executive Director – NTHFT *(attending virtually)*
Barbara Bright, Programme Director *(attending virtually)*
Stuart Irvine, Deputy Director of Finance *(attending virtually)*

EO BoD/014 Apologies for Absence / Welcome

Apologies for absence were noted from Ann Baxter, Non-Executive Director.

The Joint Chair welcomed everyone to the meeting thanking them for attending at short notice.

EO BoD/015 Declaration of Interests

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

EO BoD/016 NHS England Governance Review and Regulatory Investigation

The Joint Chair outlined the purpose of the meeting was to publically receive the report from NHS England (NHSE) regarding a governance review and regulatory investigation undertaken earlier in the year, following which a copy of the report would be published on the Trust's website.

The CE provided the contextual background to the regulatory investigation into governance and leadership, which commenced on 9 February 2022, following discussions regarding the proposed appointment of a single joint Chief Executive for the Trust and South Tees Hospitals

NHS Foundation Trust (South Tees) and the subsequent actions and behaviours of board members following those discussions.

An independent third party was appointed by NHSE to formally undertake the investigation which commenced promptly and included conducting interviews with board members and members of the Joint Partnership Board from South Tees. The objective of the investigation was to ascertain whether there had been a breach of the Trust's provider licence and whether any formal enforcement action would be required. Following the conclusion of the investigation, the findings were considered at the System Oversight Committee (SOC) of NHS England and NHS Improvement on 12 April 2022. The SOC determined that no formal regulatory action would be taken at that time and instead the actions required by the Trust should be taken forward on a voluntary basis. The Trust received the summary report from the investigation on 5 September 2022, and the delay in its receipt was noted.

The report set out a series of recommendations and requirements for the Trust, which were considered by the Board of Directors on 22 September 2022, and in a briefing at an extra ordinary meeting of the Council of Governors on 28 September 2022. The Trust was required publish the report and covering letter at the next practicable public board meeting, and formally respond to NHSE confirming acceptance of the recommendations. An action plan was to be submitted to address the recommendations with milestones for delivery, and incorporate the outcome of the independent strategic review currently being carried out by Carnall Farrar (CF) to explore opportunities for collaboration. The action plan was to be agreed by Richard Barker, Regional Director, North East and Yorkshire, NHSE.

The CE outlined the Trust's response to NHSE highlighting progress to date and the forward plan, sharing key milestones and explaining the new regulatory framework following the establishment of the ICB as a legal entity on 1 July 2022. The CE outlined that agreement had been reached on the action plan and handling strategy at an In Committee meeting of the Board of Directors on 22 September 2022. The milestones spanned a 12 month period. The information had been previously shared with the Council of Governors including a discussion with Richard Barker earlier that day. A communication and handling strategy had been developed working with NHSE .

The independent review by CF had been commissioned to develop a case for change for Teesside and explore opportunities for collaboration engaging with a wide range of partners and stakeholders through an inclusive approach, which was welcomed. The areas served by both trusts included some of the most socially deprived communities in England. The outcome from the CF review would underpin the work programme for the JPB going forward.

The Trust was committed to place based working and future governance arrangements to also include the JPB and ICB, reference to the Tees Valley Health Summit, which was the basis for future health and inequalities drive was made to contextualize the drivers for place based working.

The Trust was undertaking an independent governance review, reviewing governance and leadership from ward to board and board to ward which would be in synergy with the Care Quality Commission (CQC) Improvement Plan. The review was planned to be jointly procured with South Tees, although individual reviews would be carried out for each organisation. In addition, a capacity and capability review had commenced, to provide expertise to supplement focus and to review individual portfolios at executive, corporate directorate and care group level to ensure the correct organisational structure was in place.

The Joint Chair acknowledged it had been a very difficult period for all involved and a considerable amount of work had been undertaken to date. The appreciative enquiry approach for the CF review was important to inform the next steps.

Comments were invited from board members and a discussion ensued. CM sought clarity as to the CE's query regarding the expected timeframe for possible regulatory action. There was a commitment for it to be reviewed in the Spring of 2023 providing positive progress continued to be made. It was important for this to removed but was dependent on the Trust continuing to demonstrate positive collaboration.

The Joint Chair invited comments from the members of public in attendance. Alan Foster, former Chief Executive of the Trust attending in an informal capacity expressed his support for the Trust and the wider Tees Valley citing the history of strong performance, governance and financial performance and the disappointment at receiving such a report. There had been previous attempts for the two trusts to work together and there was a unique opportunity through the Joint Chair to take the action plan forward across both trusts for the benefit of the wider population.

Jonathan Erskine, former Non-Executive Director shared the sentiments of Alan Foster and acknowledged he had read the NHSE summary report. He felt the action plan incorporating a plan on a page was a positive step.

The Joint Chair thanked all participants for attending the meeting, and in particular the former board members valuing their time whilst at the Trust.

The meeting closed at 4:10pm.

Signed: Date:

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			This event would likely take place in the Autumn
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/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			An update would be provided at the next meeting.
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			An update would be provided as part of the bi-annual workforce report.
8 June 2022	BoD/4806	***Maternity Update*** An update regarding Ockenden Report: Part 2 to be presented at a future Board of Directors meeting.	L. Robertson			An update regarding progress against all maternity safety actions was presented at the meeting on 22 September.
no new actions from the meeting on 28 July 2022.						
22 September 2022	BoD/4885	***Foundation Trust Governance Update*** Work would be progressed to ensure that the Trust was compliant following publication of the revised national guidance	H. Heslop			Publication of the updated guidance had been delayed.
22 September 2022	BoD/4886	***Review of the Trust Constitution*** The Board approve proposed changes to the Constitution in respect of Governor terms of office and the proposed changes be formally ratified by the Council of Governors	H. Heslop			Proposed changes to the Constitution would be presented to the Council of Governors for formal ratification, having informally been agreed. A wider review of the Constitution would also be undertaken to combine all required changes.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Chair's Report										
Date:	24 November 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;
- North East Regional Chairs Meeting
- Flu vaccination / Covid-19 booster programme
- Disability Awareness Event
- East Kent Maternity Services
- NHS England Report;
- Non-Executive Director Recruitment

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

24 November 2022

Report of the Joint Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Joint Partnership Board

The Joint Partnership Board met on 19 October 2022. Updates were provided regarding the Pathology collaborative venture and development of the Community Diagnostic Centres. In addition, members from the Integrated Care Board (ICB) and Carnall Farrar attended the meeting and outlined progress to date regarding the jointly procured piece of work exploring collaborative opportunities.

2.2 Regional Chairs Meeting

I attended the North East Regional FT Chairs meeting on 6 October. Sir Liam Donaldson provided an update regarding the ICB and newly formed Integrated Care Partnership (ICP). Other agenda items included the Ockenden Report (part 2) into Maternity Services and the provision of mental health support for staff, linking in with Tees Esk Wear Valleys NHS Foundation Trust (TEWV).

2.3 Flu vaccination / Covid-19 booster programme

The Trust's annual flu vaccination and latest Covid-19 booster programme commenced in early October. All staff were encouraged to be vaccinated to protect themselves against the effects of both viruses.

2.4 Disability Awareness Event

The Trust was hosting its annual disability awareness event on 5 December. The event would be attended by some veterans as guest speakers, and internal staff members sharing their own disabilities and challenges faced in daily life.

2.5 East Kent Maternity Services

The independent report following a review by Dr Bill Kirkup into Maternity and Neonatal Services at East Kent Hospitals University NHS Foundation Trust was published on 19 October 2022. Concerns had been raised regarding the quality and outcomes of care.

2.6 NHS England Report

Following receipt of the report from NHS England regarding the governance review carried out earlier in the year, the recommendations from the Report and the Trust's action plan with key milestones were shared with the Council of Governors and publically shared at an extra ordinary meeting of the Board of Directors on 6 October.

2.7 Non-Executive Director Recruitment

The permanent recruitment exercise for to fill the Non-Executive Director vacancies substantively was progressing well. Interviews were scheduled for 1 & 2 December.

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:	24 November 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
- Shining Stars 2022
- 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
- New NHS Operating Framework
- Industrial Action
- Population Health Fellows
- Financial Wellbeing
- Care Home Training

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

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

Committees/groups where this item has been discussed	Items contained in this report are discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.
Recommendation	The Board of Directors is asked to note the content of this report and the refocus and pursuance of strategic objectives and collective work amongst the 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

24 November 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 Elective Recovery

The Trust continues to perform in line with planned trajectories for elective recovery, with a focus on reducing over 52 week waits by the end March 2023 and improving the over 40 week waiting position across all specialities. This includes the continued provision of system capacity for the Tees Valley. The Trust is the only provider in NENC who continues to meet the ERF targets and as of 16 November There are 52 patients over 52 weeks with 42% already booked with the Trust.

The forecast position continues to drive patient focused pathway changes and an improving picture of recovery.

2.2 COVID-19

While covid continues to be prevalent in the Community, the Trust has now begun to see a stabilisation of the number of covid patients in the organisation. Work to further improve the respiratory wards at UHNT was completed in October, providing a robust respiratory service in anticipation of covid, seasonal influenza and respiratory illness throughout winter.

The Trust continues to promote covid booster and flu vaccinations for staff, including volunteers, colleagues in social care and the wider care sector. Although, the uptake of vaccinations is consistent with performance across NENC, further promotion will continue through November and December to encourage increased uptake with the associated benefits for both staff and patients.

2.3 Cancer Position

As at 16 November 84, patients (a decrease from 124 the previous week) are waiting more than 62 days, from a total waiting list of 1001 with the Trust meeting its revised Cancer trajectory for the number of patients waiting over 62 days. Focussed work continues on system, process and governance to improve the backlog and compliance with the best time practice pathways. Work at an ICS level is underway to review opportunities for further improvement across specific cancer pathways. The Trust is actively engaged with this work and the newly appointed Cancer Lead, Dr Vandana Jeebun, is working with clinicians to review individual pathways and identify opportunities to reduce delays in diagnostic tests, the associated reporting and to further improve performance.

3. Strategic Objective: Health and Wellbeing

3.1 Culture and Leadership Development

Culture is the bedrock to organisational success and effectiveness and the Trust is committed to continue the culture journey. The Trust is therefore embarking on a collaboration with Clever Together to develop stronger staff engagement, as a means of empowering individuals to speak up, be listened to and valued. A Big Conversation involving staff will begin from mid-November and will run for two weeks using the Clever Together platform. To ensure engagement in this work the first

steering group was held on 2nd November to agree branding and questions to be posted on the platform. The branding for the platform will be 'Our Trust, Our Future' demonstrating the commitment to moving forward as a whole organisation. 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 complimented by a review and re-launch of the management development programme; incorporating actions from the Equality, Diversity and Inclusivity review to ensure alignment of all work strands. The Scope for Growth pilot has begun, which is a national initiative, an approach that uses career conversations to support staff at all levels to grow and develop talent. This is aimed 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 and control at the People Committee.

3.2 Research and Development

Research and Development activity remains vibrant, this year there have been 1841 participants recruited across 25 specialties. Higher than at the same point in any previous pre-COVID year. Recruitment this year has been significantly higher in the National Institute for Health and Care Research (NIHR) specialties of Reproductive Health, Children and Gastroenterology. Details below on some of these high recruiting studies.

- **iGBS3** - collecting comprehensive information about the amount of antibody that protects babies from Group B Strep (GBS) infection to establish the components of a GBS vaccine.
- **Obstetric Anal Sphincter Injury (OASI2)** – evaluation of care bundles to reduce perineal tear during childbirth
- **INGRID** – early detection of Type 1 Diabetes risk
- **COLODETECT** – to determine whether colonoscopy assisted with the GI Genius™ Intelligent Endoscopy Module improves the detection of abnormalities such as polyps and cancer compared to standard colonoscopy.

The new Tees Valley Research Alliance (TVRA) contract between North Tees and Hartlepool and South Tees will preface future working. Site visits are planned to promote research participation where activity is currently low (as part of the Tees Valley Research Alliance 2022/23 improvement plan).

Accolades:

The Obstetric and Gynaecology Research Team won Trust Team of the month in October for collaborative and proactive work with stakeholders and clinical teams.

The Trust is the first and only UK site that has recruited into the pre-diagnosis cancer trial to assess the impact on patient management if the Oncotype diagnosis test is requested on a biopsy sample taken at the time of diagnosis as opposed to a sample obtained during surgery.

3.3 Shining Stars 2022

It was fantastic to be able to attend this year's Shining Stars Awards on 4 November 2022. It was the first opportunity to physically meet for more than three years – making the event extra special. I was privileged to hear so many amazing stories of staff going above and beyond for our patients. Anyone present on the night could not fail to be inspired. There were so many worthy winners on the evening – both individuals and teams. It was a privilege to be able to present a special Chief Executive and Joint Chair Award to the communications and marketing team, as a mark of their achievements over the last year.

4. Strategic Objective: Transforming our Services

4.1 Improvement and Transformation Journey

Alongside recovery, and returning to a focus on core business, the Trust is embedding an Improvement and Transformation journey to support the strategic ambitions for the future within the context of collaboration in the system. This includes the plan to tackle the CQC actions, a review of capability and capacity, an operating model to stabilise and sustain during the winter challenges and beyond, a focus on improving quality in practice through review and support and 're-establishing our strategic intent to deliver for our communities.

4.2 Integrated Care System (ICS)

4.2.1 The ICS continues to work through system governance, strategic ICP, strategy and place based arrangements to be in place by early 2023.

4.3 North East and North Cumbria Provider Collaborative (PvCv)

4.3.1 At its last meeting in October, the NENC Provider Leadership Board supported a proposal for Foundation Trusts to work together on addressing strategic clinical risks (such as vulnerable services), harnessing strategic clinical opportunities (such as centres of excellence), continuous pursuit of collaborative, clinical improvement and connecting clinical networks. This has long been a feature of the Trust's collaborative work with South Tees during recent years and the progress the Trust and partners have made in this area will help the ICB to tackle unwarranted variation across the North East and North Cumbria, including the establishment of a Clinical Advisory Group and will be undertaken in close working with Neil O'Brien, ICB Medical Director.

4.3.2 Other significant pressures on services, importance of place-based working, working relationship with partners, approaches to commissioning, planning and procurement will be drawn together into a 'responsibility agreement' to provide clarity on responsibility, delivery expectations, escalation and resourcing for the key work programmes of the future.

4.4 Tees Provider Collaborative

4.4.1 The NHSE and ICB independent strategic review conducted by Carnall Farrar is drawing to a conclusion with a revised publication date of the final report to be received by the Trust of end November/early December to take account of additional views from stakeholders. The Trust continues to work with partners at South Tees Hospitals and across the system and places to explore the most appropriate form of collaboration that meets the needs of the patients and populations of both Trusts.

4.5 Service and Estate Developments

4.5.1 Community Diagnostic Centre – Proposed Plans Teesside

4.5.2. 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 Tees 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.

4.5.3 The Outline Business case (OBC) was submitted to NHS England a change in the business case process by the national team to secure capital funding for the CDC proposal. The CDC

proposal is now in a Short Form Business Case to secure Capital funding for the development and construction of the hub; due to be considered for approval by the national team by the end of November 2022.

4.5.4 A partnership board has been established with Stockton on Tees Borough Council to ensure effective working relationships are developed and 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.

4.5.5 There has been success in securing funding from NHSE (National System Transformation Team) for external expert support in developing the CDC service model. This will include working with clinicians across both Trusts to review and co-produce a model, looking at clinical pathways the CDC will support and where the CDC provides opportunities to enhance and/or improve for patients to improve population health as the fundamental element of the design.

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

4.6 Endoscopy Training Academy

4.6.1 The Academy has been completed and is being delivered collaboratively with South Tees NHS Foundation Trust. The Academy manager has been appointed and commenced in role. An official opening and launch event is organised for the 16 December 2022 with 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 Faculty continues to be expanded incorporating the learning agenda and seeking accreditation to create the Faculty of Learning, Leadership and Improvement. This work will enable further development as an enabler to transformational change across the organisation.

This programme continues to build Quality Improvement capability within the workforce with opportunities to become experts in the field. To support development the Quality Improvement Strategy is currently being updated titled ‘Creating a Culture of Continuous Improvement’ which sets out ambitions for the next three years. The strategy will see the development of the 100 leaders programme in to three levels of attainment in Quality Improvement building knowledge and skill, creating accreditation at Bronze, Silver and Gold. This approach will ensure expansion of Quality Improvement knowledge across the organisation and provide options that meet every individual’s level of need.

The 100 Leaders cohort 2 is almost at the end of the six-month journey with the evaluation showcase-taking place on 18th November. This evaluation will allow the packs to celebrate their successes and highlight challenges experienced. The communications campaign around the programme has been recognised nationally for an NHS Communicate Award. These leaders will support transformation work of the future, with a clear link to strategic intent.

The faculty has also begun to deliver training, in resilience and managing difficult conversations to support staff over the coming months, this is in line with the learning and leadership strategy. The design of the future management and leadership development programmes is underway in conjunction with Teesside University and North East Commissioning Services.

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 which clearly articulate the risks associated with the Trusts aging estate a separate risk has been included in the Board Assurance Framework.

A Provider Collaborative Estates Workshop was held on Tuesday 13th September, which collectively identified; the key issues facing Estates across providers; the strategic risks and opportunities and agreed next steps in developing a NENC Provider Collaboration Estates Strategy. In order to inform the discussion the Trust has submitted its 5-year capital plan, which included the escalating critical backlog risk of the aging estate.

5.3 Secretary of State for Health

Following the ascension of Rishi Sunak as Prime Minister a government reshuffle has been undertaken, seeing the reappointment of Jeremy Hunt as Chancellor of the Exchequer and Steve Barclay MP as Secretary of Stage for Health and Social Care. Mr Barclay is the fifth Health Secretary over the last five years. It is hoped this will signal a period of stability for the NHS.

5.4 New NHS Operating Framework

On 12 October 2022, NHS England has published a new operating framework, this sets out how the NHS will operate in the new structure created by the 2022 Health and Care Act. The framework has been co-created with 300 system leaders, organisations and stakeholders.

5.5 Industrial Action

Trade unions representing NHS staff have advised the Secretary of State for Health and Social Care that they are in dispute over the 2022/23 pay award. A number of the unions are balloting or have signalled their intention to ballot their NHS members to take part in industrial action. The NHS task now is to be prepared for any potential industrial so there is minimal disruption to patient care and emergency services can continue to operate with a firm focus on safety and quality provision.

5.6 Population Health Fellows

Two valued members of the clinical teams – Doctor Mostafa Helmy and physiotherapist Victoria Butler – are among a small group of health staff across the country to be selected as population health fellows. As part of an NHS England initiative to improve healthcare and reduce health inequalities across communities, Mostafa and Victoria will lead projects to improve the digitisation of maternity services and the pathways for stroke patients. I would like to wish them both good luck in their initiatives and I am excited to see the progress they make.

5.7 Financial Wellbeing

The financial challenges continue across the country and remain a concern for the workforce. In the first of several initiatives the wellbeing team is planning, a financial health and wellbeing event was held for staff recently. So many business and organisations attended the day to offer support and advice to staff. A further event is planned at the University Hospital of Hartlepool

5.8 Care Home Training

Since the North Tees and Hartlepool Education Alliance was formed five years ago, the team has helped train around 5,700 carers across the Tees Valley in a range of health subjects to improve the health of care home residents.

Made up of staff from this organisation, Tees Esk and Wear Valley NHS Foundation Trust, Stockton Council, Hartlepool Council and Alice House Hospice, this shows what can be achieved when organisations share skills and work collaboratively.

6. Recommendation

The Board of Directors is asked to note the content of this report and the refocus and pursuance of strategic objectives and collective work amongst the 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										
Date:	24 November 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.										
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 - Risk 5779 relates to the risk of potential delay in diagnosis from delay in reporting radiological imaging. This threat is currently managed through Radiology imonitoring the studies that have been delayed and prioritised where required. The risk is managed through additional resource and prioritisation of examinations.

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 – the risk relating to innovation and integration particularly as a result of external factors is currently under review and will report through Transformation and Planning, Performance and compliance committees to Board of Directors in Quarter 3.

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
5779	Delay in diagnosis from delay in reporting radiological imaging	1A	20	16	3
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

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

24 November 2022

Board Assurance Framework, Quarter 2 Report 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 has reviewed reviewed the risk appetite and the appropriateness of its strategic risks on a regular basis. Board Committees have been asked to review individual risks and threats and this will be fedback through committees to the Board of Directors in Quarter 3. A risk appetite statement will be prepared and approved in Quarter 3. An independent review of governance is currently in development with completion by end February/early March 2023 and this will include a thorough review of the Board Assurance Framework and the processes involved to ensure not only continued fit for purpose, but also to explore opportunities for streamlining of process and modernisation alongside the development of a robust Board Development Programme.

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

3 Details

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

3.2 There are currently two principal risks (1a and 3C) that are assessed with a **high** risk rating within one or more of 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 three (3) aligned threats linked to operational issues e.g. procurement, potentila radiology delays, 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 5779 relates to the risk of potential delay in diagnosis from delay in reporting radiological imaging. This threat is currently managed through Radiology imonitoring the studies that have been delayed and prioritised where required. Radiology are in the process of procuring alternative outsourcing which will be supplemented by home reporting workstations in place to facilitate insourced reporting. Urgent radiological examinations are given priority by administrative staff allocating to the reporters. The Trust is ensuring additional resource is inplace to facilitate plain film reporting.

3.8 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

3.9 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.

3.10 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

3.11 The committee will recall that the threats to the overall risk linked to transformation of our services have been cosnsidered and debated on a number of occasions throughtout the period within Board committees. The threats were largely influenced by external factors linked to ICS, ICB and the Joint Partnership Board, and were reliant on the work and collaboration of a number of external partners and stakeholders locally, regionally and nationally.

3.12 In order to gain and provide assurance to the Board of Directors, a fundamental review of this particular risk is to be undertaken with reporting back through Transformation and Performance, Planning and Compliance Committees. It is intended that the review will be concluded in late November/early December and the risk and associated threats will be presented to Board of Directors as part of the BAF in Quarter 3 report in January 2023.

3.13 The risks and threats outlined above are reflected in the minutes of the relevant Committees alongside Executive Director summary reports. A BAF Risk Radar is attached at Appendix 1 to demonstrate the breadth of risks currently monitored and managed by the trust. The radar will be 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
5779	Delay in diagnosis from delay in reporting radiological imaging	1A	20	16	3
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 5779 (High) - Delay in diagnosis from delays in reporting radiological imaging (CG2). Mitigations in place through urgent radiological examinations are givne priority by administration staff allocating to the reporters including large team of reporting Radiographers to facilitate plain film reporting; • 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. 6550 (Moderate) - Staff vacancies in maternity with management reports to Executive Team and Board updates 6534 (Moderate) - Lack of consistency in staff knowledge of the management of diabetes in ward areas 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 6515 (Moderate) - Inability to provide a 7 day midwifery bereavement service in line with Ockenden action 13 6529 (Low – reduced from Moderate) - Agency staff do not currently meet the MRHA training requirements for administration of blood products. Reduced as a result of oversight of overall training compliance by People Committee 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 is one new risk identified in this quarter: • 6525 (Moderate) delay in assessment and/or delivery of wheelchairs The following existing Moderate risks have appropriate controls in place with stringent monitoring and mitigation processes through Patient feedback monitoring, reviewed during Patient Safety & Quality Standards Committee, Patient and Carer Experience Committee, Senior Clinical Professional Huddle, Safety Panel and Executive Reports. The risks include: • 6222 - Significant harm to patients from healthcare acquired skin injuries; • 6495 (Moderate) significant waiting times for new allergy clinic appointment • 6448 (Moderate) risk of injury to staff or patients due to violence and aggression • 6285 - Low rates of medicines reconciliation on EAU due to low resources; • 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; Performance report presented regularly at PPC committee, Audit Committee, ETM and Board of Directors supported by Planning & Recovery Group with a focus on trajectory of recovery at care group level. Escalation plans are in place and business continuity is managed through the Resilience Command & Control Centre to manage day to day monitoring and management, including defined escalation triggers. Performance improvement is supplemented by a real time dashboard for ED patients displaying current waiting times which is driven by Business Intelligence tools that demonstrate trends for analysis/ actions and patient flow data, backed up by capacity and demand data to understand resource requirement for any surges in activity. System oversight framework releasedearlier this year with internal baselines established, 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 expected toward the end of Qtr 3 (December 2022).	**12 4x3**	**12 4x3**	**12 4x3**	**12 4x3**	**Minimal**

Emergency Preparedness Resilience and Response (EPRR) - 1D - There is a risk that an internal and/or external incident could disrupt or present a catastrophic breakdown of services provided by the Trust.					
There are no new risks reported in this quarter: • Risk 6062 - Emergency Planning and Business Continuity (tolerated risk) This is a low rated risk with oversight and assurance of significant EPRR related risks through the Trust Resilience Forum including ongoing monitoring and reporting of relevant local and national risks and/or changes in legislation, including through use of NEY EPRR Regional Risk Register and links with LRF. Gaps in Business Continuity Planning were addressed through the rollout of new business continuity management arrangements with new business continuity management processes currently progressing through stages of development, implementation and validation as detailed within EPRR BAF action plan and forward work programme. Continued Phase 1 service area transition to use of new BCM processes. Extended completion date to the end of October for some Care Group and Corporate Directorates; with • Phase 2 implementation and validation of service area BCM arrangements to take place between November 2022 and April 2023. Development and implementation of an EPRR training and exercise strategy to help re-establish an effective approach to EPRR training and exercising is in development with a strategy to be agreed by December 2022 followed by staggered re-implementation of training and exercising between November 2022 and November 2023 in line with identified areas of priority. Communication and increased understanding of resilience planning will be achieved through a complete re-development of the Trust Resilience SharePoint site. This will support improved accessiblity and storage of digital EPRR informatio, including plans, policies, procedures and response information. 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; • Education panels being held across all Care Groups. Involved in Trust website refresh as part of 'attraction' strategy. Talent management/appraisal section in Management Development day. User guide developed for appraisal includes additional support for assessing talent. Scope for Growth roll out commenced.	**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. • Sickness absence levels, covid related, remain high. Absences linked to stress/anxiety/depression high. Mitigations and management include bespoke action plan agreed at Executive Teamwith monthly review points.	**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. **High risk down rated** following implementation of appropriate plans, policies and e-learning and managed through People Committee. A full risk reduction plan has been implemented with monitoring of actions by Interim Chief People Officer and Chair of People committee. • All employment policies and procedures relating to Employee Relations to be updated, reviewed and agreed by Workforce committee; • Planned programme of lead investigators rolled-out and reviewed with monitoring to ensure consistency of approach, improve understanding and knowledge of process/policy; • Communication packs for managers implemented via e-learning on ESR to minimise escalation towards grievance and whistle-blowing; • Implementation of schedule of internal audits on ER processes.	**N/A**	**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 Hospital @ Home, Residential/nursing homes - bid in place to support expansion. Ageing Well (UCR 2 Hour response) - Workforce being established, funding received (combination of NREC and REC). Working with partners to understand remote home monitoring to support patients to self-manage and early intervention. Consultant in Public health is currently accelerating the development of the health inequalities agenda in collaboration and partnership with Directors of Public Health work and population health management agenda. Trust work plan for working with system partners has been produced.	**9** **3x3**	**9** **3x3**	**9** **3x3**	**9** **3x3**	**Open**

Transforming our Services (Internal) - 3B - There is a risk of failure to deliver transformational improvements that are sustainable, financially effective, aligned with local and national requirements, beneficial and which have secured commissioner support					
No new risks identified. • PMIO conduct evaluation of supporting project documents and consider levels of expertise with a view to delivering pre-project workshops. Process developed to identify required QIA documents reported through Excellence as our Standard; • Reviewed and improved process for business cases with strategic alignment resulting in a more robust process; • 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 with monitoring and ongoing development through Business Team Strategy Sessions. The CSS is currently in development stage and will be finalised during Q3-Q4.	**12** **4x3**	**12** **4x3**	**12** **4x3**	**12** **4x3**	**Seek**

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

There are no new risks identified in this Quarter.

- 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 1 and is linked to a shortfall in 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). Current mitigations include a revised Estate strategy for the Trust and ongoing work to develop a strategic outline case to establish the case for change and investment in the capital infrastructure;
- A High risk remains relating to Delivery of Savings (6188) and the challenges to deliver the CIP programme for 2022/23 and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions.
- The review of the Master Services Agreement was completed earlier in the year and a planned Follow Up audit of the Reverse SLA will be undertaken by AuditOne in 2022/23 with a completion date of Dec '22.
- 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	
Contract 6 3x2	Contract 6 3x2	Contract 9 3x3	Contract 6 2x3	
Cost 12 4x3	Cost 12 4x3	Cost 12 4x3	Cost 12 4x3	Open
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

There are no new risks reported in this period.

- 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 has been reduced to Moderate during this Quarter as a result of managing project requirements to reduce that impact to BAU, prioritising Clinical facing areas to ensure minimal impact to those areas, and currently employing four Agency staff to help reduce workload. This risk is monitored and managed through the appropriate workforce channels and through the Digital Strategy Committee.
- 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				
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				Open
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.					
The Trust is currently unergoing a period of review with regard to the risks associated with transforming our services. They are, in the main, externally focussed and will be focused around three key areas: • **Intergated Care System (ICS) and developments/progress relating to the Integrated Care Board (ICB);** • **Area-based partnerships and place-based planning including the Tees Valley Integrated Care Partnership (ICP) and the risks associated to the completion of the Clinical Services Strategy; and** • **Joint Partnership Board** The risks associated with external transformation have been discussed at Board committees on a number of occasions during 2022. However, this review is timely and it is intended that the risks will be fully reviewed in time for the Quarter 3 Board Assurance Framework report to Board of Directors in January 2023.	**12** **4x3** **12** **4x3** **12** **4x3** **9** **3x3**	**12** **4x3** **15** **3x5** **20** **4x5** **9** **3x3**	**12** **4x3** **15** **3x5** **20** **4x5** **9** **3x3**		**Seek**

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**

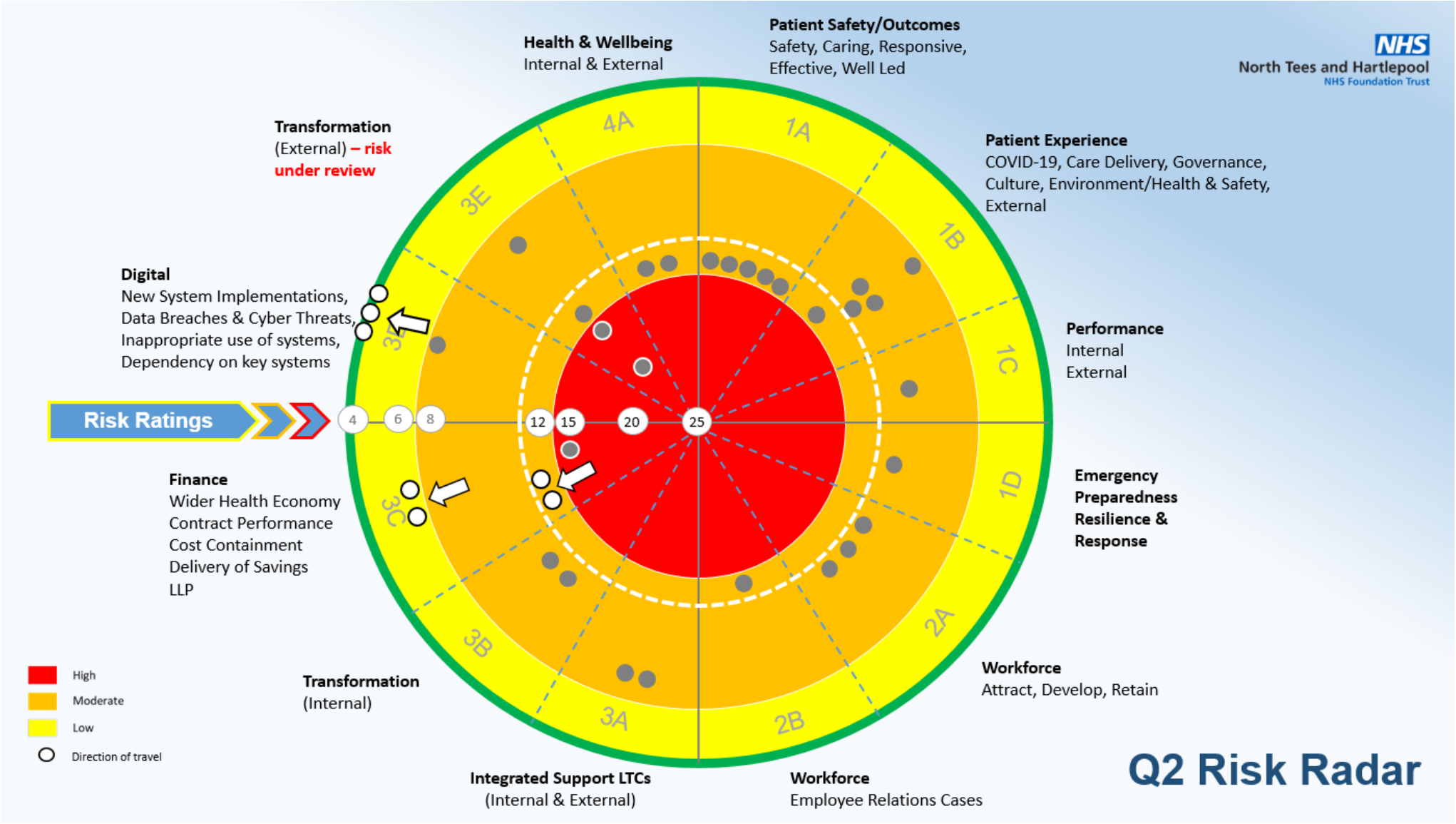
6. Recommendations

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

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

Appendix 1


Health & Wellbeing
Internal & External
Patient Safety/Outcomes
Safety, Caring, Responsive, Effective, Well Led
NHS
North Tees and Hartlepool
NHS Foundation Trust
Transformation
(External) – risk under review
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

Title:	Integrated Compliance and Performance Report										
Date:	24 November 2022										
Prepared by:	Mark MacDonald - Interim Head of Strategy, Planning & Performance Lindsey Wallace – Interim Deputy Director of Planning & Performance Keith Wheldon – Business Intelligence Manager										
Executive Sponsor:	Linda Hunter, Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Susy Cook, Chief of People Officer Neil Atkinson, Director of Finance										
Purpose	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our population First	x	Valuing our People	x	Transforming our Services		Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

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

Summary

- Operational and workforce pressures continued in October, affecting performance against key standards however, the position for the majority of those key standards remain comparable to national and regional positions.
- 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 (which have both seen a slight rise recently) and infection control measures.
- The number of patients waiting longer than 52 weeks at the end of October was 42
- The Trust achieved five of the nine cancer standards in September 2022
- Short Term staff sickness has seen an increase for September 2022, whilst Long Term sickness saw a continued decrease in September 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, winter and staffing resource. Associated risks are outlined within the Board Assurance Framework

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

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report

November 2022

Responsible Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Linda Hunter
Director of Planning & Performance

- Oversight Framework
- Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

- Safety & Quality

Susy Cook
Chief People Officer

- Workforce

Neil Atkinson
Director of Finance

- Finance

Introduction

NHS
North Tees and Hartlepool
NHS Foundation Trust

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

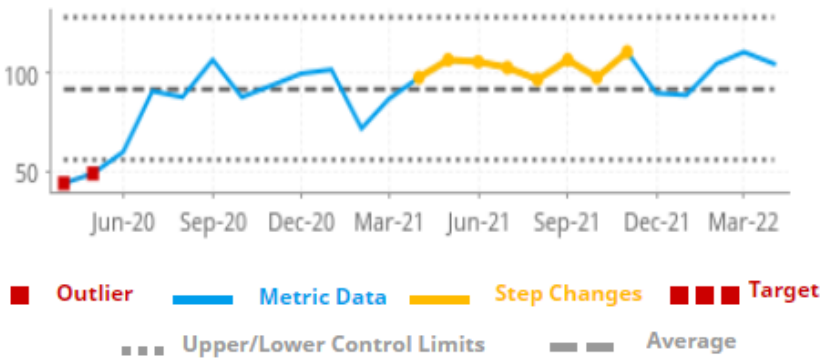
Statistical Process Control (SPC) Charts

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

OF and Efficiency & Productivity

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

The Trust continues to face the challenge of increased activity, responding to system pressures with multiple requests for mutual aid, diverts and deflections from across the system, with 61% of patients transferred to the organisation converting to admissions, an increase from 54% last month. High bed occupancy rates continue to impact upon the waits in the Emergency Department affecting patient flow however, implementation of the operating model is now supporting delivery of additional bed capacity to assist with patient flow.

The Trust achieved five out of the nine cancer standards, demonstrating a favourable position comparative to the region with a continued achievement of the 28 day faster diagnosis standard and 31 day standard.

Elective recovery continues with the focus now shifting to reducing the number of patients waiting over 40 weeks, as well as over 52 weeks. The Trust has already seen a 21% reduction from the previous month and has the lowest number of patients in this cohort (40 week waits) across the North East and Yorkshire region and second lowest overall for patients waiting over 52 weeks.

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 94.08 (September 2021 to August 2022), latest SHMI value is now 98.26 (June 2021 to May 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 October 2022 has seen a decrease within Stage 1, with a slight increases in Stage 2 and Stage 3. The number of complaints received this month continues to be consistent with pre-pandemic levels.

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

One never event from March 2022 has now been downgraded (October 2022).

Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Workforce

Sickness has increased slightly from 5.09% to 5.28% in September 2022, with only 0.74% being due to COVID related absence.

Turnover continues to reduce in October 2022, from 10.99% to 10.78%; this is the lowest rate since November 2021.

Appraisal compliance has decreased this month by 0.57% and at 85.6% still falls short of the Trust 95% standard.

Overall, mandatory training compliance has dipped below the 90% standard (89%) for the first time since March 2022, most likely the result of an increase in non-attendances due to service pressures. It is acknowledged that work is still required to focus on key topic areas which remain below the compliance level required, in particular resuscitation courses with a dedicated working group being establish to explore alternative ways of delivery.

Finance

At Month 7, the Trust is reporting an in-month deficit of £0.092m against a planned surplus of £0.112m, which is £0.204m behind plan.

The Trust is reporting a year to date surplus of £4.609m against a plan of £4.492m, which is £0.117m ahead of plan.

Total Trust income in M7 is £31.840m (including donated asset income and finance Income).

M7 pay expenditure totalled £22.009m of which £0.086m is additional spend related to the Covid-19 response (including testing costs).

M7 non-pay expenditure totalled £9.957m.

The month 7 year to date net contribution from Optimus is £0.161m against a plan of £0.095m (£0.066m ahead of plan) and the year to date net contribution from the LLP is £0.890m against a plan of £1.120m (£0.230m behind plan – including £216k of loan interest, which results in an adjusted position of £14k behind plan).

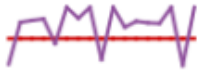
YTD, the Trust continues to benefit from slippage on non-recurrent funding which continues to result in the Trust being slightly ahead of plan.

Key risks at M7 relate to controlling run rates, ceasing any non-recurrent expenditure relating to 2021/22, CIP identification and delivery and pay award pressure.

Oversight Framework

6

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
New Cancer Two Week Rule	✗	Sep-22	83.45%	93.00%	
Breast Symptomatic Two Week Rule	✓	Sep-22	93.63%	93.00%	
28-day Faster Diagnosis	✓	Sep-22	79.93%	75.00%	
New Cancer 31 Days	✓	Sep-22	97.08%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Sep-22	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	Sep-22	87.50%	94.00%	
New Cancer 62 Days	✗	Sep-22	62.72%	85.00%	
New Cancer 62 Days (Screening)	✗	Sep-22	88.46%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✓	Sep-22	86.36%	85.00%	

Narrative

Cancer

The latest validated position for September sees the Trust achieving five out of the nine cancer standards placing the Trust third in the region. Whilst the Trust did not achieve against the 31 day subsequent treatment standard, reporting at 87.5%, numbers were small (14 of 16 patients being treated within 31 days).

The Trust reported at 83.45% against the Two Week Rule standard of 93%, with the regional position being 74.45%. This places the Trust third across the region with only one Trust in the region achieving this standard. Increased referrals for two-week rule appointments, particularly in Gynaecology, continues to have an impact on the overall pathway which results in greater demand for additional outpatient and diagnostic capacity. Referral trends are being analysed and will be shared with commissioners to raise awareness and understand referral patterns.

Cancer 31 days shows a continued improvement in performance from August to September now reporting at 97.08%, against a 96% standard, with region reporting 89.06%.

The Trust continues to achieve the 28 day faster diagnosis standard, being only one of three organisations across the region to do so.

The Cancer 62 day standard remains a pressure across the majority of pathways, which is reflective both regionally and nationally, with particular pressures evident in Colorectal, Urology and Lung.

A new Clinical Cancer Lead for the Trust took up post in October who will continue to support the focussed work with colleagues across the organisation and beyond with a clear understanding of the issues and complexity faced by encouraging change solutions to help recover the Trusts position and improve overall waiting times and patient experience.

Oversight Framework

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NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Referral To Treatment Incomplete Pathways Wait (92%)	Oct-22	77.85%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	Oct-22	29.00	28.00	
Incomplete Pathways Wait (Median)	Oct-22	8.86	7.20	
Incomplete Pathways Wait (>52 Week Wait)	Oct-22	42	0	
Diagnostic Waiting Times and Activity	Oct-22	74.01%	99.00%	

Narrative

RTT

The Trust reported at 77.85% for the RTT incomplete standard in October reporting 42 patients, who are all managed through the application of the waiting list policy, waiting over 52 weeks. This ranks the Trust 2nd lowest in the region despite an increase from the 31 patients reported the previous month. To benchmark, September's regional position (latest available data) reports the Trust at 78.4%, with the region reporting at 70.7%.

At the end of October 2022 the Trust maintained its trajectory in line with Phase 1 and Phase 2 elective recovery from NHS England and reports no patients waiting longer than 78 and 104 weeks. 8 patients waited longer than 52 weeks for an inpatient elective procedure at the end of October and teams continue the focus of ensuring all long waits are seen and treated in accordance with policy and clinical review, in the best interests of the patient.

The Trust continues to drive to reduce the number of long waiting patients with a focus on those patients waiting over 40 weeks, which has seen an improvement from September, and sees the Trust with the lowest number across the North East and Yorkshire region.

Guidance released by NHSE in October has been received which will help manage and validate patient waiting lists and will have a focus on clinical, technical and administrative validation. This will help to ensure clinical prioritisation and review as well as having a robust mechanism to actively monitor patients along their chosen pathway.

Diagnostics

Performance has seen a slight improvement in October reporting 74.01% compliance from 72.58%, however, pressures continue related to staffing capacity in a number of key areas with the largest impact continuing to be seen in Non-Obstetric Ultrasound. Capacity is projected to increase in December and January leading to a planned improved position by end of March 2023.

Endoscopy capacity continues to be affected by both long-term Consultant sickness and high levels of therapeutic demand with staffing and resource being explored to provide additional capacity.

The September regional position for Diagnostics was 81.28% with the Trust reporting 72.58%. Compliance across the region ranged from 68.30% to 95.21%.

Testing is now complete with the new outsourcing provider of Radiology reporting and reporting will commence in November.

Oversight Framework

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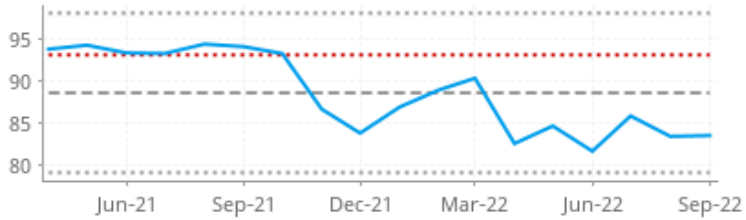
NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

Cancer - 2 Week Rule

Month	Performance	Standard
Sep-22	83.45%	93.00%

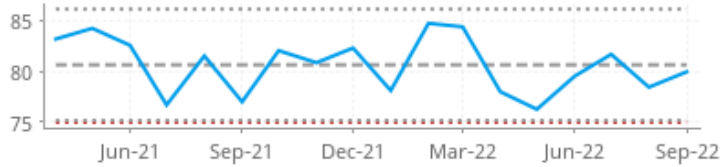


Cancer - Breast Symptomatic

Month	Performance	Standard
Sep-22	93.63%	93.00%

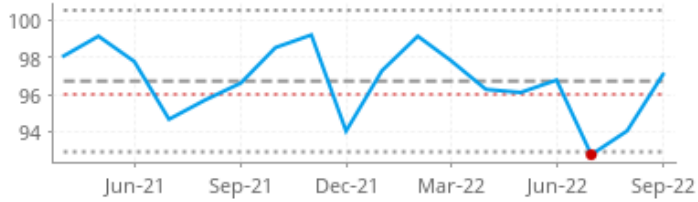
Cancer - 28 day Faster Diagnosis

Month	Performance	Standard
Sep-22	79.93%	75.00%



Cancer - 31 days

Month	Performance	Standard
Sep-22	97.08%	96.00%



Oversight Framework

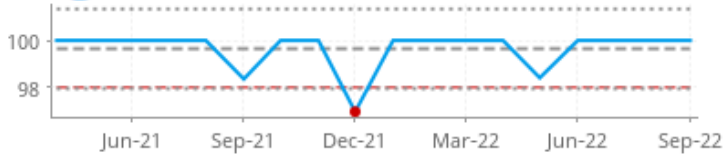
9

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

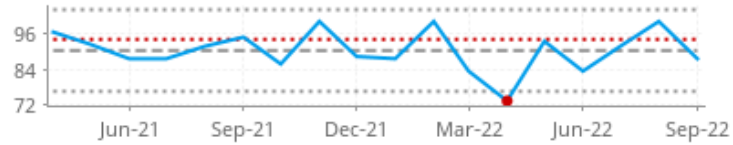
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
Sep-22	100.00%	98.00%



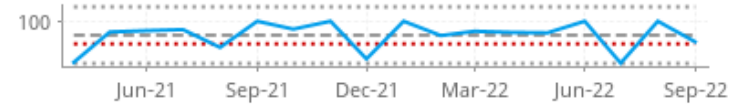
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
Sep-22	87.50%	94.00%



Cancer - 62 Consultant Upgrade

Month	Performance	Standard
Sep-22	86.36%	85.00%

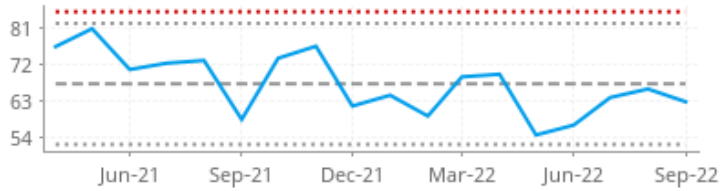


Cancer - 62 Days Screening

Month	Performance	Standard
Sep-22	88.46%	90.00%

Cancer - 62 Days

Month	Performance	Standard
Sep-22	62.72%	85.00%



Oversight Framework

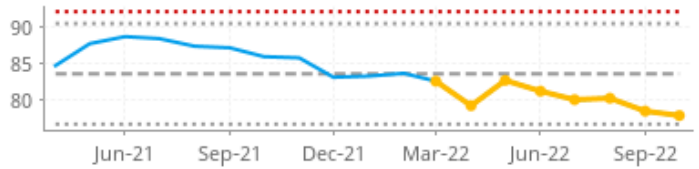
10

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

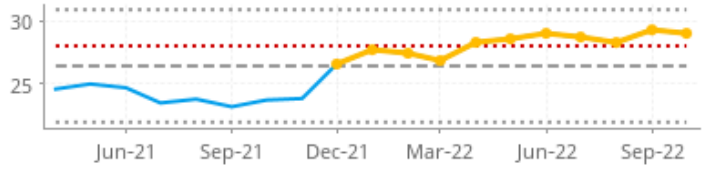
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Oct-22	77.85%	92.00%



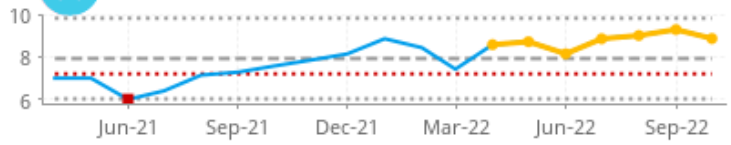
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Oct-22	29.00	28.00



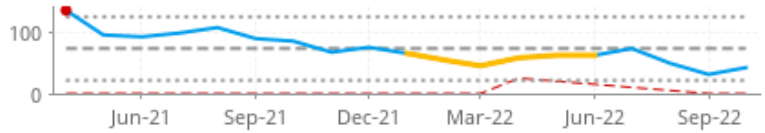
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Oct-22	8.86	7.20



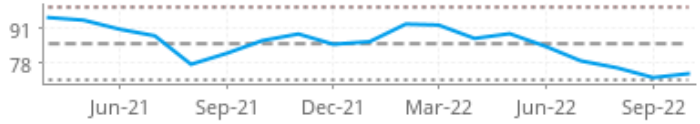
Referral To Treatment- Incomplete Pathways Wait (>52 Week Wait)

Month	Performance	Standard
Oct-22	42	0



Diagnostic Waiting Times and Activity

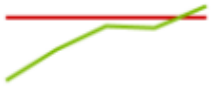
Month	Performance	Standard
Oct-22	74.01%	99.00%



Efficiency & Productivity

11

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Decision To Admit (DTA) (over 12 hours)	✗	Oct-22	27	0	
Time to Initial Assessment (mean) Type 1 & 3	✓	Oct-22	13.84	15.00	
Number of Ambulance Handovers waiting more than 60 Mins	✗	Oct-22	30	0	
65% of Ambulance Handovers completed within 15 Mins	✗	Oct-22	20.82%	65.00%	
95% of Ambulance Handovers completed within 30 Mins	✗	Oct-22	52.83%	95.00%	
2 hour Urgent Community Response	✓	Sep-22	80.72%	70.00%	

Narrative

Urgent and Emergency Care

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

Significant pressures are noted across the region affecting ambulance handovers with 30 handovers over 60 minutes in October compared to the 12 reported in September. As a way of benchmarking and comparing the Trusts position, the monthly NEAS report is considered and whilst not a mandated measure, the narrative demonstrates how well the Trust manages ambulance turnaround times. For example, NEAS reported the Trust at 51.2% of ambulance turnaround times within 30 minutes (arrival to clear), which places the Trust second in the region. An average turnaround time of 40 minutes was seen in month compared to the regional average of 49 minutes. The Trust is committed to improving compliance with ambulance turnaround times and continues to work in partnership with NEAS colleagues.

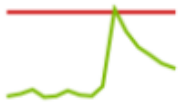
The Trust continues to receive a number of ambulance diverts and deflections and mutual aid requests from neighbouring trusts which adds to the pressures within the Emergency Department. 98 patients were transferred during October 2022, a significant increase to the 26 patients transferred throughout September, with 59 patients going on to be admitted as an inpatient. Average Length of Stay (ALOS) was 7.3 days with the longest admitted patient still in the Trust after 37 days. The Trust requested mutual aid on 8 occasions, of which 3 were accepted with a total of 13 patients transferred.

27 patients waited over 12 hours for a decision to admit with the majority of patients waiting for a bed to become available. All patients were made comfortable and cared for appropriately within the Emergency Department until a bed became available. The implementation of the new operating model with an increase in the bed base is fundamental to improving flow.

The success of the 2 hour Urgent Community Response has aided flow by responding quickly to patients within their own homes preventing the need to come in to hospital. The service is now supporting over 80% of patients within 2 hours that may well have resulted in a trip to A&E if this service was not available.

Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Outpatient Did Not Attend (Combined)	Oct-22	9.72%	9.20%	
Reducing Reviews	Oct-22	103.79%	85.00%	
Patient Initiated Follow Up (PIFU)	Oct-22	1.74%	5.00%	
Advice and Guidance	Oct-22	13.20%	16.00%	
Diabetic Retinopathy Screening	Oct-22	98.60%	95.00%	

Narrative

Outpatients

Patients who are unable to attend their appointment (Did not attend – DNA) continues to report above the Trusts standard of 9.2% however October has seen an improved position as the rate fell below 10%. The agreed programme of work focusing on improving outpatient processes continues, monitored via the Outpatient Transformation Group and includes the aim to reduce the number of patients seen in review clinics by 15% at year end.

Care Groups continue to work with clinical teams to include patient initiated follow-ups into their pathways of care. A national review of the first 9 months of PIFU has taken place which suggests almost half of the national PIFU activity comes from Trauma & Orthopaedics (20%), Paediatrics (13%) and Physiotherapy (11%). The Trust is now working with community colleagues to understand the data outcomes for Physiotherapy patients, given the national inclusion rates, with a view to including those patients who are on a RTT MSk pathway.

Efficiency & Productivity

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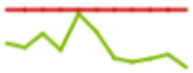
North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Electronic Discharge Summaries	✗	Oct-22	90.42%	95.00%	
Super Stranded	✗	Oct-22	47	43	
Average Depth of Coding	✓	Sep-22	6.29	3.01	
Length of Stay - Elective	✓	Oct-22	2.72	3.14	
Length of Stay - Emergency	✓	Oct-22	2.85	3.35	
Day Case Rate	✓	Oct-22	87.70%	75.00%	
Pre-op Stays	✓	Oct-22	0.78%	4.50%	
Trust Occupancy	✗	Oct-22	95.24%	90.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	✗	Aug-22	9.31%	7.70%	
Not reappointed within 28 days	✗	Sep-22	2	0	

Narrative

Electronic Discharge Summary (EDS)

All discharge summaries are being completed and October has seen an improved position with over 90% being completed within the required 24 hours. Focused work across care groups is ongoing with an identified lead to co-ordinate all activities.

Super Stranded Patients

October has seen a further improvement against this standard with 47 patients in the hospital over 21 days compared to the 59 the previous month. The Trust continues to work with its partners in Local Authorities to ensure timely discharge where clinically appropriate.

Length of Stay

Patients' length of stay in the Trust has reduced which in turn will aid the flow of patients through the hospital as bed capacity increases. Similarly, Pre-operative stays have also reduced the length of time patients need to occupy a bed with fewer patients being admitted prior to the day of their surgery.

Trust Occupancy

The Trust operated at a heighted occupancy throughout October, consistently reporting above 90% with an average of 95.24%, a 1.58% increase on the September position. Surges in activity have been seen throughout the month with increases in Covid admissions rising from 12 patients to 63 by the end of October noted with forecasts predicting a rise over the winter months.

Readmissions

The latest validated position has seen an increase in the rate compared to last month with gastrointestinal disorders being the reason for the highest emergency readmission and urinary problems being the reason for the highest elective readmission. A collaborative approach to address a number of the issues is underway to support an improvement of this position.

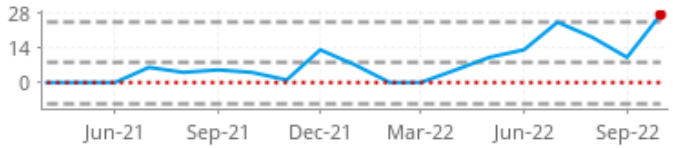
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

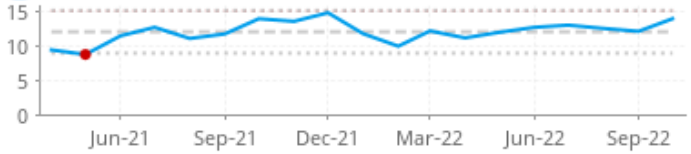
Decision to Admit (DTA) (Over 12 hours

Month	Performance	Standard
Oct-22	27	0



Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Oct-22	13.84	15.00



Number of Ambulance Handovers waiting more than 60 mins

Month	Performance	Standard
Oct-22	30	0

65% of Ambulance Handovers completed within 15 mins

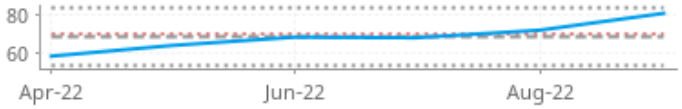
Month	Performance	Standard
Oct-22	20.82%	65.00%

95% of Ambulance Handovers completed within 30 mins

Month	Performance	Standard
Oct-22	52.83%	95.00%

2 hour Urgent Community Response

Month	Performance	Standard
Sep-22	80.72%	70.00%



Efficiency & Productivity

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North Tees and Hartlepool NHS Foundation Trust

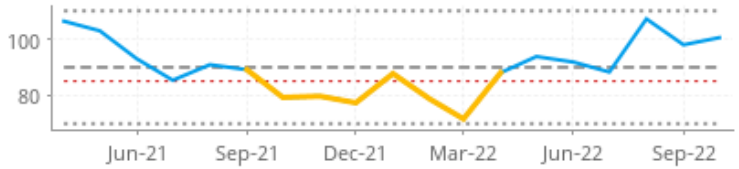
Statistical Process Control (SPC) Charts

Outpatient Did not Attend

Month	Performance	Standard
Oct-22	9.72%	9.20%

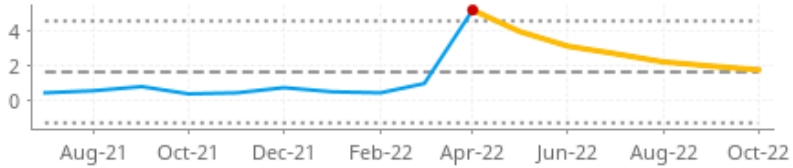
Reducing Reviews

Month	Performance	Standard
Oct-22	100.64%	85.00%



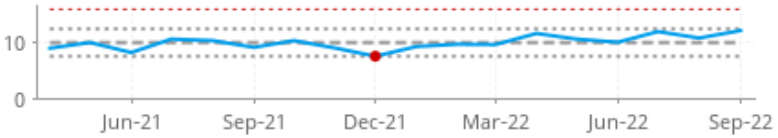
Patient Initiated Follow up

Month	Performance	Standard
Oct-22	1.74%	5.00%



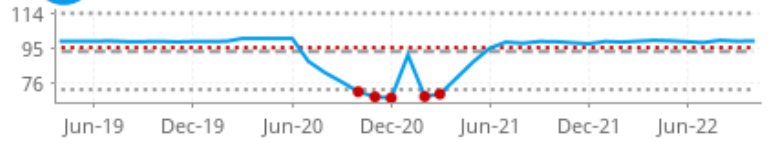
Advice and Guidance

Month	Performance	Standard
Sep-22	12.17%	16.00%



Diabetic Retinal Screening

Month	Performance	Standard
Oct-22	98.60%	95.00%



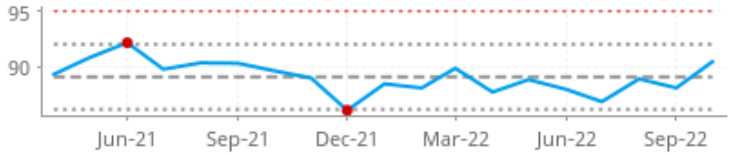
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

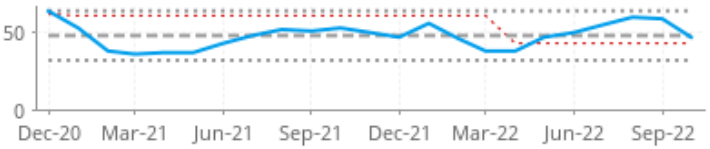
Electronic Discharge Summaries

Month	Performance	Standard
Oct-22	90.42%	95.00%



Super Stranded

Month	Performance	Standard
Oct-22	47	43

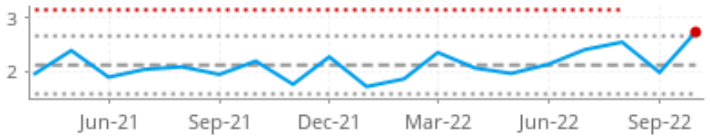


Average Depth of Coding

Month	Performance	Standard
Sep-22	6.29	3.01

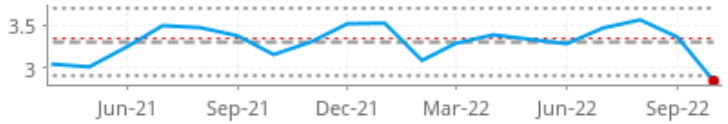
Length of Stay - Elective

Month	Performance	Standard
Oct-22	2.73	3.14



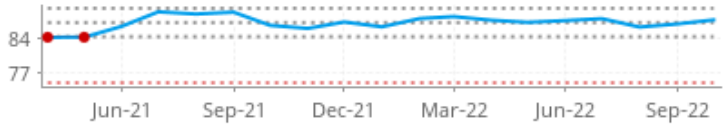
Length of Stay - Emergency

Month	Performance	Standard
Oct-22	2.85	3.35



Day Case Rate

Month	Performance	Standard
Oct-22	87.70%	75.00%



Efficiency & Productivity

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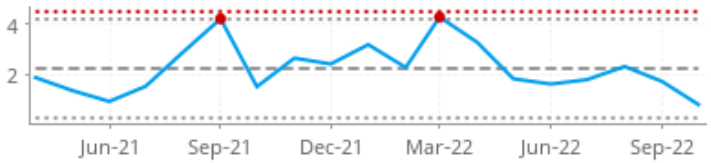
North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

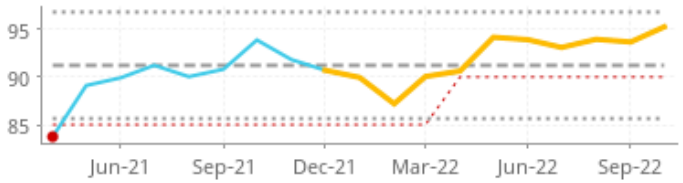
Pre-op Stays

Month	Performance	Standard
Oct-22	0.78%	4.50%



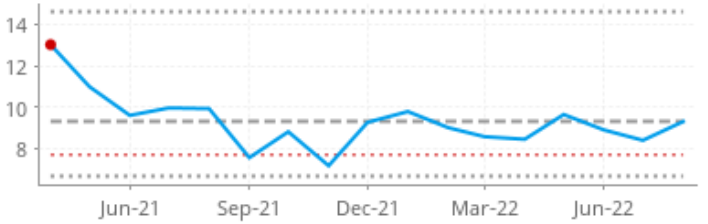
Trust Occupancy

Month	Performance	Standard
Oct-22	95.24%	90.00%



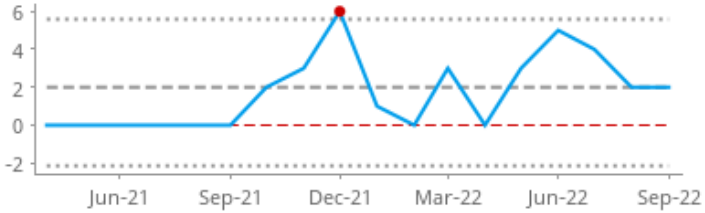
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Aug-22	9.31%	7.70%



Not Reappointed within 28 days

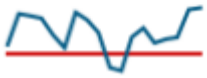
Month	Performance	Standard
Sep-22	2	0



Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Sep 21 - Aug 22	94.08	
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Jun 21 - May 22	98.26	

Standard	Standard Achieved	Month	Performance	Standard	Trend
Stage 1 Complaint	✗	Oct-22	115	107	
Stage 2 Complaint	✗	Oct-22	9	6	
Stage 3 Complaint	✓	Oct-22	6	9	
Compliments	✓	Oct-22	393	271	

Narrative

Mortality

The latest HSMR value is currently reporting at 94.08 (September 2021 to August 2022) which has increased slightly from the previous rebased value of 94.03 (August 2021 to July 2022). The latest SHMI value is now 98.26 (June 2021 to May 2022) which has increased from the previous rebased value of 97.50 (May 2021 to April 2022).

Complaints

The number of complaints has decreased by 3 in October, compared with the previous month. The total number of Stage 1 complaints received is 115, which is 8 less than the previous month, with an increase of 4 in Stage 2 complaints (from 5 in September) and a increase of 2 in Stage 3 complaints (4 in September). 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 October 2022, Length of Time to be given an Appointment was the highest theme mentioned in 23 complaints, which is an increase of 10 from September, this was spread across 17 different wards/departments. There was an increase of 5 in the theme Care and Compassion and a decrease of 10 in Communication (verbal).

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.

A Complaint Improvement Project has commenced to identify areas for improvement and associated actions. Updates will be included in future reports.

Compliments

The Trust records the compliments received onto the Greatix platform. For October 2022 the number of compliments received is 393, which is higher than the mean of 271 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	✓	Oct-22	3	4	
Never Events	✓	Oct-22	0	0	
VTE %	✓	Oct-22	97.02%	95.00%	
Fall No Harm	✓	Oct-22	65	83	
Fall Low Harm	✗	Oct-22	17	16	
Fall Moderate Harm	✗	Oct-22	2	1	
Fall Severe Harm	✓	Oct-22	0	0	

Narrative

Falls

There has been a total of 84 falls reported in October. 65 falls were reported as no harm. Low harm falls have decreased to 27 from 21 when compared to the previous month and falls reported as moderate harm increased in October to 2 falls.

Some of the themes identified from recent investigations include non-compliance in completing lying and standing blood pressures. The Trust falls lead and heads of nursing are currently reviewing the process and requirements to support ward based staff.

Safety & Quality

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North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend	Narrative
Pressure Category 1 (inpatient)	✗	Sep-22	9	4		**Pressure Ulcers** In the September 2022 reporting period, there were nine Category one pressure ulcers validated, which is greater than our expected standard of four cases, and demonstrates early identification. A decrease in Category two pressure ulcers is noted from 30 to 20, which is in line with the accepted standard of 20 cases. There has been three Category three pressure ulcers identified in September 2022, which is above the expected standard of one. There have been 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.
Pressure Category 2 (inpatient)	✓	Sep-22	20	20		
Pressure Category 3 (inpatient)	✗	Sep-22	3	1		
Pressure Category 4 (inpatient)	✓	Sep-22	0	0		

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Hand Hygiene	✓	Oct-22	96%	95%	
Clostridioides difficile (cdiff)	✗	Oct-22	7	5	
MRSA	✓	Oct-22	0	0	
MSSA	✓	Oct-22	1	2	
Ecoli	✓	Oct-22	5	6	
Klebsiella	✓	Oct-22	2	2	
Pseudomonas	✗	Oct-22	3	1	
CAUTI	✓	Oct-22	13	19	

Narrative

Infections

In October 2022, the Trust reported seven cases of Clostridioides difficile infection, which is above the predicted trajectory of five cases. Our yearly objective for 2022-23 is 54 cases of Clostridioides Difficile, with our current case figure of 31.

The Trust has reported 5 E-coli bacteraemia in October 2022, which is one below our projected case rate of six. Our yearly objective for E-coli bacteraemia for 2022-23 is 73, with 50 cases since the start of the financial year. Ongoing project work continues with a catheter care and prevalence audit being completed in November.

There have been three trust attributable cases reported for Pseudomonas infections, which remains above our projected case rate of one for October. Our 2022-23 objective is 12 cases, and we currently report 11 to date. The trust reported two cases of Klebsiella in October 2022, in line with our predicted trajectory. Our yearly objective for Klebsiella species for 2022-23 is 21 cases, currently the trust stand at 16 cases.

There has been one healthcare-associated case of MSSA in October, which is below our monthly projected trajectory of two cases. There is no national objective set for MSSA, but our own internal trust target for 2022-23 is 30 cases. The trust have had 18 cases in total for this financial year.

For the month of September, 13 CAUTI cases were reported for the trust, which is below our standard for the month.

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

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NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	✓	Oct-22	83.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	✓	Oct-22	85.00%	75.00%	
Friends and Family Test (FFT) - Maternity	✓	Oct-22	87.00%	75.00%	
UNIFY - RN Day	✗	Oct-22	75.15%	>=80% and <=109.99%	
UNIFY - RN Night	✓	Oct-22	87.58%	>=80% and <=109.99%	
UNIFY - HCA Day	✓	Oct-22	80.41%	>=80% and <=109.99%	
UNIFY - HCA Night	✓	Oct-22	125.05%	>=110% and <=125.99%	

Friends and Family

For September 2022 the Trust received 1,375 FFT returns, this is an increase on the previous months updated return of 1,352. The Very Good or Good responses returned for October 2022 is 90.69%.

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 which are forecast to improve significantly from Dec22/Jan23 but due to a lot of newly registered staff currently completing preceptorship programmes and remaining in a supernumerary position the fill rates for shift remains a challenge. In wards and departments where there is a reduced RN fill there is clear utilisation of the Nursing Associate role within the workforce models and skill mix of staff and levels of experience are reviewed daily to ensure the right skills are in the right place to deliver the safest and most efficient care to patients at all times. The daily challenges continue to be managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse.

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

Monthly recruitment processes are on-going for both Registered Nurses and Unregistered Nurses and cohort 4 of Team Support Workers are planned for recruitment in December 2022.The next cohort is to be recruited in November 2022. Approx. 35wte Pre Reg Nurses have recently taken up their positions throughout Sept/Oct 2022 with the next cohort of Pre Registered nurses (28 in total) planned for interview in November 2022 in preparation for their registration in January/February 2023.

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

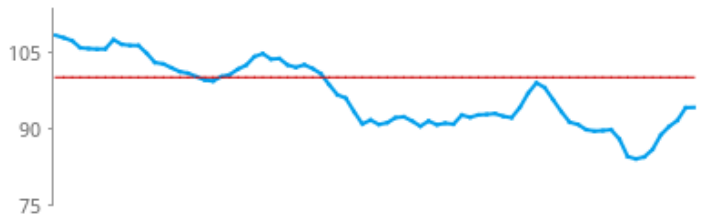
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Additional Detail Charts

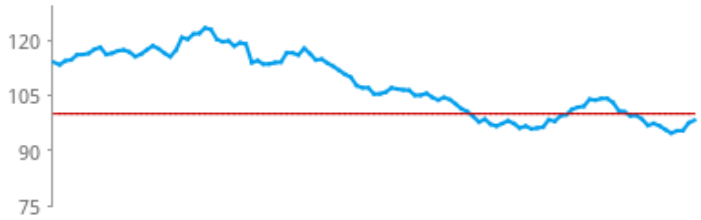
Hospital Standardised Mortality Ratio

Month	Performance
Sep 21 - Aug 22	94.08



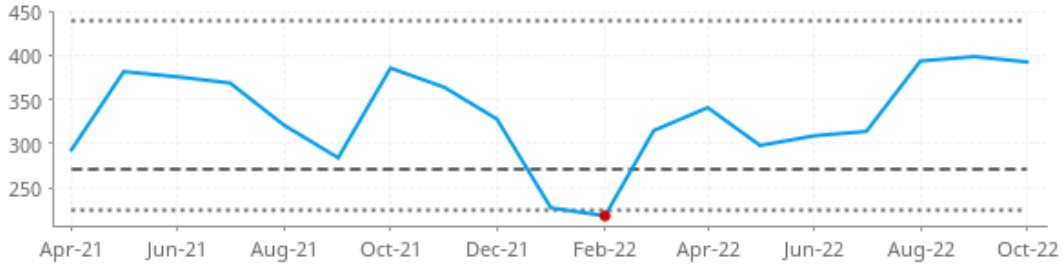
Summary Hospital-Level Mortality Indicator

Month	Performance
Jun 21 - May 22	98.26



Compliments

Month	Performance	Standard
Oct-22	393	271



Safety & Quality

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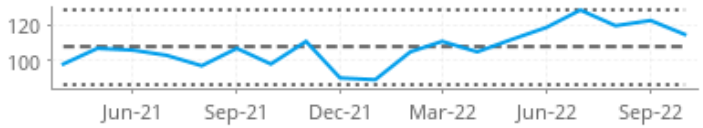
NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

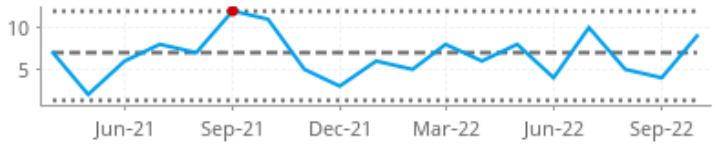
Stage 1 - Informal

Month	Performance	Standard
Oct-22	115	107



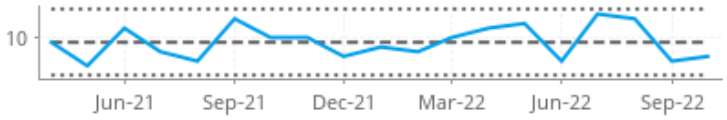
Stage 2 - Meeting

Month	Performance	Standard
Oct-22	9	6



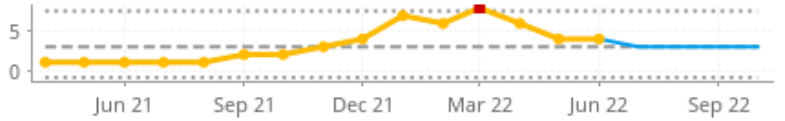
Stage 3 - Formal

Month	Performance	Standard
Oct-22	6	9



Red Risks

Month	Performance	Standard
Oct-22	3	4

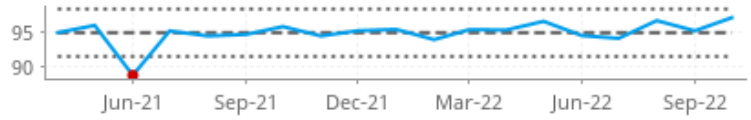


Never Events

Month	Performance	Standard
Oct-22	0	0

VTE %

Month	Performance	Standard
Oct-22	97.02%	95.00%



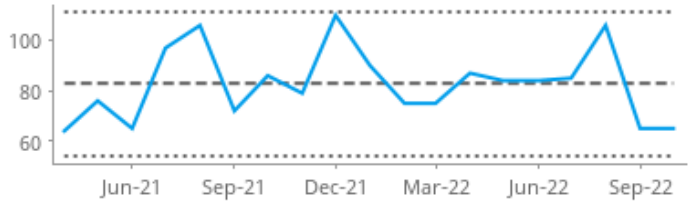
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

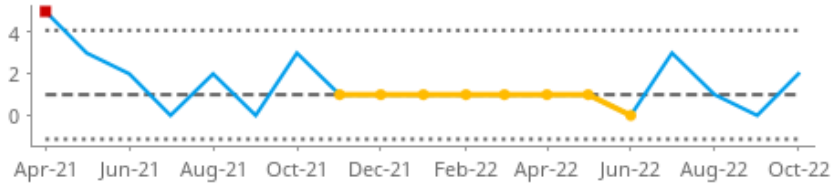
Fall No Harm

Month	Performance	Standard
Oct-22	65	83



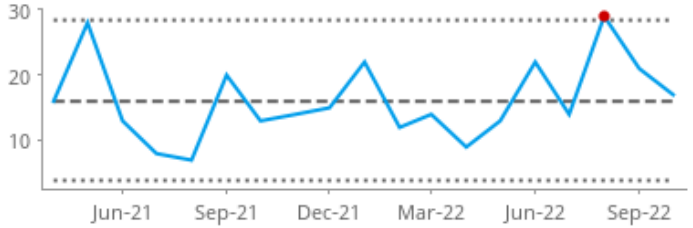
Fall Moderate Harm

Month	Performance	Standard
Oct-22	2	1



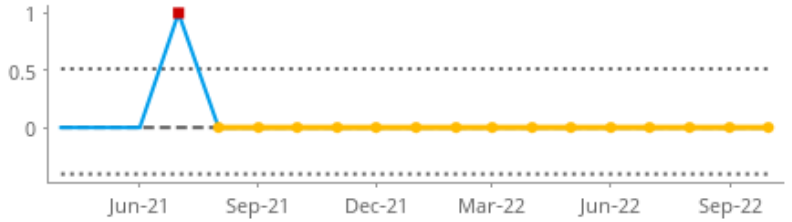
Fall Low Harm

Month	Performance	Standard
Oct-22	17	16



Fall Severe Harm

Month	Performance	Standard
Oct-22	0	0



Safety & Quality

NHS
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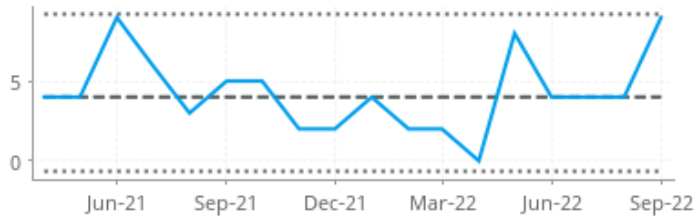
Statistical Process Control (SPC) Charts

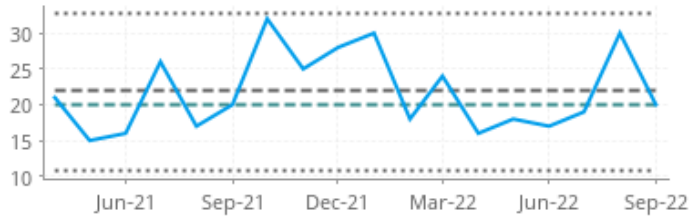
Pressure Ulcer Cat 1

Month	Performance	Standard
Sep-22	9	4



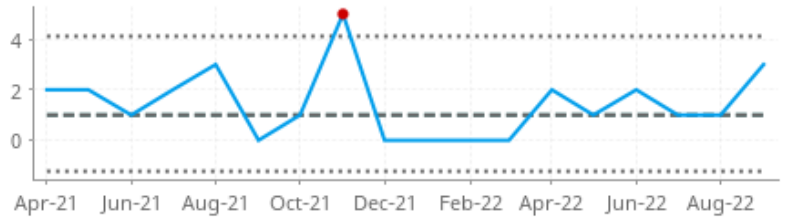
Pressure Ulcer Cat 2

Month	Performance	Standard
Sep-22	20	20



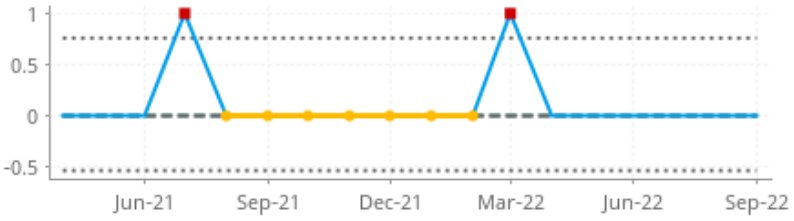
Pressure Ulcer Cat 3

Month	Performance	Standard
Sep-22	3	1



Pressure Ulcer Cat 4

Month	Performance	Standard
Sep-22	0	0



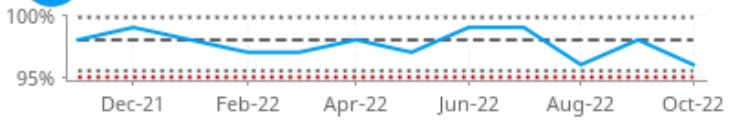
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

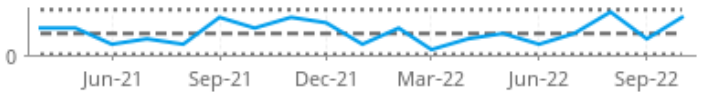
Hand Hygiene

Month	Performance	Standard
Oct-22	96%	95%



Cdiff

Month	Performance	Standard
Oct-22	7	5



MRSA

Month	Performance	Standard
Oct-22	0	0

MSSA

Month	Performance	Standard
Oct-22	1	2

Ecoli

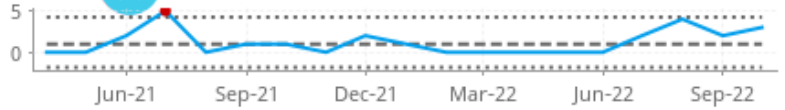
Month	Performance	Standard
Oct-22	5	6

Klebsiella

Month	Performance	Standard
Oct-22	1	2

Pseudomonas

Month	Performance	Standard
Oct-22	3	1



CAUTI

Month	Performance	Standard
Oct-22	13	19

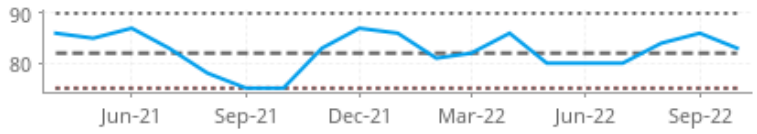
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SCP) Charts

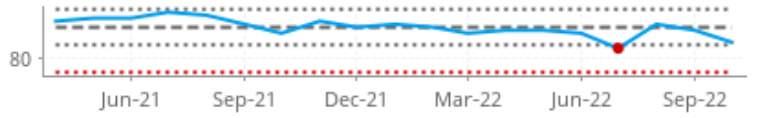
FFT Emergency Care

Month	Performance	Standard
Oct-22	83.00%	75.00%



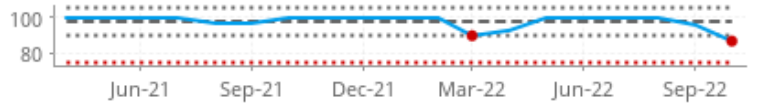
FFT Inpatient

Month	Performance	Standard
Oct-22	85.00%	75.00%



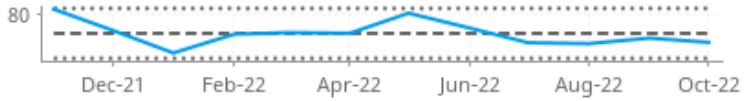
FFT Maternity

Month	Performance	Standard
Oct-22	87.00%	75.00%



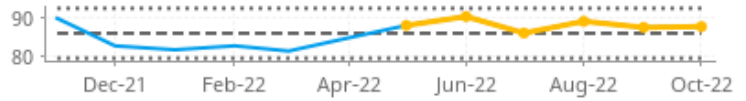
UNIFY RN Day

Month	Performance	Standard
Oct-22	75.15%	>=80% and <=109.99%



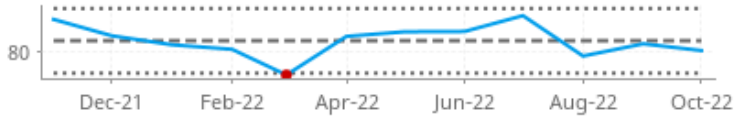
UNIFY RN Night

Month	Performance	Standard
Oct-22	87.58%	>=80% and <=109.99%



UNIFY HCA Day

Month	Performance	Standard
Oct-22	80.41%	>=80% and <=109.99%



UNIFY HCA Night

Month	Performance	Standard
Oct-22	125.05%	>=110% and <=125.99%

Workforce

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Standard	Standard Achieved				Narrative
	Month	*Performance*	*Standard*	*Trend*	
Sickness - Overall					**Sickness absence** - The sickness absence rate saw an increase in September 2022 compared to August 2022; increasing from 5.09%% to 5.28%. This was split by 4.56% non-COVID and 0.72% COVID related absence. Short term absences make up 2.62% of this figure with long term absences making up 2.66%.
✖	Sep-22	5.28%	4.00%		
Sickness Breakdown					Mental health conditions (stress / anxiety / depression) were the most common reason for absence followed by chest and respiratory problems and musculoskeletal problems. A Financial wellbeing event on the 19th of October 2022 was a huge success and id being replicated at UHH. The training for managers has been well attended and well evaluated and will now shift to a more coaching style of support in the management of absences across the Trust. A task and finish group has met and developed an action plan and process mapping of sickness absence management processes has begun.
Short Term	Sep-22	2.62%			
Long Term	Sep-22	2.66%			

Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Appraisals				
✖	Oct-22	86.17%	95.00%	
Turnover				
✖	Oct-22	10.78%	10.00%	
Mandatory Training				
✖	Oct-22	89.47%	90.00%	

Narrative

Appraisals - The position for appraisal compliance from October's overall Trust RAG report stands at 85.60% (amber) which is an decrease of 0.57% compared to September 2022's figure. Work is ongoing to remind managers of the importance of appraisals and in particular, their responsibilities in ensuring they undertake ongoing progress checks with their direct reports and highlight any areas of concern, as well as giving praise on a regular basis. Managers are also encouraged to utilise ESR Supervisor Self-Service to record completion of appraisal undertaken which automatically updates employee records thus, positively impacting on compliance figures.

Staff Turnover - Turnover reduced from 10.99% to 10.78% in October and this is the lowest rate since October 2021. Focus on feedback received from staff following engagement around reward and recognition will result in positive action with the aim of reducing the turnover further. We continue to monitor exit interview feedback.

Mandatory Training – As per previous months, there remains key topics areas which remain below the required level of compliance including manual handling, safeguarding and several resuscitation courses. A task and finish group is being established to consider a number of options around resuscitation courses being delivered differently, including exploring whether concentrating courses between March to October would reduce the number of non-attendances. The outcome of this work will be fed into the People Committee, working collaboratively with the Care Groups to ensure a solution-focussed approach is applied to increasing accessibility and availability as required.

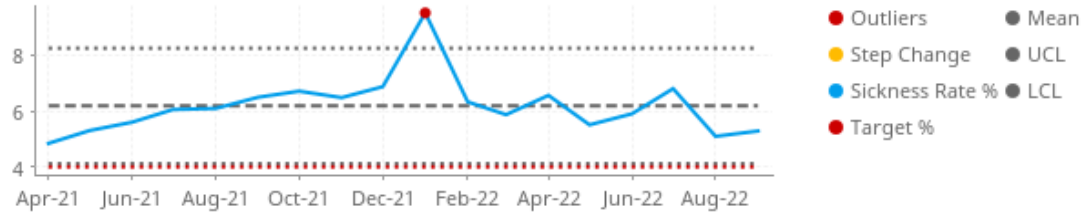
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

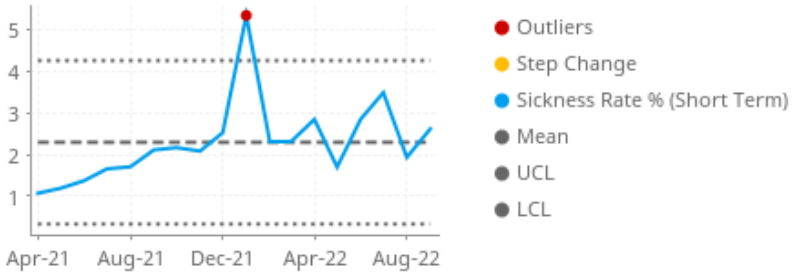
Sickness - Overall

Month	Performance	Standard
Sep-22	5.28%	4.00%



Short Term

Month	Performance
Sep-22	2.62%



Long Term

Month	Performance
Sep-22	2.66%

Workforce

NHS
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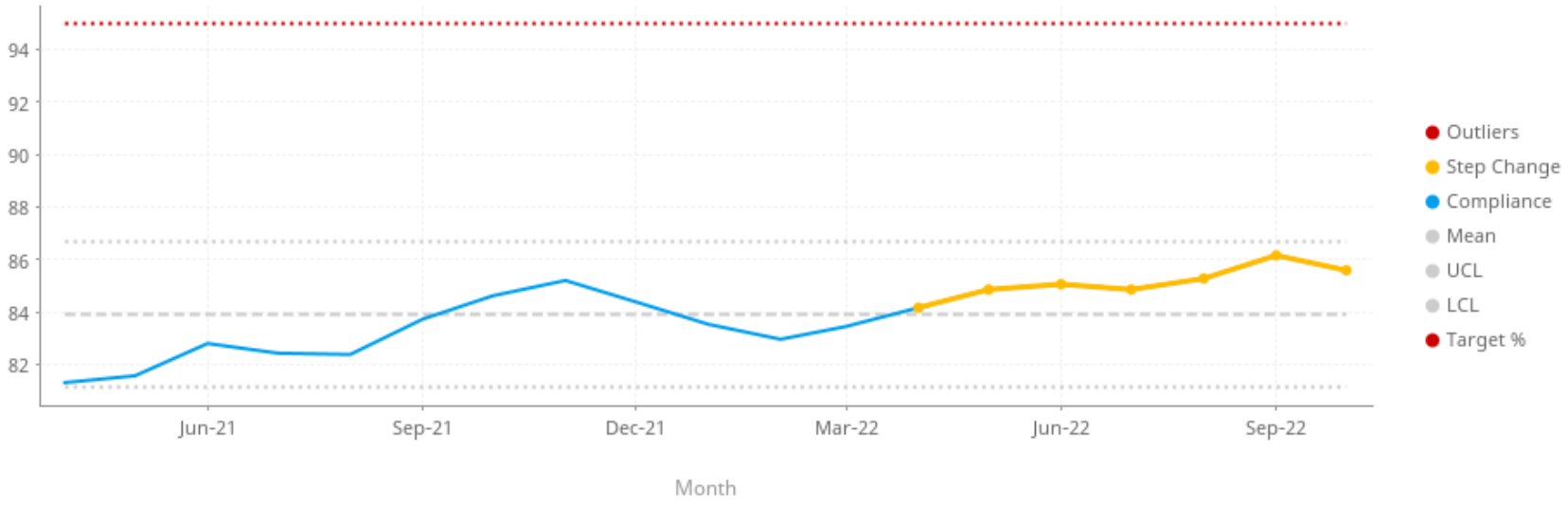
Statistical Process Control (SPC) Charts

Appraisal

Month	Performance	Standard
Oct-22	86.17%	95.00%



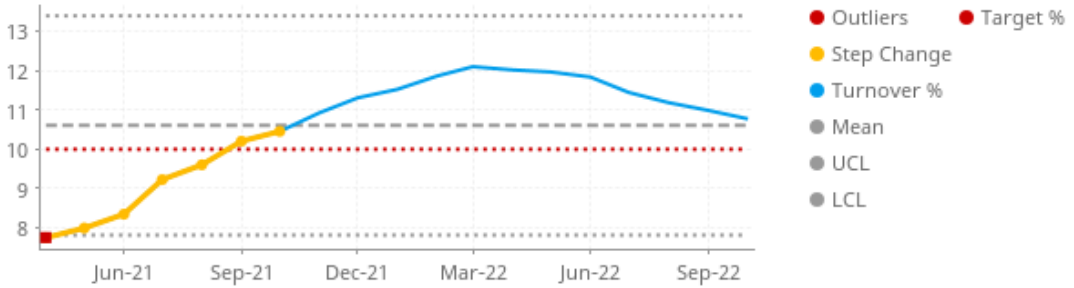
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

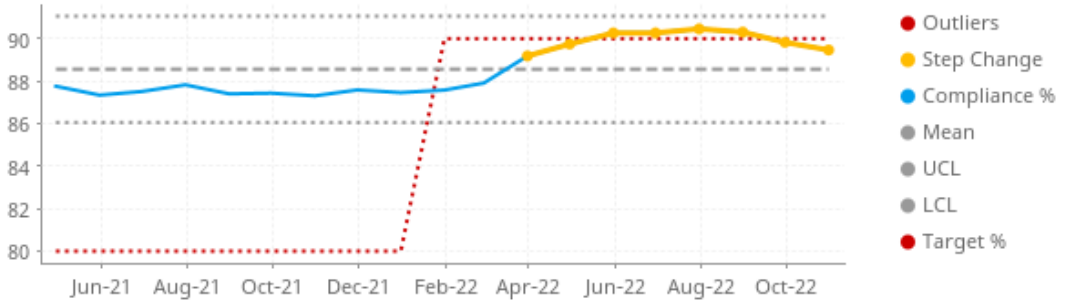
Turnover

Month	Performance	Standard
Oct-22	10.78%	10.00%



Mandatory Training

Month	Performance	Standard
Oct-22	89.47%	90.00%



Finance

North Tees and Hartlepool NHS Foundation Trust

Finance Overview - Month 7

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	112	(92)	😐
Year to Date	4,492	4,609	🙂

Balance Sheet

£m

Cash Actual	82.3
Cash Plan*	69.0

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

Capital (*)

	Plan (£m)	Actual (£m)	
In Month	1,974	1,343	🙂
Year to Date	4,975	4,859	🙂

* Capital plan rephased to commence from 01 July 2022

NHS Oversight Framework (Issued 27 June 2022)

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

NHS
North Tees and Hartlepool
NHS Foundation Trust

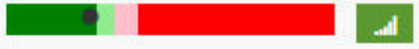
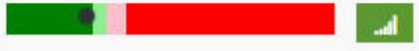
Appendix 1

RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - September 22										
Incomplete Pathways waiting <18 weeks	59.4%		78.4%	76.8%	59.9%	74.3%	69.2%	82.5%	65.9%	66.7%
Half of incomplete patients wait less than	14		9	9	14	10	11	10	12	12
Half of admitted patients wait less than	13		9	17	23	15	12	13	10	9
19 out of 20 admitted patients wait less than	67		36	43	65	48	64	43	57	59
Half of Non admitted Pathways waited less than	9		5	7	8	4	8	6	6	8
19 out of 20 non admitted patients wait less than	52		9	13	14	7	14	10	11	14
Incomplete Pathways waiting >52 weeks	401537		32	131	809	91	4723	11	1394	1666

Cancer Waiting times Summary		S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals		92.94 (1277/1374)	73.91 (405/548)	79.77 (844/1058)	56.36 (1563/2773)	94.16 (1678/1782)	65.56 (1220/1861)	83.45 (993/1190)	70.27 (1657/2358)	74.45 (9637/12944)
Breast Symptomatic Referrals		0 (0/0)	0 (0/0)	90.32 (28/31)	69.72 (99/142)	97.78 (88/90)	100 (14/14)	93.63 (191/204)	59.28 (115/194)	79.26 (535/675)
31 Day First Treatments		96.22 (178/185)	76 (38/50)	100 (126/126)	78.43 (429/547)	97.44 (190/195)	91.94 (228/248)	97.08 (133/137)	90.81 (168/185)	89.06 (1490/1673)
31 Day Subsequent Treatments - Drugs		100 (93/93)	0 (0/0)	100 (65/65)	95.8 (228/238)	100 (18/18)	96.43 (81/84)	100 (63/63)	100 (9/9)	97.72 (557/570)
31 Day Subsequent Treatments - Radiotherapy		0 (0/0)	0 (0/0)	0 (0/0)	97.38 (372/382)	100 (1/1)	56.54 (108/191)	0 (0/0)	0 (0/0)	83.8 (481/574)
31 Day Subsequent Treatments - Surgery		94.12 (16/17)	100 (4/4)	95.65 (22/23)	60.16 (77/128)	100 (12/12)	50 (5/10)	87.5 (14/16)	72.73 (16/22)	71.55 (166/232)
62 Day Target - 2WW		72.69 (86.5/119)	56.32 (24.5/43.5)	72.03 (51.5/71.5)	44.1 (93.5/212)	75.26 (108/143.5)	60.11 (105.5/175.5)	62.72 (53/84.5)	73.12 (102/139.5)	63.14 (624.5/989)
62 Day Target -Screening		100 (2/2)	65 (6.5/10)	92.06 (29/31.5)	58.76 (28.5/48.5)	100 (1/1)	50 (4/8)	88.46 (23/26)	33.33 (1/3)	73.08 (95/130)
62 Day Target - Upgrade		79.55 (17.5/22)	50 (2.5/5)	100 (0.5/0.5)	48.65 (18/37)	69.23 (9/13)	59.18 (14.5/24.5)	86.36 (9.5/11)	78.13 (12.5/16)	65.12 (84/129)
28 Day Target - 2WW		68.7 (935/1361)	57.99 (265/457)	75.45 (756/1002)	60.67 (1385/2283)	71.15 (1280/1799)	71.5 (991/1386)	77.32 (825/1067)	87.95 (1635/1859)	71.98 (8072/11214)
28 Day Target -Breast Symptomatic		0 (0/0)	20 (1/5)	100 (32/32)	90.65 (126/139)	78.76 (89/113)	100 (14/14)	98.99 (197/199)	89.23 (174/195)	90.82 (633/697)
28 Day Target - Screening		40 (2/5)	33.33 (1/3)	65.93 (89/135)	76.61 (131/171)	63.04 (29/46)	58.33 (7/12)	74.46 (137/184)	56.82 (25/44)	70.17 (421/600)
28 Day Target - Overall		68.59 (937/1366)	57.42 (267/465)	75.02 (877/1169)	63.32 (1642/2593)	71.4 (1398/1958)	71.67 (1012/1412)	79.93 (1159/1450)	87.42 (1834/2098)	72.94 (9126/12511)

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 (Oct 2022)	8.55% (Aug 2021 - Jul 2022)	8.64% (Jul 2021 - Jun 2022)	-0.09 ↓	7.57%	7.19%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Oct 2022)	1.90% (Aug 2021 - Jul 2022)	1.96% (Jul 2021 - Jun 2022)	-0.06 ↓	2.32%	1.93%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Oct 2022)	4.45% (Aug 2021 - Jul 2022)	4.53% (Jul 2021 - Jun 2022)	-0.08 ↓	4.97%	4.14%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Oct 2022)	6.90% (Aug 2021 - Jul 2022)	6.97% (Jul 2021 - Jun 2022)	-0.07 ↓	7.10%	5.88%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Oct 2022)	9.82% (Aug 2021 - Jul 2022)	9.91% (Jul 2021 - Jun 2022)	-0.09 ↓	9.67%	8.00%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Oct 2022)	8.38% (Sep 2021 - Aug 2022)	8.32% (Aug 2021 - Jul 2022)	0.06 ↑	8.48%	7.84%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Oct 2022)	2.53 (Sep 2021 - Aug 2022)	2.53 (Aug 2021 - Jul 2022)	No Change	2.33	2.14	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Oct 2022)	0.00% (Sep 2021 - Aug 2022)	0.00% (Aug 2021 - Jul 2022)	No Change	9.06%	9.61%	
Rate of telephone or Telemedicine consultations (12 mth rolling) HES Outpatients (Oct 2022)	20.82% (Sep 2021 - Aug 2022)	21.10% (Aug 2021 - Jul 2022)	-0.28 ↓	18.55%	21.17%	
Rate of telephone or Telemedicine consultations for followup consultation (12 mth rolling) HES Outpatients (Oct 2022)	21.60% (Sep 2021 - Aug 2022)	21.83% (Aug 2021 - Jul 2022)	-0.23 ↓	19.91%	23.68%	
Rate of telephone or Telemedicine consultations for first consultation (12 mth rolling) HES Outpatients (Oct 2022)	18.85% (Sep 2021 - Aug 2022)	19.28% (Aug 2021 - Jul 2022)	-0.43 ↓	15.39%	15.95%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Sep 2022)	88.10% (Aug 2021 - Jul 2022)	88.63% (Jul 2021 - Jun 2022)	-0.53 ↓	79.80%	79.23%	
Cancer waiting times - 28-day Faster Diagnosis Standard (12 mth rolling) Cancer Waiting Times (Sep 2022)	80.52% (Aug 2021 - Jul 2022)	80.09% (Jul 2021 - Jun 2022)	0.43 ↑	77.16%	71.17%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Sep 2022)	96.72% (Aug 2021 - Jul 2022)	96.86% (Jul 2021 - Jun 2022)	-0.14 ↓	91.46%	92.69%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Sep 2022)	65.01% (Aug 2021 - Jul 2022)	65.87% (Jul 2021 - Jun 2022)	-0.86 ↓	65.72%	65.05%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Sep 2022)	77.36% (Aug 2021 - Jul 2022)	77.28% (Jul 2021 - Jun 2022)	0.08 ↑	67.36%	62.18%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Sep 2022)	86.59% (Aug 2021 - Jul 2022)	87.32% (Jul 2021 - Jun 2022)	-0.73 ↓	84.17%	75.19%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Sep 2022)	83.32% (Aug 2021 - Jul 2022)	84.03% (Jul 2021 - Jun 2022)	-0.71 ↓	72.58%	58.33%	
Day case realisation rate (12 mth rolling) HES Inpatients (Oct 2022)	96.82% (Sep 2021 - Aug 2022)	96.87% (Aug 2021 - Jul 2022)	-0.05 ↓	96.74%	96.67%	

Day case rate (12 mth rolling) HES Inpatients (Oct 2022)	85.41% (Sep 2021 - Aug 2022)	85.92% (Aug 2021 - Jul 2022)	-0.51 ↓		84.99%	72.95%	
Average excess length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.13 (Sep 2021 - Aug 2022)	0.10 (Aug 2021 - Jul 2022)	0.03 ↑		0.45	0.56	
Average length of stay (12 mth rolling) HES Inpatients (Oct 2022)	3.23 (Sep 2021 - Aug 2022)	3.22 (Aug 2021 - Jul 2022)	0.01 ↑		3.94	4.79	
Average elective length of stay (12 mth rolling) HES Inpatients (Oct 2022)	1.79 (Sep 2021 - Aug 2022)	1.80 (Aug 2021 - Jul 2022)	-0.01 ↓		3.20	4.53	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Oct 2022)	3.38 (Sep 2021 - Aug 2022)	3.37 (Aug 2021 - Jul 2022)	0.01 ↑		4.05	4.80	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.21 (Sep 2021 - Aug 2022)	0.21 (Aug 2021 - Jul 2022)	No Change		0.22	0.23	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.01 (Sep 2021 - Aug 2022)	0.01 (Aug 2021 - Jul 2022)	No Change		0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.36 (Sep 2021 - Aug 2022)	0.37 (Aug 2021 - Jul 2022)	-0.01 ↓		0.42	0.48	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.81 (Sep 2021 - Aug 2022)	0.82 (Aug 2021 - Jul 2022)	-0.01 ↓		1.01	0.97	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	0.20 (Sep 2021 - Aug 2022)	0.19 (Aug 2021 - Jul 2022)	0.01 ↑		0.30	0.26	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Oct 2022)	1.27 (Sep 2021 - Aug 2022)	1.29 (Aug 2021 - Jul 2022)	-0.02 ↓		1.71	1.82	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Oct 2022)	36.14% (Sep 2021 - Aug 2022)	36.08% (Aug 2021 - Jul 2022)	0.06 ↑		40.46%	34.56%	
Elective stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Oct 2022)	5.05% (Sep 2021 - Aug 2022)	4.95% (Aug 2021 - Jul 2022)	0.10 ↑		10.94%	12.32%	
Emergency stranded rate (7+ days LOS) (12 mth rolling) HES Inpatients (Oct 2022)	16.94% (Sep 2021 - Aug 2022)	16.78% (Aug 2021 - Jul 2022)	0.16 ↑		18.15%	21.66%	
Elective super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Oct 2022)	0.55% (Sep 2021 - Aug 2022)	0.55% (Aug 2021 - Jul 2022)	No Change		2.02%	3.17%	
Emergency super-stranded rate (21+ days LOS) (12 mth rolling) HES Inpatients (Oct 2022)	3.05% (Sep 2021 - Aug 2022)	3.03% (Aug 2021 - Jul 2022)	0.02 ↑		4.85%	6.02%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Oct 2022)	90.68% (Sep 2021 - Aug 2022)	91.89% (Aug 2021 - Jul 2022)	-1.21 ↓		72.44%	77.88%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Oct 2022)	0.26% (Sep 2021 - Aug 2022)	0.25% (Aug 2021 - Jul 2022)	0.01 ↑		0.83%	0.89%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Oct 2022)	81.98 (Sep 2021 - Aug 2022)	81.28 (Aug 2021 - Jul 2022)	0.70 ↑		98.04	100.92	

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Capital Programme Performance Q2 – 2022/23										
Date:	24th November 2022										
Prepared by:	Steven Taylor, Assistant Director of Estates and Capital NT&HS LLP										
Executive sponsor:	Neil Atkinson, Director of Finance										
Purpose of the report	The purpose of this report is to provide the Board of Directors with an update as of 30 September 2022 (Quarter 2) on the progress of delivering the 2022/23 capital programme, along with the current forecast position, highlighting any risks in delivery.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Capital Programme Delivery 2022/23

The Trust's overall capital programme plan at month 3 is £21.983m and is broken down as follows:

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

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

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

Capital Spend Phasing

The phasing of the capital plan is 14% July to September, 28% October to December and 58% January to March, to allow for approval of the plan in July 2022.

Month 6 Position

As at month 6, the Trust has spent £3.5m against a year-to-date CDEL plan of £3.0m.

Slippage

There is identified slippage relating to new hospital support spend and robot enabling works. Capital Managers have been tasked to present plans at the next CRMG meeting to ensure delivery of the capital allocation.

Forecast

The Trust has a strong track record of delivery of its capital programme and is forecasting to deliver the capital plan by year end. This is underpinned by the capital performance framework which is reported to the Capital & Revenue Management Group each month.

Full details of capital programme delivery is contained in the attached report.

Month 7 Update

As at month 7, the Trust has spent £4.9m against a year-to-date plan (CDEL) of £5.0m, so is behind plan by £0.1m.

Full details of the capital programme will be presented to the Board as part of Quarter 3 reporting.

How this report impacts on current risks or highlights new risks:
This report doesn't highlight any new risks.

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

North Tees and Hartlepool NHS Foundation Trust

Capital Programme Performance Q2 2022/23

Report of the Director of Finance

Strategic Aim

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

Transforming our Services

1. Introduction / Background

1.1 The purpose of this paper is to provide an update as of 30 September 2022 (Quarter 2) on the progress of delivering the 2022/23 capital programme and also provide an update on any recent changes that have been announced nationally and regionally that will impact on the Trust's programme.

1.2 The NHS Improvement Compliance Framework requires that a minimum of 85% and a maximum of 115% of the original capital allocation should be spent on a monthly basis. Only goods and services that have been received or invoiced may be counted as expenditure.

2. Main content of report

2.1 The Trust's overall capital programme plan at Month 6 is £21.983m and is broken down as follows;

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

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

The annual capital plan for 2022/23 (detailed by scheme) was presented and approved at Capital and Revenue Management Group on 29th July 2022.
As at Month 6, the Trust has spent £3.5m against a year-to-date CDEL plan of £3.0m.

The phasing of the capital plan is 14% April to September, 28% October to December and 58% January to March, to allow for approval of the plan in July 2022.

The capital plan has been re-phased by scheme to match the July 2022 forecast, following approval of the capital programme. However, to ensure that we match to the submitted NHSI plan, the phasing in contingency is amended and for this reason, this phasing may appear as a negative.

2.2 **Estates**

Total expenditure on Estates schemes is £2.9m at the end of September 2022 against a year to date budget of £3.1m, so slightly behind plan. Estates schemes include backlog, new hospital OBC, robot enabling works and pathology collaboration.

2.3 **Medical Equipment**

Total expenditure on Medical Equipment schemes is £0.3m at the end of September 2022, against a year to date budget of £0.0m, so is ahead of plan.

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

Total expenditure on IT&S schemes is £0.3m at the end of September 2022, against a year to date budget of £0.2m, so is ahead of plan.

2.5 **Contingency**

Total expenditure on contingency schemes is £0.0m against a negative plan of £0.3m so behind plan.

2.6 **Forecast 2022/23**

The capital forecast for the year at September 2022 agrees to the annual plan.

At the Capital and Revenue Management Group meeting in September 2022, risks to the capital programme delivery were presented and the main concerns are the new hospital support £4.0m and robot enabling works £2.1m. Also, pathology collaboration will overspend by £0.6m. Therefore, there is potential slippage of £5.5m. The estates capital manager has agreed to bring forward £3m of backlog requirements from future years to support this, leaving £2.5m of potential slippage.

The medical equipment capital manager will present to the Capital and Revenue Management Group in October 2022, any medical equipment which could potentially be brought forward from future years to support CDEL delivery in 2022/23.

2.7 The overall detailed work-stream reports for Q2 are presented in **Appendix 1**.

2.8 The overall financial summary for the period to 30 September 2022 is presented at **Appendix 2**.

3. Recommendation

3.1 The Board is requested to receive this report and note the position on capital schemes up to 30 September 2022.

4. Month 7 Update

As at month 7, the Trust has spent £4.9m against a year-to-date plan (CDEL) of £5.0m, so is behind plan by £0.1m. Full details of the capital programme will be presented to the Board as part of Quarter 3 reporting.

Neil Atkinson
Director of Finance

Gillian Colquhoun
Interim Chief Information and Technology Officer/SIRO

Appendix 1 - Work Stream Reports

1. Estates Backlog Maintenance Programme

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

A detailed spend profile project by project was developed. This allows for monthly reporting against time and cost for the overall programme (as required by NHSI). £5.5m has been allocated to Backlog Maintenance which includes £1.657m of pre commitments carried forward from FY 2021/22.

Lift Replacement UHH: Replacement of the three ageing lifts in the acute block at UHH. One lift has been completed and out of the remaining two, one will include a bed evacuation capability. Work is planned to be completed by end of Q3.

Lift Replacement PCH: Replacement of the single lift at PCH. The works started in mid-July 2022 and was completed by the 7th September 2022.

DDA Audit: The final access audit report is due for sign off in November 2022. The individual site updates are as follows:

PCH: Survey complete and discussed at Access Group Meeting.
UHH: Survey now complete with draft report received end of September for review.
UHNT: Survey to commence early October with draft report due to be submitted end of October.

Roofing Repairs UHH: Phase 2 works planned for FY 2022/23 have now been completed. Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

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

The urgent repair works have now been fully costed and are due to commence on the 10th October for 26 weeks.

South Wing

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

Tower Block

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

Works to Tower Block will commence towards the end of October 2022 and includes additional wall ties and pigeon spikes.

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.

The work has been fully costed and is due to commence in October 2022 and will involve the removal of the redundant gas pipe and fitting of additional support brackets.

Total Cost: £1m (excluding VAT)

NTH Solutions will be conducting significant engagement with the services in the impacted areas to minimise disruption.

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 main staircase and the main circulation corridors around the lower ground floor and ground floor.

The replacement works will continue on both main sites into FY 2022/23. West Wing remains a high priority for FY 2022/23.

West Wing Fire Precautions: Initial remedial works were carried out and the alignment of the fire compartmentation started mid-July 2022 on the first floor and within the roof space. One of the lifts is planned to be upgraded to a patient evacuation lift by Kone and work is planned to be completed in early October 2022.

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 FY 2021/22 and the remaining spend in FY 2022/23. The installation is now 95% complete, with the majority of areas complete. The project team has consistently worked closely with the clinical teams to arrange access to clinical areas and using installation methods agreed with Infection Prevention and Control. The installation is planned to be completed by the end of October 2022 followed by soak testing and changeover date to be agreed before the end of November 2022.

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

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

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 early Q3 of FY 2022/23.

2. Other Estates Capital Developments

Community Diagnostic Hubs: Collaborative planning continues to deliver the Tees Valley element of the national plan to develop hub and spoke arrangements for diagnostic facilities outside of acute settings and within the community. Plans have been developed for the spokes at UHH, Stockton (Lawson Street) and Redcar (South Tees). The spoke delivering additional MRI scanning capability became operational on the UHH site at the end of September with Respiratory and CT scanning services operational in Q1 FY 2022/23.

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

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

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

There have been ongoing issues with regards Virgin Media installing the required fibre link between North Tees and South Tees and Lawson Street to North Tees (Trust order raised in February 2022). The project team has raised formal complaint with Virgin Media CEO and CISAS (Ombudsman). The latest position is that we have a provisional installation date in early October for the North and South Tees link. No date has been provided yet for Lawson Street but the project team continue to chase.

Pathology Collaboration: The project team has been established and external design team appointed. Work to develop the 1:100 drawing for the new cellular pathology has been agreed and signed off by pathology stakeholders from North Tees and South Tees. The overall estate plan is for microbiology to be vacated and works to commence in November with completion by Q1 of 2023/24.

Training Academy (Ward 10 UHH): Hartlepool Borough Council were successful in securing a £25m bid from the Towns Fund. This included a £1.2m project to develop a medical training academy on Ward 10 at UHH. The funding is via Hartlepool Borough Council, however, the Trust agreed to fund the first £50k for the initial design in FY 2021/22 which has now been fully expended. The procurement phase is planned for Q3.

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 Trust's business and dovetail the south ICP clinical services strategy.

Phase 1 - Additional (larger) theatre to facilitate robotic surgery in location of current storage and changing facilities. Relocation of displaced storage and changing facilities. Refurbishment and structural upgrade to theatre 1 and transformation into an integrated theatre. Theatre 1 is complete and became operational in Q2.

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.

Strategic Outline Case: The SOC has been completed and was presented Transformation Committee on 18th August 2022 and is scheduled to go to Trust Board on an agreed date.

In order to meet the May 2023 OBC completion deadline, we are progressing some preparatory work in conjunction with the external advisors (P&HS, Driver Group and PA Consulting). 4 key work streams have been identified (Estates and Commercial, Finance, Clinical and PMO/Strategic) and groups formed to provide input to establish the key OBC requirements.

3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against an initial allocation of £3m. Of this, £289k has been ordered and receipted to date. A further £508k of orders have been raised but not yet received.

To date we have taken delivery of:

- **A Canon fundus camera** for diabetic eye screening
- **Fluid management system** for manual hysteroscopic tissue removal. The device is intended to hysteroscopically resect and remove polyps and fibroids
- **2 Video stack systems** for Colposcopy, one for UHH and one for UHNT. These camera systems are used to produce still and video images in the surgical field during colposcopic procedures.
- **Gynae Couch** for Outpatients
- **Laboratory Smoke generator** for QC labs used for testing of HEPA Filters
- **3 Vital signs monitors** for patient monitoring in endoscopy treatment rooms
- **4 BP/SPO2 monitors** for blood pressure and oxygen saturation monitoring in endoscopy admission rooms
- **Blood Fridge** for blood storage in blood transfusion
- **Ultrasound Probe** for breast screening unit
- **2 Spinal operating table bases** for theatres UHNT

4. Information and Technology Services (I&TS)

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

CISCO Network Upgrade: Now complete but is a 5-year deal which incorporated a full upgrade of the wired network to the latest technology and replacement of the wireless network to support Trust wide projects. Cisco finance lease comes to an end July 2022.

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

TrakCare Hardware refresh: Now complete, this was to replace the Infrastructure on which TrakCare system runs to ensure continual reliability of the system and support. Payment agreement ends June 2023.

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

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

Networking Hardware / Infrastructure

- **Network switch replacement** – Ongoing scheme to upgrade and replace end of life hardware. Hartlepool core network to be upgraded from 4Tbps (Terabits per second) backbone speed to 12Tbps with supervisor 6T cards. Work was complete as scheduled in July 2022.
- Fibre Cable replacement – Ongoing scheme to replace the remaining legacy fibre cabling for both (North Tees and Hartlepool) data networks. New cabling will support higher data transfer rates of up to 10Gbps (Gigabits per second). Current work is being carried out to complete the old residences blocks. This work is now complete.
- Firewall Switch replacement – Ongoing scheme to upgrade and replace end of life firewall hardware. Quantum appliance required to upgrade the Digital Pathology firewall that will also be utilised for Community Diagnostics. Appliance will provide greater port density and include 10Gbps connectivity. Expected completion Q3/Q4.
- Cyber Security – Vectra AI (Artificial intelligence) appliance to be upgraded at Hartlepool. Vectra AI is used to listen and monitor for network threats on all devices throughout the network – expected completion end of Q3.

Servers & Storage

- **Server replacement** – Ongoing scheme to replace end of life server hardware services including:
    - Horizon VDI expansion – Virtual desktop technology to be increased from 100 to 200 desktops enabling a more seamless remote access solution for system access outside of the Trust. Hardware nodes now installed with system level setup to commence during August / September. Complete.
    - OPSWat –NAC (Network Access Control) for Internet access to Horizon. Cloud based posture assessment that evaluates the security states of the connecting system. Now in implementation phase with anticipated completion by the end of November 2022 – still on target but awaiting DPIA approval before deployment.
- Additional Dell Blade Centre
    - New Dell Blade Centre to be installed in the A&E server room in order to provide resilience for existing virtual environment (currently in lower ground server room). Solution will provide resilience and allow us to relocate duplicate servers (where they exist) which will allow us to maintain service during any future outages. Expected completion by the end of Q4.
- File Storage – Dell / EMC Cyber Sense which is an off line cloud based backup storage service which enables the secure off site storage of data – Now installed, currently waiting for final commissioning with supplier, expected completion date end of October 2022 following upgrade to our storage data domain.
- Data Protection suite and Residency days for Dell / EMC Cyber Sense – sign off complete. Phase 1 implementation work completed during July. Phase 2 work to begin week commencing 17th October 2022. Expected completion by the end of Q3.

Telecomms

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

Office Facilities

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

- ***ICT Office*** – Infrastructure – reconfiguration of ICT office to support a better working environment – Tendering complete. Refurb work awarded to construction company Vickers. Final paperwork currently waiting for sign off by DoF. Expected completion end of Q4.

5. Digital Strategy – Progress on developments

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

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

Nurse Admission Documentation (NAD) – The PID and options appraisal have been submitted to board. Agreement reached to proceed with March 2023 go live date (option 2). Project planning underway with Nursing Teams and ISC, with updated plans to be presented to board in October. Equipment (Laptops) have been received into the Trust and is with ICT in readiness for building. Request has been made to the Estates team to review power points across wards in order to ensure adequate points for new equipment.

ITU - The Project Kick off session took place on 6th September with InterSystems (ISC) providing a demonstration of the proposed solution. The project approach was discussed and a plan is being drafted. ISC continue to work on their solution proposal documentation, which will supplement the PID and inform the plan. The order has been raised, awaiting receipt of the change control notice which has been escalated. The equipment from MindRay has been raised/authorised, awaiting confirmation of delivery date from the supplier. Medical Engineering are leading on this as the equipment currently in use is approaching end of life and can be utilised straight away.

My 'GNCR' aka PEP (Patient Engagement Platform) – To provide a secure portal to allow patients to take control of aspects of their care, by providing electronic access to elements of their own health records. The project plan is currently under review; targeting key milestones for (a) Technical Go-Live, (b) Soft Launch, (c) 1 Trust, and (d) roll out further trusts (North Tees has been approached to consider being the first Trust to connect, discussions are taking place). As part of joining the Wayfinder initiative, GNCR and Health Call submitted a joint proposal that will support the key aim of the NHS Elective Recovery Plan in giving patients information regarding their elective care pathway. The GNCR PEP is already integrated with the NHS App but will be enhanced to include referral information made available by the central initiative.

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

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

Prostate Cancer Stratified Follow Up – HealthCall have struggled to provide a copy of the overarching contract between HealthCall and the Academic Health Science Networks (AHSN) which is an outstanding requirement for DPIA approval. HealthCall are looking into this and understands its importance on the trust to deliver within the timescales set by the Cancer Alliance.

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

BadgerNet - Progress made in respect to recruitment to the Digital Midwife role, with interviews due to be held Friday 7th October. A planning meeting will be arranged at the earliest convenience and timescales for delivery discussed. Following which an options paper will be drafted for board consideration to the implementation options. The project does have a couple of risks associated at present which have been assigned to the service for escalation. Project governance is being established and this will form part of the Project Initiation Document.

EPMA Phase 2 (includes Infusions and will remove all remaining cardex) - FP10 Templates are now available for use within TrakCare however this does not remove the need for the scripts but is work in progress. *Warfarin* – an exception report was presented at October's Digital Programme Steering Group outlining the options for delivery, a decision to progress with Option 2 'Build onsite and replace post T2022 patch' was provided.

GMAWS (Alcohol Withdrawal) – the questionnaire has been reviewed by the Alcohol Care Team and F1 doctors with feedback currently being reviewed by the project team and further changes to the questionnaire made accordingly. The OrderSet has also been tested and confirmed as acceptable. Once approved by the Medical Records Group for use, a Go Live date will be scheduled.

EDM2 – The migration from the old system (NHTop) is complete, with 2799 out of 693275 (0.3%) of patient records that failed to migrate. A process for dealing with dropouts has been agreed. NHTop will remain switched on until all dropouts have been re-imported. The archive went live on the new system (MediViewer) via TrakCare EPR and desktop launcher on 5th September. Trust wide and targeted communication continue to be issued to encourage clinical and admin users to access eLearning and familiarise themselves with MediViewer prior to specialty by speciality rollout.
The pilot for day-forward scanning into MediViewer commenced in Obs & Gynae for clinics w/c 12th September, starting with 4 consultant clinics at North Tees for the first cycle of the pilot, rolling out to all 15 at both sites in cycle 2. The first cycle of the pilot is coming to an end and a review of the product, processes, training and support is being conducted with the speciality, admin team and supplier to refine the approach for cycle 2.

The solution architecture for MediViewer failover, backup and recovery is expected to be in place ahead of Trust wide rollout in November. Work also commenced on the BS10008 accreditation with an initial gap analysis against the compliance framework; due to the ongoing issue with backup and recovery the audit timetable has been pushed back to begin December 2022. BSI informed we are the first NHS organisation to seek this accreditation.

CareScan+ The latest software release (Delta II) was deployed across Theatres and Cardiology Day Unit on Friday 7 October 2022. User training workshops along with e-learning content made available for end users to access ahead of the go live. NTH Solutions Procurement & Supplies Department once again selected CareScan+ Stock Take functionality for their quarterly Orthopaedics stock take which is scheduled to take place over the weekend of the 1st and 2nd October 2022.

A demo of CareScan+ was provided to NTHFT Joint Chairman (Professor Bell) end of August 2022 with overwhelmingly positive feedback received. Following on from this, a demo was given at South Tees on 3rd October and another demo (to include clinical colleagues) has been arranged for November. Following a demo given at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) in August 2022, a subsequent demo has been requested to showcase CareScan+ to a wider clinical audience in October. This will be predominately to senior clinicians working within the Renal Dialysis speciality.

Appendix 2 – Capital Programme Financial Position as at 30th September 2022

Capital Plan, Actual and Commitments

Reporting period: 1st April 2022 to 30th September 2022

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Commitments 2022/23 £'000
CAPITAL PROGRAMME					
Estates Backlog					
Building Sub Structure	1,453	582	431	151	1,254
Compliance	2,019	1,051	924	127	490
Energy Conservation	1,867	452	369	83	110
Patient Environment	716	497	676	(179)	162
Service Developments	942	259	298	(39)	34
Estates Backlog Total	**6,997**	**2,841**	**2,699**	**142**	**2,050**
New Hospital support					
New Hospital Support	4,461	143	112	31	18
New Hospital Support Total	**4,461**	**143**	**112**	**31**	**18**
Robot Enabling Works					
Robot Enabling Works	2,400	15	21	(7)	7
Robot Enabling Works Total	**2,400**	**15**	**21**	**(7)**	**7**
Pathology Callaboration					
Pathology Callaboration	1,400	107	34	73	83
Pathology Callaboration Total	**1,400**	**107**	**34**	**73**	**83**
Medical Equipment					
Medical Equipment	2,650	2	281	(279)	510
Medical Equipment Total	**2,650**	**2**	**281**	**(279)**	**510**
IT					
ICT	1,650	207	334	(128)	88
IT Total	**1,650**	**207**	**334**	**(128)**	**88**
GDEFF					
GDEFF	0	0	1	(1)	9
GDEFF Total	**0**	**0**	**1**	**(1)**	**9**
Service Developments					
Contingency	1,500	(314)	38	(352)	49
Service Developments Total	**1,500**	**(314)**	**38**	**(352)**	**49**
Tech Capital Funding					
Tech Capital Funding	350	0		0	
Tech Capital Funding Total	**350**	**0**	**0**	**0**	**0**
IFRS16					
IFRS16	176	0		0	0
IFRS16 Total	**176**	**0**	**0**	**0**	**0**
Community Diagnostic Hub					
Community Diagnostic Hub - North Tees	0	0	(1)	1	33
Community Diagnostic Hub - South Tees	0	0	(0)	0	0
Community Diagnostic Hub Total	**0**	**0**	**(1)**	**1**	**33**
Targeted Investment Fund					
TIF	0	0	5	(5)	21
Targeted Investment Fund Total	**0**	**0**	**5**	**(5)**	**21**
TOTAL CDEL	**21,584**	**3,001**	**3,525**	**(524)**	**2,867**
TOTAL CDEL	**21,584**	**3,001**	**3,525**	**(524)**	**2,867**
DONATED ASSETS					
Donated					
Donated	399	198	43	155	36
Donated Total	**399**	**198**	**43**	**155**	**36**
Digital Pathology					
Digital Pathology	0	0	(51)	51	0
Digital Pathology Total	**0**	**0**	**(51)**	**51**	**0**
DONATED ASSETS TOTAL	**399**	**198**	**(8)**	**206**	**36**
GRAND TOTAL	**21,983**	**3,199**	**3,516**	**(317)**	**2,903**

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title	Board of Directors Elective Recovery Briefing												
Date	24 November 2022												
Prepared by	Eoin Carrol, Care Group Manager Levi Buckley, Chief Operating Officer												
Executive Sponsor	Levi Buckley, Chief Operating Officer												
Purpose of the report	The paper provides an update on the elective recovery programme												
Action required	Approve			Assurance			Discuss	X		Information	X		
Strategic Objectives supported by this paper	Putting our population First	X		Valuing our People	X		Transforming our Services	X		Health and Wellbeing			
Which CQC Standards apply to this report	Safe	X		Caring			Effective	X		Responsive	X		Well Led	X

Executive Summary and the key issues for consideration/ decision

- Elective recovery progressing well within the Trust with high degrees of confidence in achieving the zero >52 week WL position and continued delivery of zero >104 week waits.
- Workforce remains the most significant challenge for the organisation with absence due to latest Covid19 variant having had a significant impact on theatre staffing.
- Insourcing continues in to support additional activity with a focus on cancer surgery including colorectal, Gynae, breast and urology.
- The Care Group plans include continued focus on Hartlepool Hospital for planned elective work during the winter period, to minimise the impact on reduced activity.
- There is a potential national focus on holding lists at 52 weeks in some specialties with any capacity utilised for system mutual aid. The Trust continues to offer support for long waits within the Tees Valley and will explore how this national approach may affect internal plans.

How this report impacts on current risks or highlights new risks

This report addresses risks identified within the Board Assurance Framework. Specifically Performance and Compliance (BAF 1C) and Transforming Our Services (BAF 3B)

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is asked to note the content of the Board briefing.
Next steps for presentation e.g. Board Committee/Board meeting	

North Tees and Hartlepool NHS Foundation Trust

Board of Directors Meeting

November 2022

Elective Recovery Update

1. Introduction

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

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

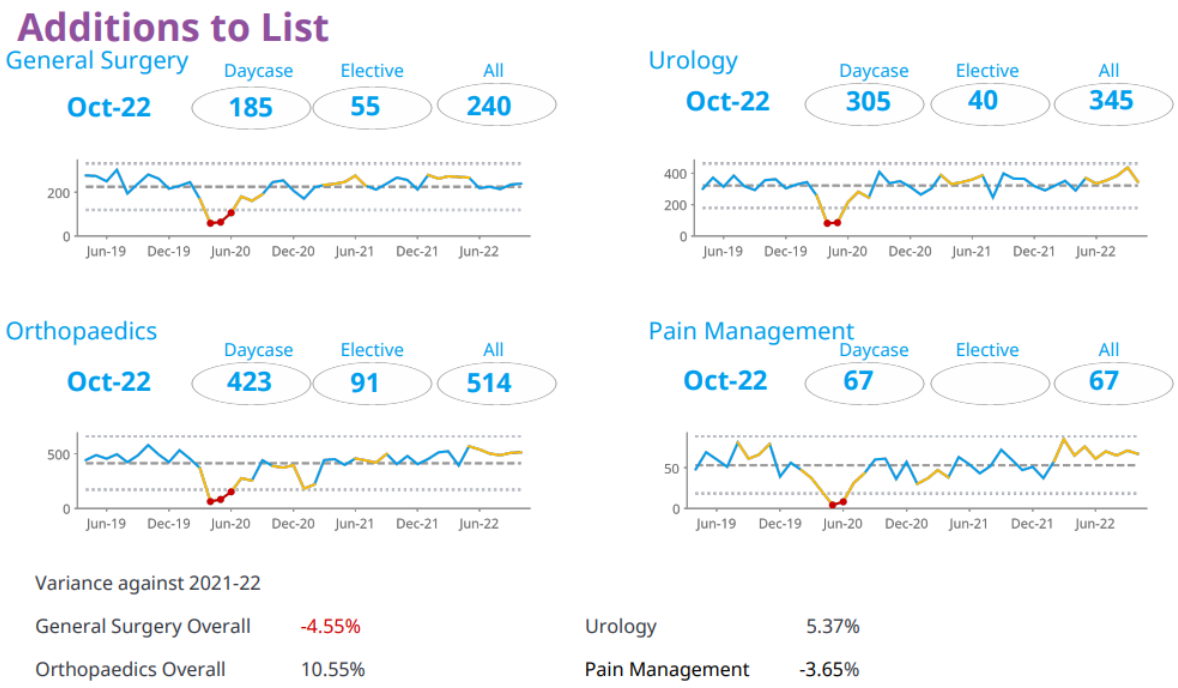
- the patient level detail of current elective waits; (>104/78/52 and >40 week waiters)
- the growth required to continue to deliver the 104% activity target within funded establishment
- the workforce required to ensure sustainable delivery
- the associated workforce and recruitment trajectories
- the short, medium and long term requirements to achieve these targets
- plans to ensure all necessary arrangements are in place to protect elective capacity during the 22/23 winter period
- all associated risks, not least financial, faced by the Trust in achieving the elective recovery plans including the provision of mutual aid for long waters within the wider Tees Valley and NENC ICB

2. Current Position

The Trust remains one of the top performing organisations both within the NENC system and nationally. As previously reported to the Board of Directors the Trust commenced recovery planning during the first wave of the covid pandemic. In spite of further waves of covid the organisation remains the top performer in the NENC against the Elective Recovery Fund (ERF) attracting £6.964 million income during 2021/22 and a 2022/23 year to date (M5) total of £3.029 million. This has supported the organisation in undertaking additional activity both internally and as system support for >78 and>104 week waiters.

2.1 Inpatient waiting list growth 2019 – 2022

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



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

2.2 Progress to date

Graph 2 below describes the elective recovery month on month progress to date. The graph describes the elective recovery percentage against the national trajectory of 104% and is updated as of the 14th November, hence the lower percentage position outlined within M8.

Month on month % variance from plan

Admissions % of trajectory		Month								
Care Group	Group	1	2	3	4	5	6	7	8	Total
Care Group 1	Day Cases	151%	117%	109%	125%	108%	115%	109%	96%	116%
	Elective	107%	153%	143%	91%	194%	156%	141%	91%	134%
Care Group 2	Day Cases	108%	88%	88%	99%	92%	102%	93%	91%	95%
	Elective	89%	238%	306%	245%	405%	93%	85%	79%	192%
Care Group 3	Day Cases	104%	98%	105%	105%	99%	117%	99%	104%	104%
	Elective	107%	102%	96%	76%	125%	106%	110%	93%	102%

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

2.3 NE&NC Performance.

The Trust remains a high performer within the wider system including the provision of capacity for the wider Tees Valley. Table 1 below illustrates the relative performance across the ICS in respect of >52 week waiting times. The Trust does not have any patients waiting over 78/104 weeks for surgery and continues to support the wider system in driving these number down

across the ICS. Work is underway to model the waiting list shape and size through to March 2023 to ensure that the Trust can maintain a zero >78 and zero 104 week wait position.

52+ Week Waiters	WE 25 Sep 22	WE 02 Oct 22	WE 09 Oct 22	WE 16 Oct 22	WE 23 Oct 22	WE 30 Oct 22	% with TCI or appt	Oct 22 Plan	Change from previous week	Avge volume change per week (based on latest 4 weeks)
GATESHEAD HEALTH NHS FOUNDATION TRUST	91	95	84	80	73	79	65%	*20*	6	-4
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	23	16	26	31	31	26	54%	*0*	-5	3
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	5,066	4,964	4,922	4,791	4,791	4,539	26%	*2,479*	-252	-106
NORTH ICP	5,180	5,075	5,032	4,902	4,895	4,644		*2,499*	-251	-108
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1,600	1,654	1,665	1,767	1,880	1,943	22%	*640*	63	72
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	151	139	131	130	128	119	71%	*100*	-9	-5
CENTRAL ICP	1,751	1,793	1,796	1,897	2,008	2,062		*740*	54	67
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	35	34	40	47	49	43	84%	*0*	-6	2
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1,798	1,798	1,713	1,684	1,594	1,626	38%	*1,027*	32	-43
SOUTH ICP	1,833	1,832	1,753	1,731	1,643	1,669		*1,027*	26	-41
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	847	857	852	843	855	844	31%	*730*	-11	-3
NORTH EAST & NORTH CUMBRIA	**9,611**	**9,557**	**9,433**	**9,373**	**9,401**	**9,219**	29%	*4,996*	**-182**	**-85**

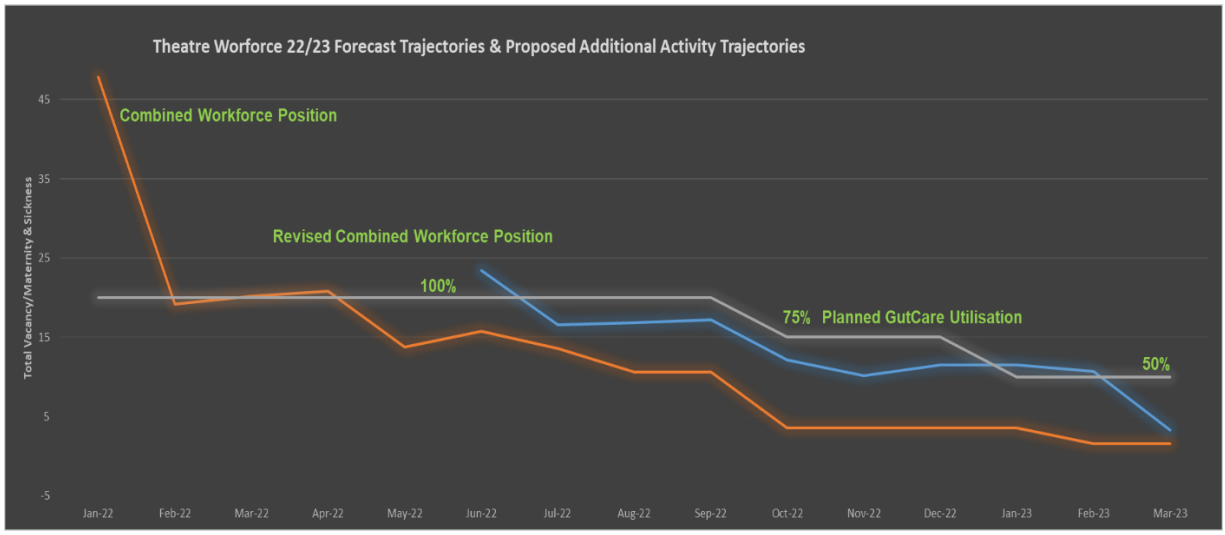
Table 1: Weekly ICS Recovery Report

3. Theatre workforce mapped against proposed insourcing activity

Workforce pressures remains a key constraint within both the Trust and the wider system. However, the Care Group has maintained effective internal processes to manage this against both short and long term activity trajectories. Internal and overseas recruitment has, and continues to, take place. Graph 3 below highlights the anticipated downward trend of the combined impact of all theatre workforce including absenteeism, vacancies and maternity leave over the next 6 months. Whilst the Care Group acknowledges that this remains a forecasted position it is based on current and planned appointments. It is anticipated that the Care Group will start to see the impact of these recruitment drives during Q3 with a more resilient workforce position at the beginning of Q4.

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

The graph demonstrates the Care Group workforce plans to reduce reliance on additional activity and ensure sustainable growth and delivery through recruitment and retention of the workforce. The Trust will use this forecasting to inform the level of continued use of additional activity into quarter three and four depending on how the additional activity is reported i.e. monthly, quarterly or annualised. It is important to note that the additional workforce associated within current business cases required to deliver the 104% target are included within the workforce trajectories.



Graph 3: Theatre workforce forecast trajectory

4. Winter Planning

In terms of winter planning the Collaborative Care Group has a proven track record of managing and delivering the elective programme during times of escalation and surge. This coming winter the collaborative Care Group will continue to work with the other Care Groups to ensure that the impact of planned activity on unplanned pathways in mitigated. Initiatives will include proactively moving a number of subspecialties up to University Hospital Hartlepool, increasing day case activity on the North Tees site, prioritisation of demand and using the additional activity flexibly across the week as opposed to increasing additional weekend lists.

5. Risks and Mitigations

Risk	Mitigation
Continuation of gap in theatre workforce into quarter three due to a combination of sickness and the ability to recruit to vacancies.	Phased plan of support through GutCare and planned international recruitment and training.
Negative impact on morale of theatre staff when using GutCare to provide additional capacity.	The Care Group regularly links in with the unions and staff side representatives. The use of insourcing is a short term solution with a long term approach to ensure sustainable workforce through substantive recruitment.
The 104% assumes that the wider system activity carried out within the Trust is counted towards the Trusts activity increase and is funded accordingly.	Work towards agreement with regards to funding flows which support system cooperation and collaboration. Supported through DoF system discussions.
Activity increase includes system activity which requires shared administration	Work on going at operational level where there is joint working e.g. spinal services to

structures and processes across organisations.	develop shared standard operational practices.
These proposals establishes the collaborative care trajectories, however, further work needs to be undertaken to include other elective activity to ensure delivery of the 104% across all areas e.g. endoscopy.	Further work is taking place with the other care groups who deliver aspects of the elective workload at all points of delivery. Monitored through Recovery Group.
Consultants' willingness to undertake additionally at weekends etc. due to concerns over pension tax implications.	Explore a sustainable approach to delivery of additionally through an alternative platform i.e. Full recruitment to reduce reliance on additional sessions. Await national clarification of revised pension arrangements.
Elective Recovery Funding (ERF) is currently non-recurring and therefore any recurrent permanent recruitment is at risk to not be funded 2023/24 onwards. Lack of clarity at ICB level on the arrangements for funding over performance on ERF activity.	Proactively manage succession planning and exit strategies if activity reduces in the longer term. DoF/commissioner discussions on system approach to funding over-performance against ERF trajectories.
A further wave of Covid / Flu pandemic which significantly compromises staffing / elective capacity.	Ensure workforce is sustainable through recurring recruitment and continuation of insourcing available if required as demonstrated in this paper.
The national NHSE approach to addressing over 78 and over 104 week waits is likely to result in request for additional mutual aid, especially for York and Scarborough. Further detail is being collated by the ICB and this may result in request to hold lists at greater than >40 week positions.	Continued monitoring of internal sub specialty waiting list at Care Group level, monitored through the Trust Recovery Group. Attendance at NENC Elective Recovery Group to support system planning in response to mutual aid requests.
Increasing waiting list due to high levels of primary care referrals in Q1 and Q2. This will result in additional activity in some specialities especially gynaecology and cancer pathways.	Collaborative work across Care Groups and with primary care colleagues to model the impact of increased referrals. Weekly Care Group reviews of waiting list positions to model future waiting list impact.

6. Summary

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

7. Recommendations

The Board of Directors is asked to note:

- the strong year to date performance including the provision of capacity for the wider Tees valley
- the detailed planning for 2022/23 to deliver the national elective trajectories of 104% of baseline activity
- the analysis of current risk and mitigation plans
- the regular monitoring of the elective recovery trajectories through the Executive Management Team

Levi Buckley
Chief Operating Officer

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

	Data Protection and Cyber Assurance DSPT Year End SIRO & DPO Report 2021/22										
Date:	24 November 2022										
Prepared by:	Neil Dobinson, Data Protection Officer (DPO)										
Executive sponsor:	Gillian Colquhoun, Interim Chief Information Technology Officer / SIRO										
Purpose of the report	The purpose of this report is to provide an update and level of assurance to the Trust Board of Directors relating to the range of Information Governance (IG) and cyber security activities within the Trust.										
Action required:	Approve		Assurance	X	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe	X	Caring		Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

1. Information Governance (IG) Framework

A number of IG Policies and procedures have been reviewed and updated since the last Board of Directors report, in addition to the creation and approval of some specific policies that are necessary to meet the evolving IG agenda. IG polices have been reviewed to bring in line with General Data Protection Regulations (GDPR) requirements and the Data Protection Act 2018.

2. Information Governance (IG) - Key Performance Indicators 2021/22

The Trust measures performance against three key areas to determine compliance with IG requirements.

a) ***Data Protection (IG) training*** has been challenging due to Covid-19, however due to the change in the DSPT submission date the Trust has achieved **97%** compliance.

b) ***Subject Access Requests*** cumulative compliance for the 2021/22 DSPT was **98**%.

c) **Data Security Protection Toolkit (DSPT) compliance** - The Trust has self-assessed compliance with all mandatory evidence items, and were compliant with all mandatory assertions, the Trust scored as all **'Standards Met'**; compliance has been assured by Audit with '**Significant Assurance'** given.

4. Information Governance Risks

Currently, there are 14 open risks on the IG risk register and 22 on the ICT risk register which is an increase compared to the same period last year. There is currently one high/red risks highlighted with an action plan in place to mitigate / lower the risk level. The key cyber risks are now highlighted in the BAF and are shown in more detail in the content of the main report.

5. Data Protection by Design

The Trust continues to see a strong compliance and buy in from services with 'Data protection by design' principles and this is reflected in the number of new Data Privacy Impact Assessments (DPIA's), which have been submitted in 2021/22 for projects which meet the mandatory criteria. A total of 13 new DPIA's have been approved in the reporting period. A new DPIA Standard Operating Procedure (SOP) is now in place to support Information Asset Owners (IAO) in the completion of a DPIA, training is scheduled for IAO's to further support the process.

6. Data Security Protection Toolkit (DSPT) 2021/22

The DSPT for 2021/22 sets out 110 mandatory evidence items which cover these 10 standards, the Trust must evidence compliance against all ten in order to gain full compliance.

The Trust submitted its DSPT submission on the 23 June 2022. The Trust has self-assessed compliance with all 10 standards and all 110 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as **all 'Standards Met' for the 2022 DSPT**.

The 2022 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during May 2022 prior to the DSPT submission. The Trusts overall assessment scored as ***'Substantial'*** across all 10 National Data Guardian Standards and against the criteria for independent veracity of the Trusts self-assessment. The Trust received no recommendations or actions as a result of the independent audit.

7. Incident reporting

The Trust actively encourages staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy. Any incident involving loss or damage to personal data is comprehensively investigated by the Trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and the Trust's risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than the on the Trust. Those incidents deemed to be of a 'high risk' are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the Trust.

During the 2021/22 DSPT reporting period the Trust reported *four potential high risk incidents* to the ICO with a fifth incident reported but then rescinded when no breach was subsequently identified. All incidents reported to the ICO have since been closed by the ICO with no further actions pending.

In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred key actions have been undertaken, a summary can be found in the main report.

8. Cyber Security

In light of recent global events and in line with National Cyber Security Centre advice the NHS focus on Cyber security and threats has rightly been shifted back up the agenda. As such all NHS bodies recently received new central *NHS Operational Instructions & Advice on improving cyber security resilience (March 2022)*. As part of this there were six immediate action items, the Trust has confirmed that the required mitigations are in place for these items:

- ***Patching*** – The Trust has provided assurance in DSPT assertion 8.3.2
- ***Access control*** - The Trust has provided assurance in DSPT assertion 4.5.3
- ***Monitoring*** - The Trust has provided assurance in DSPT assertion 8.3.5
- ***Backups*** - The Trust has provided assurance in DSPT assertion 7.3.5

- ***Incident response and Business continuity planning*** - The Trust has provided assurance in DSPT assertion 7.2.1 and further testing is scheduled
- ***Awareness*** - The Trust has provided assurance in DSPT assertion 3.3.1 and further activities are planned

The SIRO will provide a further update to board including actions and requirements derived from this exercise.

There are currently twelve cyber security risks on the corporate risk register, all rated as 'Medium Risk'. The top three risks identified are:

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

The above risks have been escalated via the Board Assurance Framework (BAF) to the Trust Board and action plans are in place to resolve. (Detail on these risks have been limited in this report due to security purposes).

Further information on this can be found in the body of the main report.

9. Reporting and Assurance

There have been no notable changes to the reporting and assurance framework since the last report. The governance structure can be seen in the main body of this report.

How this report impacts on current risks or highlights new risks:	
See section 4 above and section 5.3 & 6.3 in the full report	
Committees/groups where this item has been discussed	• Information Management and Information Governance Committee (IMIG) • Digital strategy Committee (DSC)
Recommendation	The board of directors are asked to note progress to date and confirm their approval of the approach, governance and assurance methods outlined in this report.

Meeting of the Board of Directors

November 2022

Data Protection and Cyber Assurance Report

Report of the Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO)

1. Background

The establishment of the role, Senior Information Risk Owner (SIRO) required by the Information Governance Toolkit (now DSPT) was one of several NHS Information Governance (IG) measures identified to strengthen information assurance controls for NHS information assets. With the advent of UK-GDPR and the Data Protection Act 2018 the role of Data Protection Officer (DPO) was also created to provide additional organisational assurance.

2. Purpose

The purpose of this report is to provide the board of directors with an update on Trusts Data Protection (IG) and cyber security agenda and to provide assurance to the compliance of IG and Cyber requirements.

3. Organisational Context

North Tees and Hartlepool NHS Foundation Trust is responsible for protecting the information it holds and is legally required under the UK GDPR and Data Protection Act 2018 (DPA) to ensure the security and confidentiality of personal and special categories of information processed. These responsibilities also apply to other organisations working on behalf of the Trust. The UK GDPR and Data Protection Act 2018 provides a regulatory framework for the processing of personal information, including the holding, use or disclosure of such information.

The lawful and correct treatment of personal and special categories of information is vital to the successful operation of, and maintaining the confidence with the Trust and the individuals with whom it deals.

Therefore, the Trust will, through appropriate management and strict application of criteria and controls:

- Observe fully conditions regarding the fair collection and processing of data;
- Meet its legal obligations to specify the purposes for which data is used;
- Collect and process appropriate data and only to the extent that it is needed;
- Use compliant process to fulfil operational needs to comply with any legal requirements;
- Ensure the quality of data used is accurate;
- Apply strict checks to determine the length of time data is held and establish a compliant disposal process where necessary;
- Audit compliance with legislation and appropriate standards and escalate findings to the SIRO and IMIG committee.
- Ensure that the rights of people about whom data is held can be fully exercised under the legislation. (These include: the right to be informed that processing is being undertaken; the right of access to one's personal information; the right to prevent processing in certain circumstances; the right to correct, rectify, block or erase information.);
- Take appropriate technical and organisational security measures to safeguard personal and sensitive personal data;
- Ensure that personal data is not transferred abroad without suitable safeguards.

The UK-GDPR and DPA lay down regulations for the handling of personal data. For all such data it is essential to abide by the principles in Article 5 of UK-GDPR which govern the care and use made of the data.

Under DPA and UK-GDPR Personal data refers any information relating to an identified or identifiable living individual (data subject) an identifiable individual is one who can be identified:

- directly or indirectly, in particular, by reference to an identifier such as a name,
- an identification number,
- location data,
- an online identifier e.g. including IP addresses internet cookies.
- one or more factors specific to the physical, physiological, genetic, e.g. DNA, mental, economic, cultural or social identity of that natural person.

Special Categories of Data was previously referred to as sensitive information under preceding legislation (Data Protection Act 1998) and refers to any personal data revealing;

- racial or ethnic origin,
- political opinions,
- religious or philosophical beliefs,
- trade union membership,
- the processing of genetic data,
- biometric data for uniquely identifying an individual,
- data concerning health or
- data concerning an individual's sex life or sexual orientation

4. Information risk, roles and responsibilities

4.1. Senior Information Risk Owner (SIRO)

The Chief Information and Technology Officer (CITO) fulfils the key role of Senior Information Risk Owner (SIRO) within the Trust, the SIRO is responsible for the trust information risk management framework.

4.2. Data Protection Officer (DPO)

The Data Protection Officer (DPO) is a role mandated in law under UK-GDPR, the DPO is responsible to inform and advise the Trust and it employees about their obligations to comply with DPA and UK-GDPR. The DPO will monitor compliance, ensuring policies; awareness raising and training of processing personal data is available to all staff. The DPO will act as a point of contact for all staff and provide advice and guidance on completion of data protection assessments (DPIAs). The DPO is the first point of contact for the ICO and for individuals whose data we process. The DPO will report any risks or issues to the SIRO.

4.3. Information Asset Owners (IAO's)

Information Asset Owners are senior individuals involved in running the relevant business function. Their role is to understand and address risks to the information assets they 'own' and to provide assurance to the SIRO on the security and use of those assets.

4.4. Information Asset Administrators (IAA's)

Information Asset Administrators ensure that policies and procedures are followed, recognises actual or potential security incidents, consult relevant individuals on incident management and ensure that information asset registers are accurate and up to date.

4.5. Caldicott Guardian & Deputy Caldicott Guardian

The Caldicott Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient identifiable information. Acting as the 'conscience' of the organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

The Caldicott Guardian also has a strategic role, which involves representing and championing confidentiality and information sharing requirements and issues at senior management level and, where appropriate, at a range of levels within the organisation's overall governance framework.

5. Information Governance (Data Protection)

Information Governance is "*a framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in modern health services*". It brings together, within a singular cohesive framework, the interdependent requirements and standards of practice. It is defined by the requirements within the Information Governance Toolkit against which the Trust is required to publish an annual self-assessment of compliance.

Information is a vital asset, both in terms of the clinical management of individual patient's/service users and the efficient management of services and resources throughout the Trust. It plays a key part in clinical governance, service planning and performance management.

It is therefore of paramount importance that information is effectively managed, and that appropriate policies, procedures, management accountability and structures provide a robust governance framework for information management to assure and demonstrate the proactive use of information as determined by legislative acts, statutes, regulatory requirements and best practice.

Information Governance (IG) applies to all information management activity in its broadest sense and underpins both clinical and corporate governance. Accordingly, it should be afforded appropriate priority as good information governance underpins all of the Trust's values.

5.1. Policy and Strategy

The following IG & ICT Policies, Strategies and Privacy Notices have been reviewed, updated and ratified during the report period in order to meet the evolving IG & ICT agenda:

Policies & Strategies	Standard Operating Procedures	Privacy Notices
IG25-Records Management Policy	ICT-SPAP1 Systems Privileged Access Protocol	NT&H Employee Privacy Notice
IG44-Collaboration Tools Acceptable Use Policy	HCR-SAR01 Right of Access, Rectification, Restriction and Erasure	NT&H Patient Privacy Notice
IG39-Secure Transfer of Information Policy	IG-PBD01 Data Protection by Design and Default – DPIA Procedure	NT&H Patient Privacy Notice (Children's)
IG43-Data Minimisation policy		
STRAT12-Digital Strategy		

5.2. Key Performance Indicators (KPI)

The Trust IG team use KPI's to measure performance against national and local standards and targets.

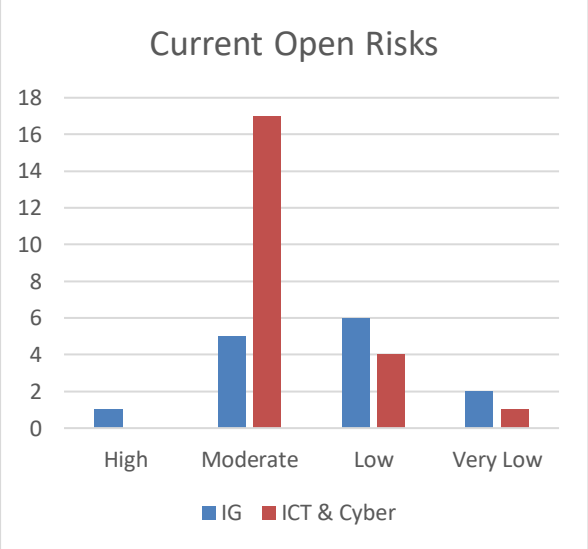
The KPI's are set is three measurable areas, staff compliance with IG training, compliance with the fulfilment of subject access requests (patient/staff requests for information we hold on them) and the Trusts compliance level against the Information Governance Toolkit (DSPT).

KPI Indicator	2021/22 Trust Target	2021/22 Actual	Previous Year
Data Security Training Completed By Staff In Period	95%	97%	+2%
Subject Access Requests - Complaince with response period of one calendar month (cumlatitve % for the period)	98% > 100%	98%	-1%
DSPT Toolkit Compliance @ year end for mandatory compliance requirements	100%	100%	100%

5.3. Risks

IG and ICT/Cyber risks are managed via the Datix risk register and are reported into, and reviewed by, the Information Management and Information Governance (IMIG) Committee.

These risks are reviewed, analysed/themed and where appropriate, corrective actions agreed and implemented.



Key ICT risk themes include:

- Cyber security
- End user file share permissions
- Medical Devices

Key IG risk themes include:

- Compliance with data subject rights
- Storage of corporate & healthcare paper records
- Correspondence errors
- Access to data via Trust systems and networks
- Staff non-compliance with policy and procedure
- The use of email

5.4. Data Security and Protection Toolkit (DSPT) – June 2022 Submission

The Data Security and Protection Standards for health and care set out the National Data Guardian's (NDG) data security 10 standards. Completing DSPT self-assessment, by providing evidence and judging whether we meet the assertions, will demonstrate that our organisation is working towards or meeting the ten NDG standards:

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to Incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Accountable Suppliers

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. The DSPT for 2022 set out 110 mandatory evidence items which cover these 10 standards, the Trust must evidence compliance against all ten in order to gain full compliance.

The Trust submitted its DSPT submission on the 23 June 2022. The Trust has self-assessed compliance with all 10 standards and all 110 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the 2022 DSPT.

The 2022 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during May 2022 prior to the DSPT submission (see Table 1). The Trusts overall assessment scored as ***'Substantial'*** across all 10 National Data Guardian Standards and against the criteria for independent veracity of the Trusts self-assessment. The Trust received no recommendations or actions as a result of the independent audit.

Assessment Outputs

Overall risk assessment across all 10 National Data Guardian standards	Confidence level of the Independent Assessor in the veracity of the self-assessment
Substantial	**Substantial**
All of the standards are rated as 'Substantial'	**Low level of deviation-** the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment

Table 1: Overall risk rating:

National Data Guardian (NDG) Standard	No. of Toolkit Assertions Assessed by Independent Assessor	Assertion level Risk Assessments				NDG standard level Risk Ratings		Overall DSP Toolkit Ratings
		No of Assertions rated **Critical** and (Weighted Risk Score)	No. of Assertions rated **High** and (Weighted Risk Score)	No. of Assertions rated **Medium** and (Weighted Risk Score)	No. of Assertions rated **Low** And (Weighted Risk Score)	Risk Rating Scores [Total points/ no. assertions assessed] - see appendix B.	Overall Risk Rating at the National Data Guardian Standard level- see appendix E.	Overall risk assurance across all 10 NDG standards
1.Personal Confidential Data	1 of 4				1 (1)	1	Substantial	Substantial
2.Staff Responsibilities	1 of 1				1 (1)	1	Substantial	
3. Training	1 of 4				1 (1)	1	Substantial	
4. Managing Data Access	3 of 5				3 (3)	1	Substantial	
5.Process Reviews	1 of 3				1 (1)	1	Substantial	
6. Responding to Incidents	1 of 3				1 (1)	1	Substantial	
7.Continuity Planning	2 of 3				2 (2)	1	Substantial	
8.Unsupported Systems	1 of 4				1 (1)	1	Substantial	
9. IT Protection	1 of 6				1 (1)	1	Substantial	
10. Accountable Suppliers	1 of 5				1 (1)	1	Substantial	
TOTAL	13 of 38				**13**		Substantial	

5.5. Incident reporting

Any incident involving loss or damage to personal data is comprehensively investigated by the Trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and the Trust's risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than the on the Trust. Those incidents deemed to be of a 'high risk' are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the Trust.

The Trust actively encourages staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy. During the 2021/22 DSPT reporting period the Trust reported four potential high risk incidents to the ICO with a fifth incident reported but then rescinded when no breach was subsequently identified. All incidents reported to the ICO have since been closed by the ICO with no further actions pending.

The following incidents were reported to the Information Commissioners Office (ICO) in the DSPT 2021/22 reporting period (July 2021 to June 2022):

Incident ID	Reported Date	Brief Description	Outcome
25699	October 21	Disclosure of personal data in error caused by non-compliance with Trust policy – Impact on one data subject	• Incident Closed by ICO • Additional staff training given / procedures reviewed
26668	January 22	Inappropriate access and sharing of data by staff member. Non-compliance with Trust policy – Impact on one data subject	• Incident Closed by ICO • HR disciplinary actions as per policy • Additional staff training given
27436	March 22	Unauthorised sharing of data by staff member. Non-compliance with Trust policy – Impact on one data subject	• Incident open with ICO • HR disciplinary actions as per policy • Additional staff training given
28444	June 22	Potential for disclosure of personal data in error caused by non-compliance with Trust policy – Impact on one data subject	• Incident Closed by ICO • Additional staff training given / procedures reviewed

As in previous years, in order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred during 2021-22 the following key actions were undertaken or are planned:

- Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation and national guidance.
- Continued programme of comprehensive quality assurance and spot checks to ensure all departments are complying with Trust polices relating to the protection of personal data.
- Continue to provide annual Data Security Training inclusive of Cyber Security and the provision of targeted training in areas of non-compliance.
- Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Information Management and Information Governance Committee.
- Full annual review of information assets and information flows thought the Trust within a redesigned framework to comply with UK-GDPR requirements.
- HR processes followed where repeated non-compliance has been found.

In accordance with UK GDPR Article 37, the Trust has an appointed Data Protection Officer (DPO) whom provides support, advice and assurance to the board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

5.6. Data Protection by Design

It has always been good practice to adopt privacy by design approach and to carry out a Privacy Impact Assessment (PIA) as part of this. However, the GDPR made privacy by design an express legal requirement, under the term 'data protection by design and by default'. The Trust has adopted this approach.

It also makes 'Data Protection Impact Assessments' or DPIAs – mandatory in certain circumstances.

- where a new technology is being deployed
- where a profiling operation is likely to significantly affect individuals; or
- where there is processing on a large scale of the special categories of data.

The Trust continues to see a strong compliance and buy in from services with 'Data protection by design' principles and this is reflected in the number of new DPIA's which have been submitted in 2021/22 for projects which meet the mandatory criteria.

2021/22 DPIA's Status	Qty
DPIA's Approved In Period	13
DPIA's at Final Review Stage (pending approval)	6
DPIA's Work In Progress	27

Due to the high volume of DPIA's coming through the system, aligned to the Trusts high digital maturity level, an updated Standard Operating Procedure and new tailored training on the completion of a DPIA has been developed and training is being delivered directly to Trust Information Asset Owners (IAO).

5.7. Data Protection and Security Audits 2021/22

Throughout 2021/22, eighteen different randomly chosen locations across the UHNT and UHH sites were audited, with an even split between clinical and non-clinical departments. The purpose of these audits is to ensure that the departments within the Trust are complying with Trust data protection and security policies and procedures and where they are not being followed actions have been assigned and mitigated. A number of minor actions were assigned (not detailed in this report for security reasons) and successful mitigation put in place to ensure compliance to policy and procedure. No moderate or major actions were identified.

The full audit report has been submitted to the Information Management & Information Governance Committee (IMIG) for assurance.

6. Cyber Security

The Trust has implemented a Cyber Security Strategy and is actively engaging with NHS Digital through their CareCert programme to further underpin the Trust cyber readiness.

As part of this the Trust is undertaking rigorous testing in the form of independent cyber assessments using the Cyber Essentials Plus assessment and the NHS IT health check assessment via NHS Digital.

In light of recent global events and in line with National Cyber Security Centre advice the NHS focus on Cyber security and threats has rightly been shifted back up the agenda. As such all NHS bodies recently received new central ***NHS Operational Instructions & Advice on improving cyber security resilience (March 2022)***.

As part of this there were six immediate action items, the Trust has confirmed that the required mitigations are in place for these items:

- ***Patching*** – The Trust has provided assurance in DSPT assertion 8.3.2
- ***Access control*** - The Trust has provided assurance in DSPT assertion 4.5.3
- ***Monitoring*** - The Trust has provided assurance in DSPT assertion 8.3.5
- ***Backups*** - The Trust has provided assurance in DSPT assertion 7.3.5
- ***Incident response and Business continuity planning*** - The Trust has provided assurance in DSPT assertion 7.2.1 and further testing is scheduled
- ***Awareness*** - The Trust has provided assurance in DSPT assertion 3.3.1 and further activities are planned

The operational instructions also provided a number of priority improvements (not detailed in this report for security reasons) which NHS organisations should seek to implement urgently in order to improve protection, resilience and recovery capabilities. The Trust's SIRO, IT and security team are reviewing the suggested improvement actions and request board support for any required technical and or process measures required to ensure compliance.

The SIRO will provide a further update to board including actions and requirements derived from this exercise.

6.1. Cyber Security Training / Awareness

The Trust continues to provide cyber security training as part of its mandatory IG training (97% compliance) and plans are in place to further strengthen the cyber element of this training into 2023.

A joint North & South Tees NHSFT board session, focusing on Cyber security took place in March 2022 facilitated by Templar Executives and will provided boards with GCHQ verified cyber awareness training.

6.2. Cyber Security Risks

The Trust has identified various risks linked to the Trust's cyber security challenges which were identified following an ICT Security Audit. The risks identified are covered within other ICT risks on the Trusts Risk Register.

There are currently twelve cyber security risks on the corporate risk register, all rated as 'Medium Risk'.

The top three risks identified are:

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

The above risks have been escalated via the Board Assurance Framework (BAF) to the Trust Board and action plans are in place.

Summary of the current Cyber risks*:

ID	Risk Title	Description
6166	Connected Medical Devices and Equipment	Medical devices running outdated and unpatched computer operating systems that also do not have Anti-Virus on them or may be unsupported.
6165	Cyber Threat Exploit Kits	Exploit kits include a collection of ready-made exploits usually planted in compromised websites or used in advertising campaigns. Exploit kits have the ability to identify exploitable vulnerabilities in a user's browser or web application and automatically exploit them.
6161	Cyber Threat Botnets	A botnet is a number of Internet-connected devices, each of which is running one or more bots. Botnets can be used to perform Distributed Denial-of-Service attacks, steal data, send spam, and allows the attacker to access the device and its connection.
6160	Cyber Threat Ransomware	Ransomware is a type of malicious software cyber criminals use to block you from accessing your own data. The digital extortionists encrypt the files on your system and add extensions to the attacked data and hold it "hostage" until the demanded ransom is paid.
6159	Cyber Threat Phishing	Phishing is the fraudulent attempt to obtain sensitive information or data, such as usernames, passwords and credit card details, by disguising oneself as a trustworthy entity in an electronic communication
6157	Cyber Threat Web Application attacks	Web application attacks are those attacks directed against available web applications, web services, and mobile apps. Such attacks try to abuse APIs that are incorporated in web applications.
6156	Cyber Threat Web Based attacks	Web based attacks are those that make use of web-enabled systems and services such as browsers (and their extensions), websites (including Content Management Systems), and the IT-components of web services and web applications.
6155	Cyber Threat Malware	Malware is any software intentionally designed to cause damage to a computer, server, client, or computer network. A wide variety of malware types exist, including computer viruses, worms, Trojan horses, ransomware, spyware, adware, rogue software, and scareware.
6154	Cyber Threat DOS/DDOS	In computing, a denial-of-service attack is a cyber-attack in which the perpetrator seeks to make a machine or network resource unavailable to its intended users by temporarily or indefinitely disrupting services of a host connected to the Internet.
6164	Cyber Threat Insider Threat	Insider threat refers to the threat that an insider will use his/her authorized access, wittingly or unwittingly, to do harm to the security of the Trust.
6163	Cyber Threat Identity Theft	Identity theft is a cyber-threat in which the attacker aims at obtaining confidential information that is used to identify a person or even a computer system. Such confidential information may be: identifiable names, addresses, contact data, credentials, financial data, health data, logs, etc. Subsequently, this information is abused to impersonate the owner of the identity. Identity theft is a special case of data breach.
6192	End User File Share Permissions	Risk of end users creating Shares on central file stores and not setting appropriate controls.

**full risks are not detailed in this report for security reasons and a high level description is given*

7. Reporting and Assurance

There have been no notable changes to the reporting and assurance framework since the last report.

8. Recommendations

The board of directors are asked to note progress to date and confirm their approval of the approach, governance and assurance methods outlined in this report.

Gillian Colquhoun
Interim Chief Information and Technology Officer/SIRO

Neil Dobinson
Data Protection Officer (DPO)

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	NHS Core Standards for EPRR – Compliance and Organisational Capabilities
Date:	24 November 2022
Prepared by:	Stewart Ellison, Emergency Planning Officer Levi Buckley, Chief Operating Officer
Executive sponsor:	Levi Buckley, Chief Operating Officer
Purpose of the report	The NHS Core Standards for EPRR set out the minimum standards expected of NHS organisations to ensure they are able to meet their statutory obligations in respect of Emergency Preparedness, Resilience and Response. This report aims to provide Board level assurance of the current position of the Trust with a focus on the following areas: **1.** Status of compliance against the Core Standards for EPRR for the 2022 reporting period. **2.** Reflection on the impacts, response and identified areas of learning associated with significant disruptions and incidents occurring over the past 12 months. **3.** Overview of EPRR development work completed over the past 12 months together with the proposed areas of priority for ensuring the ongoing development of EPRR processes over the upcoming year.

Action required:	Approve	√	Assurance	√	Discuss		Information	
Strategic Objectives supported by this paper:	Putting our Population First	√	Valuing our People		Transforming our Services		Health and Wellbeing	

Which CQC Standards apply to this report	Safe	√	Caring	√	Effective	√	Responsive	√	Well Led	√

Executive Summary and the key issues for consideration/ decision:

Following an assessment of the Trusts existing EPRR arrangements it has been determined that the Trust is fully compliant against 91% of the standards applicable to NHS Acute Trusts. This provides an overall assurance rating of **Substantial Compliance**, indicating full compliance against 89-99% of the 2022 NHS EPRR Core Standards.

Although significant improvements have been made to the Trust's EPRR arrangements over the past 12 months, indicated in part by a move to 'full compliance' across all standards relating to Business Continuity, the static compliance rating following the 2021 Core Standards review is a reflection of:

- The re-introduction of the full range of assessable standards following scaled back assessment criteria over the 2020 and 2021 reporting periods.
- The reduced ability of the Trust to divert resources for the purposes of training and exercising throughout the COVID-19 pandemic.
- The introduction of new mandatory training requirements in July 2022.

Key priorities identified over the upcoming year to support ongoing improvements to the Trust's EPRR arrangements, include:

- Development and re-introduction of a full EPRR training and exercise calendar, aligned to the updated requirements set out within the national EPRR Framework.
- Full review and refresh of high priority EPRR plans, policies and processes to ensure alignment to changes in national guidance and compliance with internal governance arrangements.
- Continued implementation of new business continuity management processes, including processes of validation.

• Ongoing refining of processes for monitoring and reviewing EPRR incidents and risks, including standardisation of debriefing processes.	
How this report impacts on current risks or highlights new risks:	
This report is aligned with the EPRR risks detailed within the Board Assurance Framework.	
Committees/groups where this item has been discussed	Trust Resilience Forum
Recommendation	The Board of Directors is asked to: **1.** Receive the above report as assurance that the Trust continues to meet its statutory requirements in respect of EPRR compliance. **2.** Acknowledge the essential role that EPRR plays in the effective operation of the Trust and support identified proposals for the ongoing development of associated plans, policies and processes. **3.** Support the continued oversight of EPRR functions through the Trust Resilience Forum.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

24 November 2022

NHS Core Standards for EPRR
Compliance and Organisational Capabilities

1 Introduction

Under the terms of the Civil Contingencies Act (2004) North Tees and Hartlepool NHS Foundation Trust has a statutory duty to plan for and respond to any emergency or disruption that could affect the continuation of critical services, impact patient safety or threaten the continued operation of the Trust. Within the health service this work is referred to as 'Emergency Preparedness, Resilience and Response' (EPRR).

As part of the NHS England EPRR framework, providers and commissioners of NHS funded services must provide assurance that they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

To support NHS England in discharging it's duty to seek formal assurance that the NHS is ready to respond effectively to incidents and disruptions all NHS providers are subject to an annual process of assurance against a pre-determined set of core standards.

The NHS Core Standards for EPRR set out the minimum standards expected of NHS organisations in England to ensure they are able to meet their statutory obligations in respect of EPRR and provide organisations with a clear framework through which to assess the application and effectiveness of organisational plans, policies and processes to determine:

- Status of compliance against a minimum set of standards.
- Areas of best practice.
- Areas for improvement.

The core standards are set out across 10 distinct domains, the definitions for which can be found within Appendix 1.

This report aims to provide Board level assurance of the current position of the Trust in respect of EPRR with a focus on the following areas:

1. Status of compliance against the Core Standards for EPRR for the 2022 reporting period.
2. Reflection on the impacts, response and identified areas of learning associated with significant disruptions and/or incidents occurring over the past 12 months.
3. Overview of EPRR development work completed over the past 12 months together with the proposed areas of priority for ensuring the ongoing development of EPRR processes over the upcoming year.

For the purposes of this report, and in recognition of the Trusts vision to provide the best healthcare for everyone within our population, it should be acknowledged that where the Trust has indicated areas of full compliance this **should not** be seen as an indication that no further improvements can be made. Full compliance shows only that processes are at least in line with the minimum standards described. As reflected within the Trust's EPRR policy (RM35), the ongoing reflection and internal assurance of current processes is an essential part of ensuring continuous organisational improvement and the ongoing effectiveness of EPRR arrangements.

1.1 Re-introduction of Standards

Due to organisational and national priorities throughout the COVID-19 pandemic, it should be noted that during the 2020 and 2021 reporting periods the Trust was only required to undertake and report on a partial assessment of its EPRR arrangements.

For the current core standards assessment period NHS England have undertaken a full review of EPRR core standards to ensure they reflect the changing landscape of the NHS and up to date national best practice guidance relating to emergency preparedness.

As we emerge from the pandemic and to enable a holistic reflection of the current preparedness and response capabilities of the NHS, this year's core standards process has required the Trust to undertake an assessment across the full, revised, spectrum of EPRR core standards.

In direct comparison with the scope of last year's core standards assessment, the Trust has had to reflect on its current compliance against 64 standards rather than the 46 standards reported on within the 2021 reporting period. This includes the re-introduction of standards relating to training and exercising as well as updated standards linked to recent changes to the structure of the NHS and the national EPRR framework following the introduction of Integrated Care Boards in July 2022.

2 Executive Summary – Core Standards Assessment

Following an assessment of the Trusts existing EPRR arrangements it has been determined that the Trust is **fully compliant** against 91% of the standards applicable to NHS Acute Trusts. The following table shows the compliance status against each of the specified domains:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable To Acute Trusts
1. Governance	6	6	0	0	0
2. Duty to risk assess	2	2	0	0	0
3. Duty to maintain plans	11	10	1	0	0
4. Command and control	2	1	1	0	0
5. Training and exercising	4	1	3	0	0
6. Response	7	7	0	0	0
7. Warning and informing	4	4	0	0	0
8. Cooperation	4	4	0	0	3
9. Business continuity	10	10	0	0	1
10. CBRN	14	13	1	0	0
Total	**64**	**58**	**6**	**0**	**4**

An assessment of compliance against each of the standards shows that the Trust has an organisational assurance rating of **Substantial Compliance** indicating that the Trust is fully compliant against 89-99% of applicable NHS EPRR Core Standards.

It should be noted that this year's Core Standards percentage is the same as the percentage reported for the 2021/22 period. Although significant improvements have been made to internal arrangements over the course of the year the static percentage rating is a direct result of the changes reflected within section 1.1 of this report and the resulting and ongoing impacts

of the COVID-19 pandemic (reduced capacity to train and exercise plans, etc.). Further information relating to areas of partial compliance has been provided in section 3.2.

2.1 Compliance Assurance

Although the core standards requires the Trust to reflect on its own compliance through a process of organisational self-assessment it is important to acknowledge and gain assurance from the additional steps taken to ensure a degree of impartiality has been applied to the results of the assessment process . To ensure our compliance rating is a true and accurate reflection of the current position of the Trust the following steps have or will be undertaken in support of this year's assessment:

- Collective review and ongoing feedback of current EPRR processes undertaken by the Trust Resilience Forum, Business Continuity Focus Group and the Executive Management Team throughout the year to identify, progress and provide assurance on identified areas for improvement and the effectiveness of EPRR arrangements.
- A detailed independent peer review of our compliance rating by a designated partner organisation from within the NE&NC ICB footprint. For this year's Core Standards assessment, North Tees has been partnered with Gateshead Health NHS Foundation Trust with the planned review of core standards compliance scheduled to take place on 20th October 2022.
- Informal regional check and challenge event scheduled to take place on 4th November 2022 to enable a multi-organisational evaluation of the interpretation and evidence selection applied to each of the core standards by different organisations within the NE&NC ICB footprint.

The result of any review processes, including identified gaps and notable areas of best practice, will be used to help provide assurance of our compliance and shape the EPRR forward work programme for the upcoming year.

3 Advancements, Identified Strengths and Areas for Improvement

3.1 Organisational Advancements and Identified Strengths

Although it is essential to highlight any gaps and areas for improvement within existing EPRR arrangements it is also important to reflect on areas of full compliance to help recognise where:

1. Changes/recent improvements have been made, resulting in areas of increased core standards compliance.
2. Particular areas of strength and/or best practice have been demonstrated in the preparation and application of processes relating to EPRR.

3.1.1 Areas of Increased Compliance

Following the 2021 core standards assessment period work has been undertaken to help improve the Trusts compliance rating against the following areas:

Domain	2021 Compliance Rating	2022 Changes in Compliance Rating
D9 – Business Continuity	The 2021 core standards assessment recognised some elements of the Trust's business continuity arrangements as achieving **partial compliance** only. It was identified that further work was required to ensure a clear scope and set of objectives for Business Continuity Management was put in place to enable a	Over the past 12 months some significant steps have been taken towards improving the business continuity management arrangements across the Trust, including: • Establishing a Business Continuity Focus Group to help provide Trust wide engagement in the development, implementation and governance of business continuity arrangements. • Development and launch of a Business Continuity Management policy (RM38).

	consistent Trust wide approach to the administration, implementation, activation and monitoring of business continuity arrangements.	• Development and rollout of new operational business continuity and critical function templates. The new policy and templates were launched on 1st July 2022 with a 3-month implementation period allocated to all Care Group and Corporate Directorates to transition to use of new processes. The development and introduction of new business continuity arrangements has improved both the consistency in approach and internal governance of business continuity across the Trust with a greater focus given to holistic business continuity management (e.g. daily monitoring and mitigation processes) rather than arrangements focusing on business continuity response alone (i.e. when a disruption occurs). Although further work is required to fully embed new processes the work undertaken and progress made over the past 12 months in improving business continuity management arrangements within the Trust has enabled us to meet with the minimum **full compliance** requirements for business continuity set out within the 2022 Core Standards reporting period.
D10 - CBRN	Following changes made to national requirements associated with CBRN equipment and resources Acute NHS Trusts are required to hold a minimum of 24 Powered Respirator Protective Suits for responding to CBRN incidents. At the time of the 2021 core standards assessment the Trust only held 14 suits and as such was only able to report **partial compliance**.	Following the receipt of 10 additional Powered Respirator Suits in March 2022, received as part of the national PRPS procurement programme, the Trust now holds 24 PRPS suits and is able to report **full compliance** against standards associated with CBRN equipment and resources.

3.1.2 Identified Strengths

In conjunction with the improvements made to EPRR arrangements over the course of the past 12 months the following areas have been assessed and highlighted as areas of high compliance that should be maintained and built upon to ensure they continue to remain effective aspects of the Trusts EPRR arrangements going forward.

Domain	Identified Strengths	Overview
D4 – Command and Control	On Call Mechanisms and Command and Control	The Trust has an effective command structure and integrated on call mechanism in place helping to support effective situational awareness, appropriate escalation of issues and concerns, and the swift response of pre-identified, role specific operational, tactical and

		strategic staff. The on call structure includes staff undertaking the following roles: • Director on Call • Manager on Call • Senior Care Group on Call • ICT on Call • Estates on Call • On Call Communications Officer
D6 - Response	Situation Reports	The Trust continues to have a clear process in place for enabling the collation and distribution of operational information to support internal and external situational awareness, improving the ability of Trust to respond effectively to incidents and disruptions. The ability to maintain an effective awareness of the operational position of the Trust has been further improved by the co-location of all teams associated with patient flow and discharge enabling continuous dynamic interaction supported by the availability of live up to date operational information helping to support effective decision-making.
D7 – Warning and Informing	Communication with Partners and Stakeholders	The Trust has a wide range of clear and well-practiced mechanisms in place for the cascade of important information before, during and after incidents and disruptions, this includes: • Systems for issuing important internal messages relating to current, planned and ongoing incidents. • Effective systems for issuing communication alerts associated with the activation of critical and major incidents. • Effective use of media and social media channels to provide essential public information and updates.
D8 – Cooperation	Local Resilience Forum Engagement	The Trust continues to engage and maintain strong relationships with Cleveland Local Resilience Forum through regular attendance and active participation in multi-agency planning groups and training and exercise events. By maintaining strong relationships with the LRF the Trust ensures it continues to uphold its responsibilities as a Category 1 responder by helping to maintain a joined up, multi-agency approach to emergency preparedness. Over the past 12 months the Trust has actively engaged with the LRF across a wide range of multi-agency meetings and events, including: • LRF Strategic Board • LRF Tactical Business Group • LRF Training and Exercising Group • LRF Business Continuity Group • LRF Risk Assessment Group • LRF Death Management Group

		• Exercise Lemur (national power outage exercise) • Exercise Hydra (Hartlepool Power Station Exercise) • Radiation Monitoring Workshop • Whole-of-Society Resilience Workshop

3.2 Identified Areas for Improvement

The 2022 Core Standards assessment has provided assurance that there are **no** standards for which the Trust is deemed to be non-compliant, however a partial level of compliance has been identified across a small number of standards. Areas of partial compliance are linked to standards within the following domains:

- **Domain 3:** Duty to Maintain Plans
- **Domain 4:** Command and Control
- **Domain 5:** Training and Exercising
- **Domain 10:** CBRN

The table below outlines areas of partial compliance and provides assurance on the identified actions for strengthening our compliance within these areas. All areas of partial compliance will be prioritised within the EPRR work programme for the upcoming 12 month period.

Domain	Areas of Partial Compliance	Identified Actions for Improvement
D3 – Duty to Maintain Plans	Of the 11 standards associated with our duty to maintain plans 1 area of partial compliance has been identified against plans relating to: **1.** Evacuation and Shelter Although the Trust has plans in place which cover all areas for which plans have been specified as essential, the risk based prioritisation of EPRR work over the past 12 months (development of business continuity management processes, etc.), and the ongoing pressures on internal resourcing, has continued to impact the ability of the Trust to fully embed and undertake scheduled reviews of some plans.	Any plans that have exceeded or are due to exceed their stated review period will be formally reviewed over the course of the upcoming year. The review of plans will be prioritised based on their associated risk with the final ratification of updated plans undertaken by the Trust Resilience Forum and Executive Management Team to ensure alignment with current national guidance and compatibility with wider organisational EPRR arrangements. A more detailed overview of the Trusts current position and steps for improving arrangements relating to evacuation and shelter can be found within section 4 of this report.
D4 – Command and Control	Due to recent national changes made to the mandatory training requirements of health commanders within the NHS, all staff who undertake an operational, tactical or strategic health command role, including on call staff, are required to undertake the new national Principles of Health Command training and provide evidence of the	Over the next 12 months work will be undertaken to ensure alignment with new national competency requirements associated with NHS health commanders, this will include: • Developing a combined EPRR responder training and exercise strategy to outline steps for achieving full

	minimum occupational compliance associated with their role. The result of these changes means that the current internal training offered to on call staff only meets with partial levels of compliance.	minimum occupational compliance across all levels of command and control. • Identifying all operational, tactical and strategic staff who are required to undertake principles of health command training and ensure enrolment on upcoming regional PHC courses. (**Note:** Staff identified as strategic incident commanders have already started to undertake PHC training throughout September 2022, with 66% of identified strategic response staff within the Trust registered on upcoming courses). • Developing a process for recording and monitoring individual responder compliance against minimum occupational standards.
D5 – Training and Exercising	As a result of the COVID-19 pandemic the capacity and availability of resources through which to undertake EPRR training and exercising has been significantly limited since March 2020. Although many of the Trusts incident processes have been utilised for real over the course of the pandemic, due to the reduced ability of the Trust in being able to facilitate and maintain a full EPRR training and exercising programme, 3 of the applicable standards associated with training and exercising have been highlighted as areas of only partial compliance.	One of the key focuses for the upcoming 12 months is to agree and re-instate a full programme of EPRR training and exercising. This will be prioritised based on: • National minimum requirements (as outlined in the NHS England EPRR Framework). • Organisational risk based priorities. The training and exercise programme will be overseen, monitored and reported on through the Trust Resilience Forum.
D10 - CBRN	As with other aspects of training and exercising the capacity and availability of resources over the course of the COVID-19 pandemic has prevented a full programme of CBRN training from being delivered, as such a rating of partial compliance has been applied to standards associated with CBRN Training Programmes.	A number of steps are already underway to re-instate a full CBRN training and exercise programme. Work already undertaken to support this includes re-instating live tests in the deployment of the Trusts onsite decontamination tent and the instigation of a best practice review of CBRN processes and training, supported by key ED staff. The re-instigation of a full CBRN training and exercise programme will be included as part of the EPRR

		forward work programme for the upcoming year.

4 2022 Core Standards Deep Dive Review

In addition to the overarching core standards for EPRR, and to help support a national understanding of the wider capabilities of the NHS, the annual self assessment process requires NHS organisations to undertake a focused deep dive review across a specified area.

It should be noted that the overall EPRR Core Standards compliance rating does not take into account the results of the deep dive review.

The focus of the 2022 deep dive review is **Evacuation and Shelter**.

The Trust has site specific evacuation and shelter plans in place for both the North Tees and Hartlepool hospital sites. The current plans were finalised and agreed for use in November 2020 and are aligned to the Trust's fire evacuation and wider incident response processes.

The deep dive review indicated that the Trust is fully compliant against 10 of the 13 standards, including those associated with:

- Processes for the activation and coordination of plans.
- Defined processes for the incremental evacuation of Trust buildings.
- Agreed steps for the triage, movement and transportation of patients.
- Mechanisms for communicating with staff, patients, families and partner organisations.

Following the installation of new fire alarm and evacuation systems at both North Tees and Hartlepool hospital sites the Trust has undertaken a significant amount of work to help improve the effectiveness and familiarisation of evacuation processes over the past 12 months, including:

- A full review of onsite evacuation processes.
- Enhanced multi-team training and exercise events focusing on developing the knowledge and understanding of staff, familiarisation and testing of onsite evacuation techniques and use of resources.

Although significant steps have been taken to improve capabilities for the onsite evacuation of wards the deep dive review has highlighted some areas of partial compliance associated with the wider aspects of full onsite and offsite evacuation and reciprocal cross-organisational support. This includes standards associated with:

- The alignment of plans to the revised national evacuation and shelter guidance released in October 2021.
- Undertaking equality and health inequality assessments of evacuation and shelter plans.
- Full training and exercising of existing plans.

Areas of partial compliance highlighted as part of the deep dive review will be prioritised for inclusion in the EPRR forward work programme for the upcoming year.

It should be noted that following the identification of urgent work required to improve fire compartmentation measures within the roof and ceiling voids of the West Wing of North Tees Hospital, and with the agreement of Cleveland Fire Brigade, temporary changes were made to the evacuation processes within the first floor of West Wing in June 2022.

Although the deep dive review does not take into account and directly reflect the temporary arrangements implemented as a result of this, it has helped provide better insight into gaps and improvements to processes, most notably those linked to the implementation of regular familiarisation and testing programmes. Some of the lessons learnt as part of this work will

help inform the implementation and improvement of wider evacuation and shelter measures going forward.

5 Incidents and Disruptions

The importance the Trust places on ensuring the ongoing effectiveness of EPRR arrangements is evidenced through the Trust's EPRR and Business Continuity Management policies. The policies set out the approach of the Trust in ensuring EPRR arrangements are developed and maintained with 'use in mind'.

It is recognised that although the Trust has effective measures in place for identifying and mitigating the likelihood and severity of incidents and disruptions occurring, they cannot always be prevented. The development of effective EPRR arrangements is important to ensure we are appropriately prepared to respond when incidents do occur.

The important role that EPRR arrangements play is evident by reflecting on the range of incidents and disruptions (planned and unplanned) that have impacted the Trust over the past year. EPRR arrangements have been integral in supporting the overall management and response to a range of incidents and disruptions at both service and organisational level, this includes through the use of command and control processes, business continuity arrangements and incident specific response plans.

The following table shows the variety of incidents and disruptions, which have affected the Trust over the past year, and have required the application of EPRR processes to ensure their effective management and response.

Type/Category	Information
COVID-19	The Trust has continued to respond to and manage the impacts of COVID-19. This includes the management of the business continuity impacts associated with staffing levels and the requirements to support the ongoing NHS and LRF response at both local and national level.
ICT	The Trust has experienced a number of disruptions associated with the use and availability of ICT systems over the course of the year, as a result of both planned and unplanned disruptions. These include those relating to: • Ongoing system updates and programmes of maintenance to ensure the continued effectiveness and security of systems. • Network outages linked to internal hardware failures. This includes a full outage following the failure of air conditioning units in July 2022. • Disruptions associated with faults originating from external service/system providers.
Estates and Facilities	A programme of maintenance and improvement continues to be implemented across the Trust estates. Although proposed areas of work are planned to help minimise disruptions a number of unavoidable disruptions to services do occur which require appropriate preparatory steps to be taken to ensure the effective management and continuity of services throughout. Over the past year some of the pre-planned works associated with disruptions to estates and facilities include: • Fire Alarm and Lift Installation Programme • Fire Compartmentation Improvements • Equipment Installations (e.g. Installation of CT Scanner)

	The resulting impacts of pre-planned work have include disruptions to areas including: • Electricity Supply • Cold and Hot Water Supply • Ward Usage A number of unplanned disruptions impacting estates and facilities have also occurred over the course of the year which have required the use of EPRR processes, including: • UHNT Mortuary Flooding (January 2022) • Electrical Infrastructure Fault at UHH (December 2021)
Procurement/Supplies	There are a number of ongoing national disruptions to the procurement of medical supplies which continue to impact the Trust. Although there has been limited disruptions to the continuity of essential services this is an ongoing issue which is been monitored closely and, where necessary, measures put in place to oversee the management and response to any disruptions that do occur.
Severe Weather	A number of significant severe weather events have impacted the Trust over the past 12 months, including: • Winter Storms (Storm Arwen, etc. November 2021 – February 2022) • Extreme Hot Weather events (July 2022) The Trust has utilised a number of existing EPRR processes to monitor, prepare for and respond to severe weather events, including plans and processes relating to: • Severe Weather (e.g. heatwave plan.) • Communicating with Partners and Stakeholders (e.g. staff, patients, public, Cleveland LRF, etc.) • Command and Control

5.1 Monitoring and Assurance

In order to ensure the effectiveness of the Trusts response to future incidents ongoing monitoring and assurance activities are regularly undertaken by the Trust Resilience Forum, with support from the Business Continuity Focus Group. Monitoring and assurance activities are designed to ensure existing EPRR arrangements are applied appropriately, are fit for purposes and continue to support the ongoing development of EPRR arrangements across the Trust. These include activities associated with:

- Monitoring and evaluation of EPRR incidents and risks
- Oversite of identified actions and recommendations following the evaluation of incidents (e.g. debrief reports, etc.).
- Assurance of activities relating to planned disruptions.
- Assurance of new and existing plans prior to use.

It is our intention to undertake a 6 month review of the Core Standards with particular focus on areas of partial compliance to provide ongoing assurance as to the progress being made with improving the Trust's EPRR arrangements.

5.2 Forward Look (Winter Preparedness)

As we look ahead to the winter period and with the risks associated with the increase in cost of living, energy crisis, winterbourne illnesses and potential periods of industrial action, EPRR processes will continue to be essential in helping the Trust monitor, prepare for and respond effectively to incidents and disruptions over this period.

6 EPRR Work Programme

An important aspect of ensuring the effectiveness of internal arrangements and alignment with the national framework for EPRR is through the development and implementation of an ongoing and appropriate programme of work designed to embed existing practices, maintain resources and to support continuous organisational improvement.

Although predominantly focussing on planned work over the upcoming 12 month period, the forward work programme should be recognised as a flexible, rolling progression of work shaped by both existing and emerging organisational, regional and national priorities associated with EPRR. Areas of influence used to help shape the forward work programme include:

- Current guidance and good practice.
- Lessons identified from incidents and exercises (organisational and multi-agency).
- New and emerging risks (organisational, local, regional and national).
- Outcomes of assurance and audit processes (cores standards, etc.).
- Routine tasks and statutory requirements.
- Organisational preparedness.

Due to the Trust-wide responsibilities associated with EPRR, and in recognition that different areas of the Trust hold lead responsibilities for the development of different aspects of work, the forward work programme is developed on an ongoing basis with collaborative input from across the Trust to ensure it is a holistic reflection of all associated, upcoming areas of work.

The forward work programme for the upcoming year will be set following completion of the core standards assessment and agreed by the Trust Resilience Forum to ensure it is reflective of any identified priorities associated with areas such as:

- Training and exercising
- Resource development (plans, processes, equipment, etc.)
- Organisational, local and national risks

Likely areas of priority over the upcoming year include:

- Development and re-introduction of a full EPRR training and exercise calendar, aligned to the updated requirements set out within the national EPRR Framework.
- Full review and refresh of high priority EPRR plans, policies and processes to ensure alignment to changes in national guidance and compliance with internal governance arrangements.
- Continued implementation of new business continuity management processes, including processes of validation.
- Ongoing refining of processes for monitoring and reviewing EPRR incidents and risks, including standardisation of debriefing processes.

7 Recommendations

It is requested that the Board of Directors support the following recommendations to help support the EPRR capabilities of the Trust:

1. Receive the above report as assurance that the Trust continues to meet its statutory requirements in respect of EPRR compliance.
2. Acknowledge the essential role that EPRR plays in the effective operation of the Trust and support identified proposals for the ongoing development of associated plans, policies and processes.
3. Support the continued oversight of EPRR functions through the Trust Resilience Forum.

Appendix 1 – NHS Core Standards for EPRR Domain Overview

Domain	Overview
1. Governance	• A policy statement, outlining the organisation's commitment to deliver EPRR, must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS Core Standards for EPRR are delivered. • Organisations must have an appointed Accountable Emergency Officer (AEO) who is a board level director and responsible for EPRR in their organisation. This person should be supported by a non-executive board member.
2. Duty to Risk Assess	• Organisations should have provision in place to regularly assess the risks to the population it serves. This process should consider the community and national risk registers. • A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring and escalating EPRR risks.
3. Duty to Maintain Plans	• Appropriate and up to date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.
4. Command and Control	• A robust and dedicated EPRR on call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, 7 days a week, and provide the ability to respond or escalate notifications to executive level. • Personnel performing the on call function should be appropriately trained in major incident response.
5. Training and Exercising	• EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role. • Arrangements must be exercised through, as a minimum, a: ➢ communications exercise every six months ➢ table top exercise once a year ➢ live exercise every three years ➢ command post exercise every three years
6. Response	• Staff trained in incident response should be available to respond to incidents from within an Incident Coordination Centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself or be unavailable at the time of response.
7. Warning and Informing	• Tested processes should be in place for communicating with partners and stakeholders, and warning and informing public and staff when responding to major incidents, critical incidents and business continuity incidents. • Organisations should also have an appropriate media strategy to enable communication with the public. This should include identification of and access to trained media spokespeople able to represent the organisation.
8. Cooperation	• Arrangements should be in place to share appropriate information with stakeholders. This includes participation in Local Health Resilience Partnerships (LHRPs) to demonstrate engagement and co-operation with other responders.
9. Business Continuity	• Up to date business continuity plans setting out maintenance of critical activities when faced with disruption should be in place within each organisation. These planning arrangements should be aligned to current nationally recognised business continuity standards.
10. CBRN	• Acute, specialist, mental health and community healthcare providers are required to have planning arrangement in place for the management of CBRN incidents. NHS Ambulance Trusts also share this requirement and their specific responsibilities in relation to CBRN are set out in 'Interoperable capabilities'.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Winter Resilience Plan 2022/23										
Date:	24 November 2022										
Prepared by:	Care Groups Levi Buckley, Chief Operating Officer										
Executive sponsor:	Levi Buckley, Chief Operating Officer										
Purpose of the report	To provide the Board with an update on the Trust and system winter planning and preparedness. The Trust winter resilience plan has been developed to ensure strong operational resilience over winter months though to Easter 2023. The winter plan supports maintaining the elective recovery programme alongside managing operational pressures to support safe and timely flows within the hospital on a 24 hour, seven days a week basis.										
Action required:	Approve	√	Assurance	√	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	√	Valuing our People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe	√	Caring	√	Effective	√	Responsive	√	Well Led	√	

Executive Summary and the key issues for consideration/ decision:
Winter operational pressures across health and social care lead to increases in both emergency and non-elective demand and an increase in the clinical acuity of patients. The ongoing of impact the covid pandemic is resulting in increased pressures on patient flow and hospital resources. This paper provides an overview of the Trust winter plan for 2022/2023, including key risks and mitigating actions.
How this report impacts on current risks or highlights new risks:
This report is aligned with issues identified in the Board Assurance Framework. Specifically 1A, Patient Safety/Outcomes, 1B Patient Experience and 1C Performance.

Committees/groups where this item has been discussed	Care Group Senior Management Team Meeting Operational Management Team Executive Team
Recommendation	The Board of Directors is asked to: • Note the content of this report and recognise the due diligence applied to the winter planning process and proposals for managing surges in activity over the winter months, and throughout the year, whilst maintaining quality, patient experience and operational and financial efficiency. • Note the system approach to the production of the Winter Plan and the engagement with partners through formal structures that provides assurance of system engagement and collaboration with partners. • Be cognisant of the dynamic external environment and the potential impact of evolving national and regional directives that may impact on overall recovery and resilience.

North Tees & Hartlepool NHS Foundation Trust

Winter Plan 2022/2023

1. Introduction

Each winter brings a number of challenges to how health and social care services are delivered. However post COVID 19 pandemic has seen a number of intermittent surges in demand for health and social care throughout the year. Alongside the importance of maintaining elective recovery, and specifically cancer diagnostics and treatment plans need to be more robust than ever. Over the winter period pressures hit all parts of the health system with key areas of risk associated with planning for winter including:

- Influenza, COVID-19 and the potential for further pandemic outbreaks;
- Cold weather and an anticipated rise in associated respiratory infections;
- Meeting the needs of a frail and elderly population and chronic medical conditions;
- Predicted increase in paediatric respiratory viral illness
- Staff retention and sustainability, including sickness, test and trace, self-isolation and associated absence, during long periods of pressure and major system change

Innovation unlocked through our response to the pandemic has presented opportunities to radically change the way care is delivered, rapidly expanding the shift of activity from hospital to community settings. System working has been an integral component of these changes with a shared commitment to provide the most robust services befitting to the people we support across Teesside.

The national policy direction and the opportunities offered through the ICS and Provider Collaborative reinforce the requirement to develop an ambitious and responsive operating model. This will continue the organisation's approach to increasing the provision of care in people's homes and the community, strengthen links between health care providers to minimise duplication, create efficiency and collaborate as a Tees Valley Integrated Care Partnership to build sustainable services for the future.

During winter 21/22 elective care was managed successfully with front loading of procedures prior to the onset of winter months, and the maximum use of both hospital sites and the independent sector to ensure minimum disruption to elective care. The use of Waiting List Initiatives has also been fully engaged with in a focused manner to improve the Trusts position in terms of >104/78/52 week waits. Theatre capacity has flexed in response to those sub-specialties with the highest demand in order to ensure the biggest impact.

2. Context and Aims

2.1 The Trust and wider system has continued to see a change in the traditional seasonality of surge during winter with intermittent and extended periods of surge being experienced throughout the year. As a result many of the schemes that are stepped up in winter such as

escalation beds have remained in place during the year.

2.2 The aims of the plan are to achieve the following:

- Improved patient experience and patient outcomes.
  Admission avoidance and increased provision in the community including virtual wards
- Reduce over 30 minute ambulance handover delays
- Zero tolerance of 6 and 12 hour waits in the ED department and 12 DTA
- Bed occupancy at 90% or lower
- Enable timely discharge and reduce stranded patients

2.3 In order to achieve these aims the winter plan is based on the key principles:

- Sufficient capacity to meet the pressures of winter in addition to intermittent surge; COVID and seasonal flu
- Prioritisation of schemes that are not only achievable but also deliver value for money and have a positive impact on managing surge and escalation in the winter period
- Utilise community assets to deliver care at home, preventing inappropriate attendances or admissions to hospital and to enable early supported discharge from hospital
- Maintained focus on 'Criteria to Reside' and reduced lengths of stay
- Ensure correct bed base to meet demand whist remaining agile to manage surge
- Ensure Integrated Command and Control Centre (ICC) principles with appropriate escalation as per internal action cards and system wide OPEL
- Elective planning to minimise the risk of cancelled procedures
- Support delivery of Urgent and Emergency Care Standards, encompassing timely patient care
- Flu planning and Covid 19 booster - vaccination uptake alongside predicted flu pressures for 2022/23, with the aim to implement a comprehensive action plan to mitigate risks.
- Regular and timely engagement with local authorities and primary care to support escalation across pathways.

2.4 Daily SitRep reporting including weekends and Christmas period incorporating the weekly 'Discharge Patient Tracking List' submission using the newly developed OPTICA tool to monitor long lengths.

2.5 The Trust's Chief Executive is the Chair of the Local A&E Delivery Board and with organisational membership at the Urgent and Emergency Care Network, the Trust supports the wider planning agenda with regard to system wide issues influencing continuous improvement. It is essential that robust and transparent escalation and timely response is enacted across the system to support admission avoidance and timely safe discharge.

2.6 Risks have continued to be identified to ensure that mitigation can be introduced into the system to minimise any impact on safety, quality and financial and operational efficiency.

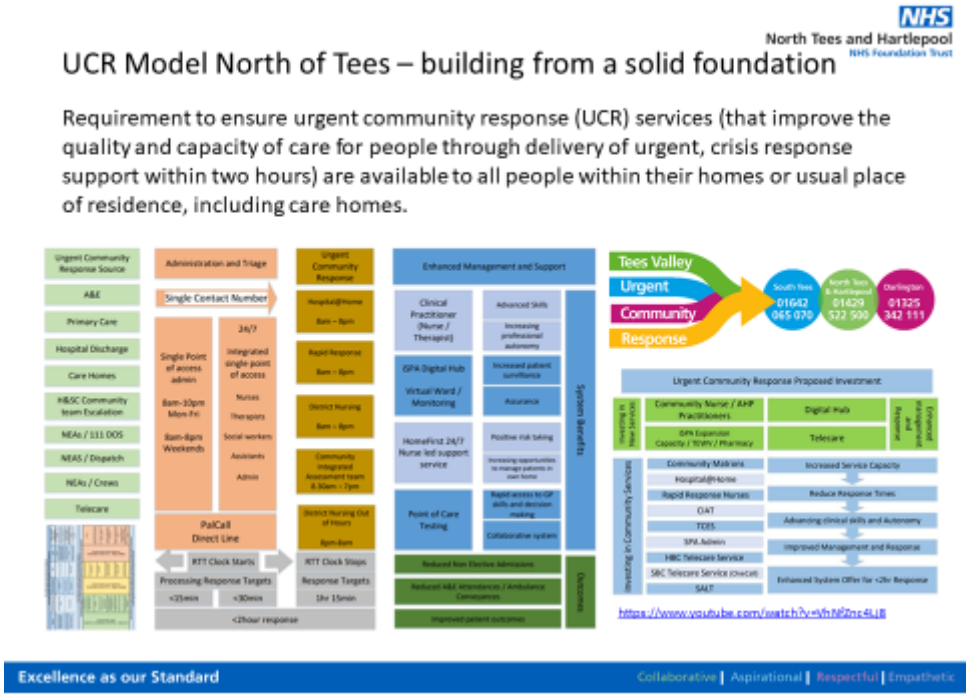
3. Winter Plan 2022/23

3.1 The evolving operating model recognises the intermittent extended periods of surge throughout the year post Covid- 19 pandemic which has contributed to challenging periods of patient flow through non elective pathways and increase in over 12 hour ED waits and ambulance handover delays at the front of house. A process of continuous improvement has taken place across the Trust with the following key developments:

- Introduced RSU model of care, staffing ratios allowing for visibility, continuous monitoring and increased capacity for ventilation and oxygen. Aligned with critical care.
- Integrated ICC including:
    - purpose-built environment, information & technology
    - effective site management & coordination of flow and discharge
- Implementation of EPIC and ENIC roles/process in ED and QI programme for ambulance handovers, triage and initial assessment
- Developing community infrastructure – national recognition for integrated discharge model inc, development of OPTICA (web-based discharge support tool)
- Significant elective recovery and system support utilising University Hospital Hartlepool

3.2 The new Trust operating model includes recognises the ongoing intermittent surge pressure additional to winter and includes additional capacity:

- Front of house assessment capacity within the Emergency Assessment Unit and Surgical Decision Unit
- Additional workforce to manage an increase in activity and patient acuity on resus and majors in the Emergency Department.
- Establishing a Short Stay Frailty Unit on ward 37 will enable the efficient and effective management of frail patients that require hospitalisation ensuring that their length of stay is limited and over medicalisation avoided. By locating these patients in a dedicated area, it will enable specially trained frailty staff to advice upon their care-planning, treatment and discharge process linking in with families and carers.
- A Patient Flow Facilitator supporting each ward working with the integrated discharge team to support timely discharge.
- Overnight patient transport to support front of house assessment services.
- Bed capacity to take account of modelling assumptions from 2021/22 and predictive analysis for 2022/23 including:
    - Commissioning care home bed capacity to support discharge of medically optimised patients.
    - Additional G&A bed capacity that can be flexed up during periods of winter surge.
    - A virtual ward, which is a safe and efficient alternative to NHS bedded care that is enabled by technology.
- Development of an urgent 2 hour response service offer integrated with IsPA:



3.3 The operating model includes the following assumptions:

- Optimal Occupancy <90%
- Community infrastructure/home first principles remain the priority point of delivery.
- Assess to admit model, utilising SDEC principles, to support right place/clinician first time to support ED flow.
- Virtual wards development, local and national priority – NTHFT as system leader.
- Workforce required to manage inpatient beds including workforce review requirements (safe staffing/RESET)
- Ability to respond to escalation timely with associated triggers through OPEL plan revision (in line with agreed operating model and revised Tees surge policy)

3.4 The operating model within the Trust is focussed on delivering a transformational home safer sooner model with the following priorities:

- Community hub delivering Same Day Emergency Care (SDEC)
- ISPA 24/7 Clinical triage model working with system partners (assess to admit)
- Home First Discharge to Assess
- Frailty Front of House
- Criteria to Reside implementation
- Discharge pathway 2 – re focus
- Enhanced Care Transformation
- One Front Door with streaming to the most appropriate area (assess to admit)
- Wider System Preparation

4. Bed Model and Surge capacity

4.1 The bed model increases the permanent funded bed capacity and is a core part of the new operating model. A workforce plan to enable delivery of the new bed model is being implemented.

4.2 There is a phased approach to escalation beds at times of surge. This demonstrates flexible working between care groups and opportunities to escalate areas based on demand with the best utilisation of workforce. This has been realised by expanding current ward and making preparations for operating a partial or full resilience ward.

4.3 Proactive management of elective activity between the North Tees and Hartlepool site has been successfully deployed for a number of years now. This approach reduces the elective demand during times of surge, Jan/Feb, and increases the availability of beds. There are plans to put on additional emergency surgery and orthopaedic trauma lists to support flow through theatres and as such the organisation as a whole. This will have a positive impact on lengths of stay and improve overall capacity.

5. Workforce

5.1 Sickness absence within the organisation can create additional pressures, which is recognised as a risk. The Trust embedded additional sickness management processes during 2020/21 to focus on key areas of both short and long term sickness plus monitoring of COVID isolation levels. Significant work is on-going to understand the overarching staff profile and influences on absence to support sickness reduction. Managers will be expected to utilise existing Business Continuity Plans with the intention of utilising and pooling resource in clinical areas and will be considered on a daily basis.

5.2 Rotas will be planned 6-8 weeks in advance to ensure the most effective use of resource and avoid unnecessary recourse to bank/agency. Any necessary temporary staffing usage will be escalated in accordance with 'Break Glass' standard operating procedure. Daily capacity and staffing meetings will highlight the requirement for additional capacity and staffing. Safe Care Live data will be analysed to determine the over/under-utilisation of staff, and will support the safe and efficient redeployment of staff, in line with safe staffing guidance.

5.3 The volunteer's resilience plan can be activated in any circumstances when increased pressures occur which will mean:

- Communication to be forwarded to the Volunteer Services as levels of pressure increase and OPEL levels rise.
- At induction all volunteers will be asked if they would be willing to support the Trust in times of pressure. Volunteer coordinator/representative to liaise with RCC re deployment of volunteers as and when they attend Trust.
- The volunteer driver service to extend current medication delivery service.
- The 'Home but not Alone' project will allow volunteers to identify those patients most at need of practical support at the point of discharge. This will facilitate discharges at an earlier point in the day, irrespective of need for transport or medication.
- The Volunteer Responder Service will enable volunteers to be more flexible and respond to urgent need within the Trust site, in terms of collection and distribution of medication/equipment and the movement of patients as appropriate. Accessible via the Trust Vocera devices.

- Volunteer driver service also supports the discharge of wheelchair bound patients by driving Trust adapted vehicles.

6. Internal Operational and Wider System Collaboration

6.1 Agreed Operational Pressure and Escalation Levels (OPEL) with on-going work to ensure wider utilisation and system response i.e. primary care, public health, mental health. This is to provide an objective consistent approach to escalation and associated actions. There is a system in place to initiate a system wide escalation through the A&E Delivery Board.

6.2 The Clinical Site Managers and the patient flow team provide the operational command and management of patient flow, whilst the Manager on Call provide the tactical response and the Director on Call provided the strategic response. The severity of pressure, due to surges in activity, is continually assessed by Care Group Managers engaging the Manager on Call (MoC) and escalation activated according to the OPEL with the involvement of the operational teams in hours. At each level of the OPEL associated actions include from reassessment of training and utilisation of clinical staff in non-clinical roles to declaration of a critical incident level 1.

7. Financial Plan

7.1 As part of the Trust's internal financial framework and issuing of control totals, a reserve has been allocated for the new operating model and winter expenditure.

8. Risks and Mitigation

8.1 Although significant planning has been undertaken by the organisation there are clearly still risks that need to be considered. The table below outlines the identified risks and potential mitigation: -

RISK	MITIGATION
Surges in activity and patient acuity.	Utilisation of passed additional capacity, OPEL escalation and mutual aid. Review of the bed predictor tool to more accurately support decision making and planning for surge
Continued pressure in COVID-19 demand that affects flow / impact on ITU / impact on elective programme	Close monitoring of COVID impact and utilisation of triggers to manage this and step down of services should this be required
Workforce vacancies, sickness levels and COVID isolation impacting challenging the ability to open additional beds.	Rolling recruitment programmes for hard to recruit to posts, over-recruiting where required. Implementation of evidence-based workforce planning methodology required to support Care Groups with alternative workforce models, roles and rota-planning.

	Monitoring of absence and daily staffing meetings to ensure shared responsibility to ensure safe staffing across the organisation.
Utilisation of agency staff if inability to recruit to vacancies and resilience posts.	NHSP recruitment drive and strict management of agency deployment.
Potentially insufficient flu vaccinations for local communities and staff	Coordinated approach to flu programme and system working to manage supplies and demand across partnerships
Increased demand on urgent care/ED due to changing operating models within primary care	Weekly meetings to monitor impact and implement measures within the system to support
Adverse weather conditions and impact on staff travel and NEAS	Use of alternative methods of transport and support from other agencies
Regional divert policy. Potential exacerbation of out of area activity	System assurance – effective collaboration between key stakeholders and impact of diverts on partner organisations
Full realisation of system support to facilitate admission avoidance and timely discharge does not materialise	Enhanced Out of hospital initiatives and continuing collaboration with primary and social care. Strengthened already established relationships following the first wave of COVID to allow timely discussions/escalations.
Insufficient funding to support surge capacity	Close monitoring of expenditure by Care Group Directors and Director of Finance. Resilience funding to resource agreed schemes only with weekly monitoring of expenditure. Seek additional support from the Clinical Commissioning Groups or restrict additional resources.
Cancellation of elective activity to facilitate surges in emergency activity.	Flexible bed bases. Elective Care Recovery. Weekend Lists and utilisation of University Hospital Hartlepool
Impact on referral to treatment standard from cancellation of elective procedures.	Tight management of referral to treatment and control of theatre lists to ensure that none are wasted.

Potential infection control pressures i.e. outbreak management, mixing surgical and orthopaedic procedures	Support from ICPT to manage outbreak and implement measures required Move additional elective activity to Hartlepool site, supported by appropriate clinical cover.

9. Summary and Conclusion

9.1 In summary of the 2022/23 winter planning and operational delivery, the Trust has reflected on the previous winter period and the challenging pressures across the system resulting in additional resource requirements to managing the global pandemic, patient acuity, safe staffing and quality of service provision. This has, in turn, informed the preparation and planning for operational resilience and surge management for this coming winter. The Trust's plans were robust and enabled a controlled approach borne out in the introduction of quality initiatives, clear lines of accountability in the command and control structure and robust financial management, whilst focussing on maintaining patient safety and quality outcomes.

9.2 Emerging from a pandemic it is expected to be a particularly challenging and difficult winter of 2022/23 with surges in activity throughout the year. The new operating model and winter reslience plan anticipates the key initiatives required to maintain quality, safety and patient experience whilst managing the majority of elective activity and sustaining operational and financial efficiency. The risk and mitigation plans provide assurance to our patients that they will continue to receive safe and effective care

Levi Buckley
Chief Operating Officer

Contributions by:
Care Group Directors
Care Group Managers
Service Leads
Heads of Nursing
Finance Business Partners
Health and Wellbeing Practitioner
Emergency Planning Officer
LLP

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Learning from Deaths Report, Quarter 2, 2022-23											
Date:	24th November 2022											
Prepared by:	Janet Alderton, Head of Patient Safety											
Executive sponsor:	Medical Director											
Purpose of the report	To provide an overview of the learning obtained through the review of deaths that occur within the organisation. Also, to provide details from the clinical teams around actions that have been implemented as a result of the overall learning and, where available, to provide an evaluation of the impact of these.											
Action required:	Approve	X	Assurance	X	Discuss	X	Information	X				
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People		Transforming our Services		Health and Wellbeing	X				
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X		

Executive Summary and the key issues for consideration/ decision:

- The Trust HSMR value is 94.08 (September 2021 to August 2022), this is an increase from the previous reported value of 94.03 (August 2021 to July 2022). The latest SHMI value has increased slightly to 98.26 (June 2021 to May 2022) from the previously reported value of 97.50 (May 2021 to April 2022). Both statistics remain "within expected" ranges.
- The successful implementation of the Medical Examiners role has prompted a review of the Trusts policies; the Trust Mortality Lead and the Lead ME are reviewing the overall strategy and policy in relation to learning from deaths. The planned changes are expected to support clinical staff in completing reviews and identifying learning to generate quality improvement measures.
- There is summary information in the report relating to actions initiated as a result of learning from deaths in patients in relation to the Specialist Palliative Care Team, Maternity Services and Intensive Care team.
- To date in 2022-23, there are four cases that have been as Serious Incidents, all have been investigated and it is possible that the overall outcome may have been different with different care provision. There is one further case still being investigated and the outcome of this investigation will be reported in future reports.

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

Any new risks identified through mortality review processes are assessed and added to the risk register as needed.

Committees/groups where this item has been discussed	• Patient Safety & Quality Standard Committee • Patient Safety Council
Recommendation	• The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover. • The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation. • The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

Board of Directors

Title of report:	Guardian of Safe Working Hours Report										
Date:	24 November 2022										
Prepared by:	Mr Rajesh Nanda, Guardian of Safe Working Caroline Metcalf, Senior Rota Lead										
Executive Sponsor:	Deepak Dwarakanath, Medical Director and Deputy Chief Executive Officer										
Purpose of the report	The New Junior Doctor Contract (2016) requests that the Guardian of Safe Working Hours (GOSW) prepares a quarterly report to the Board of Directors. These reports contain information relating to the safe working of doctors within the Trust.										
Action required:	Approve		Assurance	✓	Discuss	✓	Information	✓			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	✓	Transforming our Services	✓	Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well Led	✓	

Executive Summary and the key issues for consideration/ decision:

The Trust appointed a new Guardian of Safe Working, who commenced in post in September 2022.

Team members have returned to post, restoring business and administrative provision for the Guardian. The Trust is exploring additional support for the Guardian's team as part of succession planning.

Exception reporting continues to be the mechanism used to highlight non-compliance with safe working hours, lack of support, and missed educational opportunities. Overall, there has been an increase in the number of exceptions, which shows an improvement in engagement. Additional hours worked continues to be the main cause for exception reporting, mainly amongst foundation and specialty trainees year 1 and 2 within medicine specialties.

Trends identified through exception reporting and staff feedback has resulted in a number of recommendations from the Guardian in relation to workforce numbers, workload, induction, and handover on medical wards. Issues raised are also a reflection of workforce pressures highlighted in the GMC Survey.

Following on from the Guardian's report, the medicine leadership team have held initial discussions to identify opportunities to address concerns raised. They are now exploring the feasibility of implementing suggestions put forward and any necessary support required.

Options under consideration include-

1. Adjustments to working patterns to provide blocks of acute work and back of house work
2. Recruitment of additional Trust doctors
3. QIPP exercise to improve efficiency of doctors
4. Continuation of the Physicians Associate programme
5. Redrafted job adverts and job descriptions to make posts more appealing
6. Using Trust doctors differently to attract them into post and improve patient continuity
7. Working with clinical attachments to provide them with UK experience so they can register with the GMC

8. Participation in the NHS Professionals Doctors Gateway: EU Graduate Programme to help address long-term vacancies. Including looking at the possibility of the Certificate of Eligibility for Specialist Registration (CESR) route for some of these candidates.

A number of these initiatives will be reliant on funding which will need securing. Some initiatives, such as the Physicians Associate programme, contributes to the current medical overspend.

There are also a number of other factors outside of the Trusts control which continue to present challenges, such as sickness absence, increasing numbers of less than full time doctors (in full time training slots), occupational health recommendations which restrict out of hours and weekend work, and delays in home office immigration processes.

A meeting is scheduled with the Guardians team to explore options further, and an update will be provided in the next Guardian report.

How this report impacts on current risks or highlights new risks:
• Impact of rota gaps and staff absence resulting in trainees working additional hours • Possible breaches to safe working hours and rest requirements resulting in fines. • Continued pressures could result in excessive working hours and could affect wellbeing.

Committees/groups where this item has been discussed	Patient Safety and Quality Committee October 2022
Recommendation	The Board of Directors is asked to note the content and accept this report.

Guardian of Safe Working Report

Executive Summary

This report highlights the latest data from the exception reporting system and forms part of the reporting requirements of the 2016 contract for doctors and dentists in training. The report highlights key issues reported by doctors in training.

Between January and September 2022, there have been 157 exceptions reported, an increase to previous years. The main reason for submission continues to relate to additional hours worked, due to workload and staffing levels. Mainly within Medicine specialties (79%).

As there has not been a Junior Doctors Forum since April 2022, an engagement session took place with junior doctors in medicine in September 2022. Issues and trends suggest inadequate staffing levels, high workloads, insufficient handover arrangements, and poor local induction. Exception reports also reflect these themes. Other issues identified include poor quality and availability of hot meals during out of hours, and issues with the availability of computer equipment. The next Junior Doctors Forum takes place in October 2022.

The disparity of bank pay rates across the region continues to be a cause for concern among doctors in training. The Senior Rota Lead has agreed to take this back to the LET Collaborative Bank for further discussion.

Guardian recommendations:-

1. Evidence based and holistic review of minimum staffing levels on medicine base wards
2. Consider further expansion of new roles such as Physicians Associates, and Advanced Nurse Practitioners to complement the medical workforce
3. Review current handover processes on EAU, to ensure shifts are coordinated and with adequate time allocated, so that they take place in work time
4. Include handover arrangements in local induction, generic work schedules, and on rosters
5. Strengthen local induction so doctors understand how the department works, and what is expected of them and others whilst on duty
6. Improve both the quality and availability of hot food during out of hours, offering card payment or change machines where necessary

The medical leadership team are reviewing feedback and recommendations. A follow-up meeting will then take place in November, and will include reflection on findings from the GMC survey.

Upcoming work includes the development of posters to promote exception reporting and signposting of support available to doctors. Production of training videos for both doctors in training and supervisors and made available on the Trust intranet site. Development of quality standards for generic work schedules. Attendance at national and regional guardian conferences.

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

Mr Rajesh Nanda

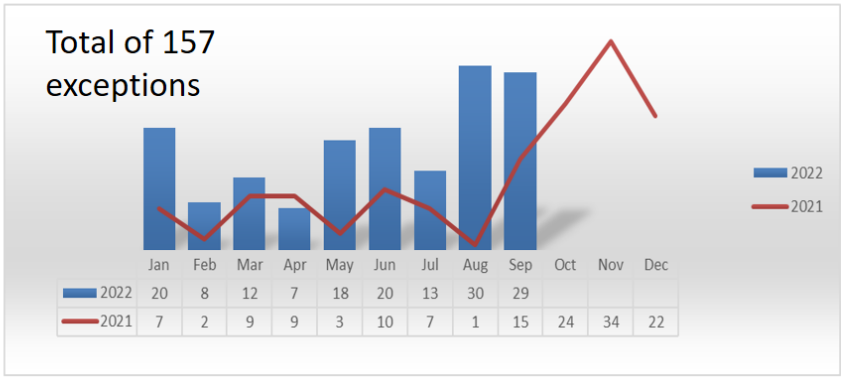
Guardian of Safe Working

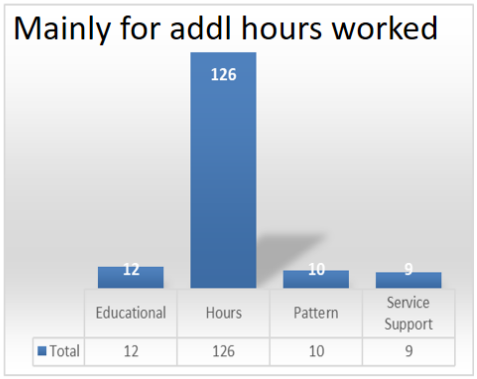
Appendix One: Exception Reporting

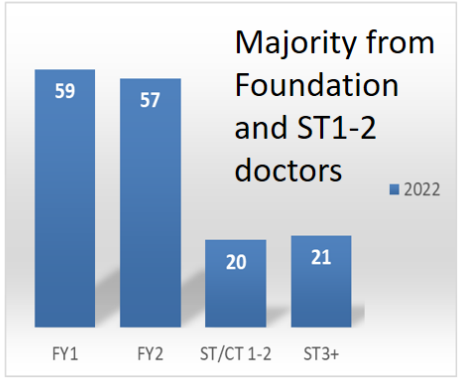
Exception Reporting

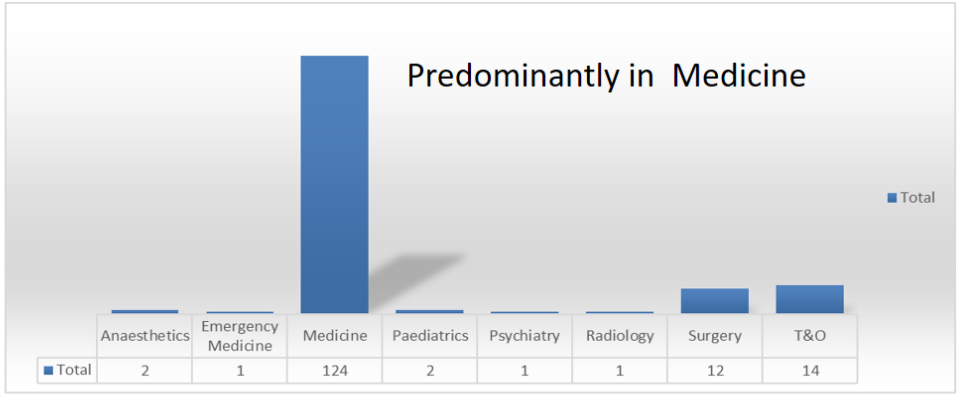
January to September 2022

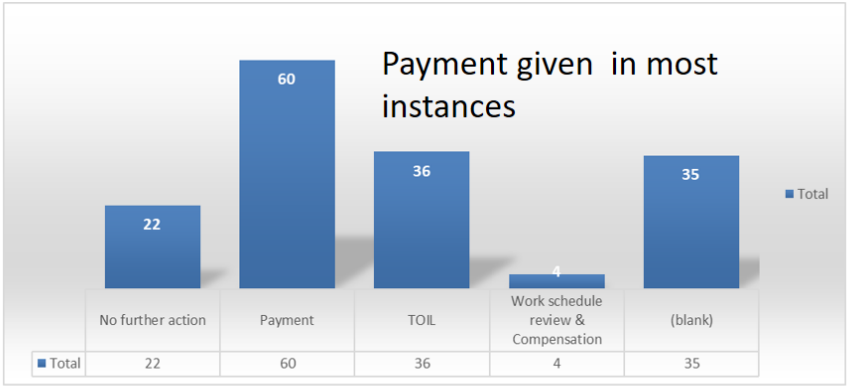
NHS
North Tees and Hartlepool
NHS Foundation Trust











Plan from the Medicine Department

Initial discussions have taken place amongst the clinical rota leads around ways to address concerns raised by doctors. They are exploring a number of prospects to optimise the use of the current workforce and improve recruitment. These investigations are to look at the feasibility of implementing suggestions and any support required.

Option		Additional Comments
1.	Review of current working patterns.	Look at the possibility of having blocks of acute work and blocks of back of house ward work. Dependent on workforce numbers, and limited by working hours and rest rules.
2.	Explore the possibility of recruiting additional Trust doctors, meetings scheduled with finance.	Trust doctor posts are difficult to recruit to and other initiatives look to address some of these challenges.
3.	QIPP exercise to improve the efficiency of doctors and assist in reducing exceptions.	
4.	Continuation of the Physicians Associate programme to complement the medical workforce	This programme remains unfunded and is a financial risk for the department as it forms part of the medical workforce overspend.
5.	Redrafted job descriptions and adverts for Trust doctors to make posts sound more appealing.	This focuses on using Trust doctors for continuity on wards and removing out of hours elements, this may help make the posts more attractive. Any out of hour's gaps will need covering by bank.
6.	Working with finance to explore the possibility of utilising Trust Doctors differently to attract them into post.	This focuses on using Trust doctors for continuity on wards and removing out of hours elements, this may help make the posts more attractive. Any out of hour's gaps will need covering by bank.
7.	The department are working with a number of clinical attachments who are not GMC registered but do have overseas medical qualifications.	By supporting them in gaining NHS experience, they will be able to register with the GMC. This support coupled with a good experience may attract them into Trust posts.
8.	Participation in the NHS Professionals Doctors Gateway: EU Graduate Programme to help address long-term vacancies.	Including looking at the possibility of the Certificate of Eligibility for Specialist Registration (CESR) route for some of these candidates.

Risks and further consideration: A number of these initiatives will be reliant on funding which will need securing. There are also a number of other factors outside of the Trusts control which continue to present challenges, such as sickness absence, increasing less than full time doctors (in full time training slots), occupational health restrictions restricting out of hour and weekend work, and delays in home office immigration processes.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

24th November 2022

Learning from Deaths Report, Q2, 2022-23

Report of the Medical Director

1. Introduction/Background

1.1 In March 2017, the National Quality Board (NQB) published national guidance "Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care". The guidance provides requirements for Trust to implement as a minimum in order ensure there is a focused approach towards responding to and learning from deaths of patients in our care.

1.2 The Trust strives to improve the care provided to all of our patients; the overall aim is to identify, understand and implement improvements where any issues may be related to the provision of safe and effective quality care. It is considered that as safety and quality improvements are initiated effectively and embedded, then the mortality statistics will naturally be maintained within "as expected" range.

1.3 The information presented in this report provides an overview of learning from deaths that has been obtained from mortality scrutiny and case reviews undertaken by the Trust. Information from a variety of speciality areas is being provided within the reports on a cyclical basis.

1.4 The number of mortality reviews undertaken by the Trust has been significantly reduced during the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. The introduction of the Medical Examiners scrutiny has assisted in ensuring all in-patient deaths are reviewed.

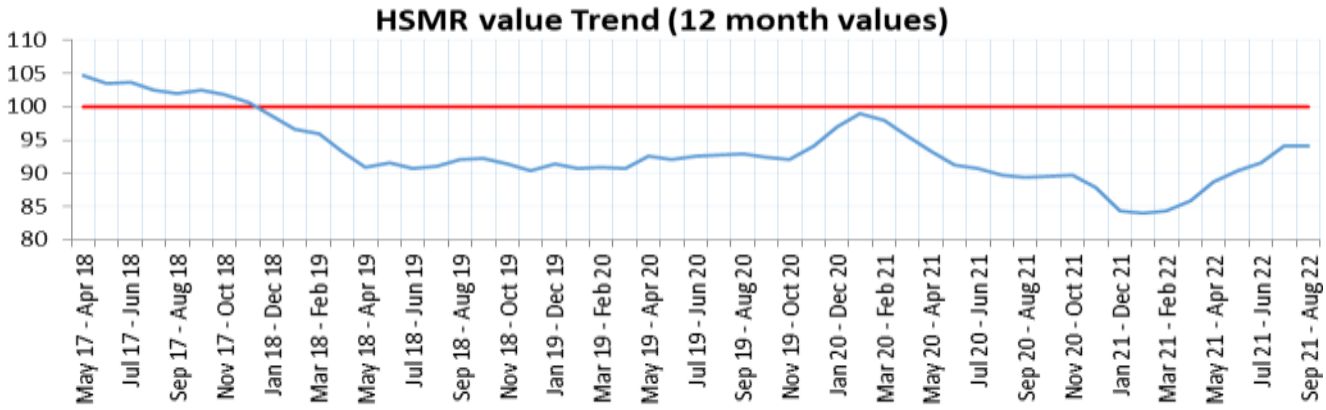
2. Mortality Data

2.1 Information related to mortality is gathered from data provided routinely by the Trust to the national system where all hospital episode statistics (HES Data) is collated. Hospital Standardised Mortality Ratio (HSMR) examines information covering 56 diagnostic groups that are identified as accounting for 80% of hospital deaths nationally.

This information is used to calculate an overall HSMR taking into account, gender of the patient, age, how the patient was admitted (emergency or elective), levels of deprivation, how many times they have been admitted as an emergency in the last year, if palliative care was provided and various details relating to presenting complaint on admission.

2.2 The latest HSMR value is now **94.08** (September 2021 to August 2022), this is an increase from the previous rebased value of **94.03** (August 2021 to July 2022).

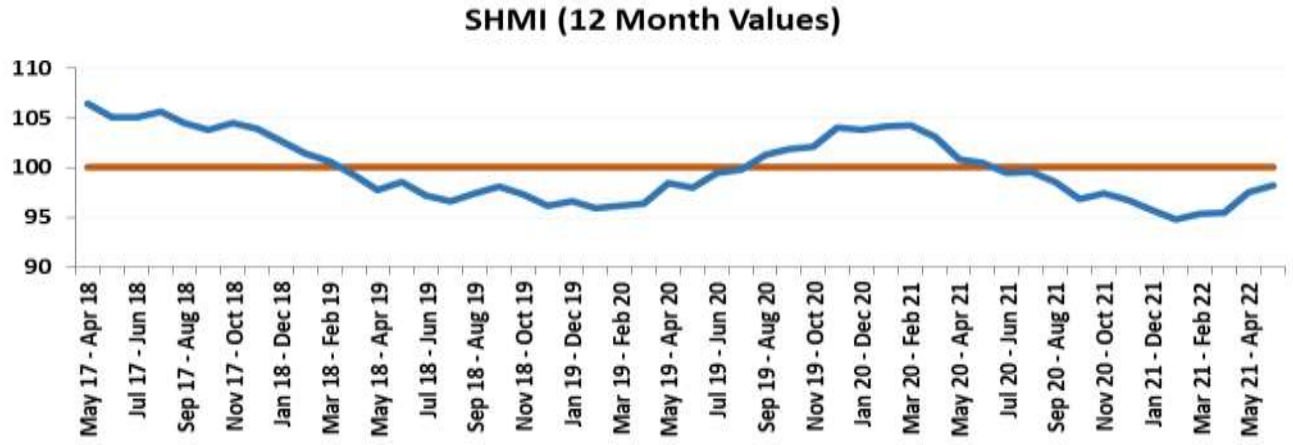
2.3 The value of 94.08 continues to remain inside the 'as expected' range. The following chart displays the 12 month rolling HSMR trends from April 2018 to August 2022:



2.4 The Trust currently has the 13th lowest HSMR value from the 124 Trusts nationally, and the second lowest value of the eight North East Trusts.

2.5 The Summary Hospital-level Mortality Indicator (SHMI) is a ratio between the number of actual (observed) deaths to the "expected" number of deaths for an individual Trust, including deaths in hospital and up to 30 days following discharge. The ratio is calculated with consideration of gender, age, admission method, admissions in the last year and diagnosis being treated for the last admission.

2.6 The latest SHMI value is now this has increased to **98.26** (June 2021 to May 2022) from the previous rebased value of **97.50** (May 2021 to April 2022). The value of 98.26 continues to remain inside the 'as expected' range. The graph below shows the 12 month rolling SHMI from April 2018 to April 2022:

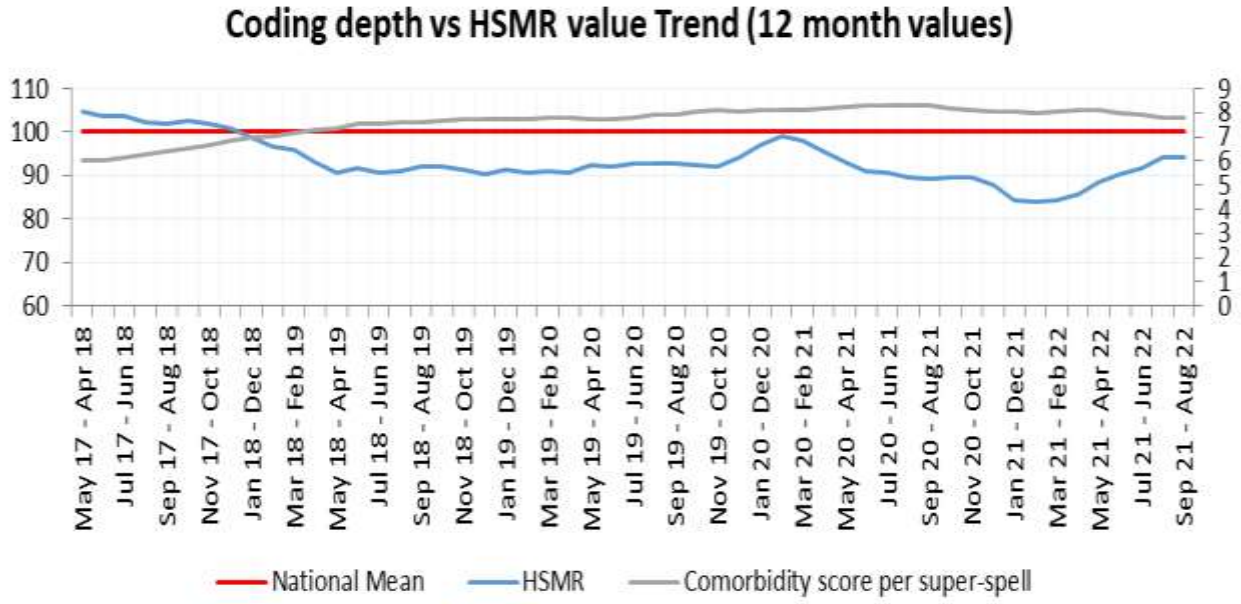


2.7 The Trust currently has the 23rd lowest SHMI value from the 122 Trusts nationally, and the fourth lowest of the eight North East Trusts.

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

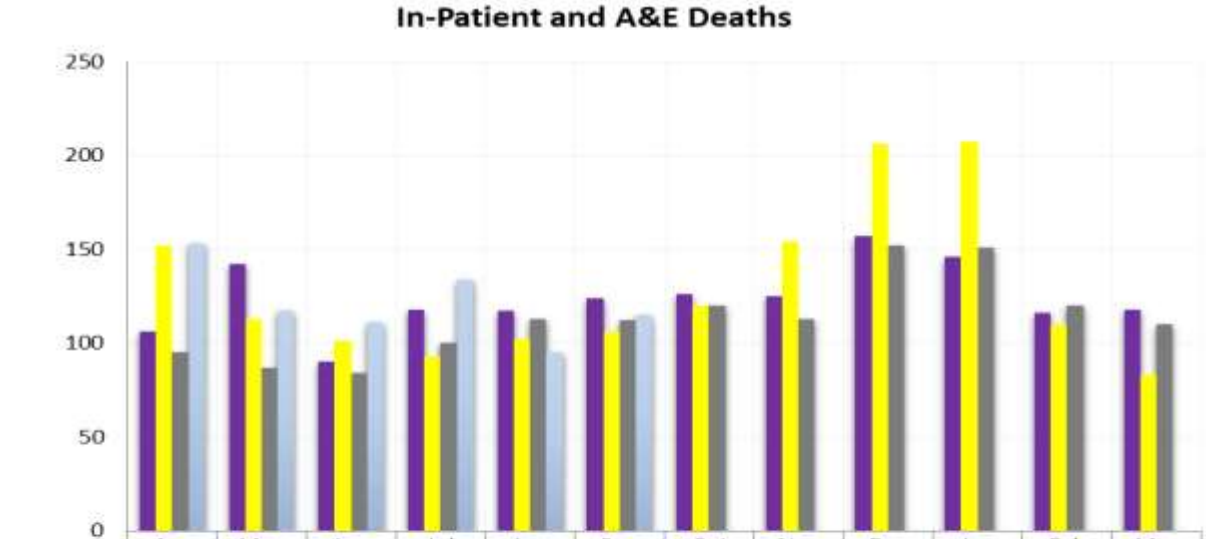
The Trust is currently maintaining a high level of clinical coding, with a current average of eight co-morbidities recorded for patients; this level of coding is now thought to more accurately

reflect overall health problems and deprivation within the local population. Maintaining this level of information reflects the quality in not only the clinical documentation, but also the quality of the clinical coding activity within the organisation. This has been challenging during the Covid pandemic, there had been changes in clinical coding national requirements; previous reports had highlighted that this had led to some uncertainty in relation to longitudinal prediction of the mortality statistics.



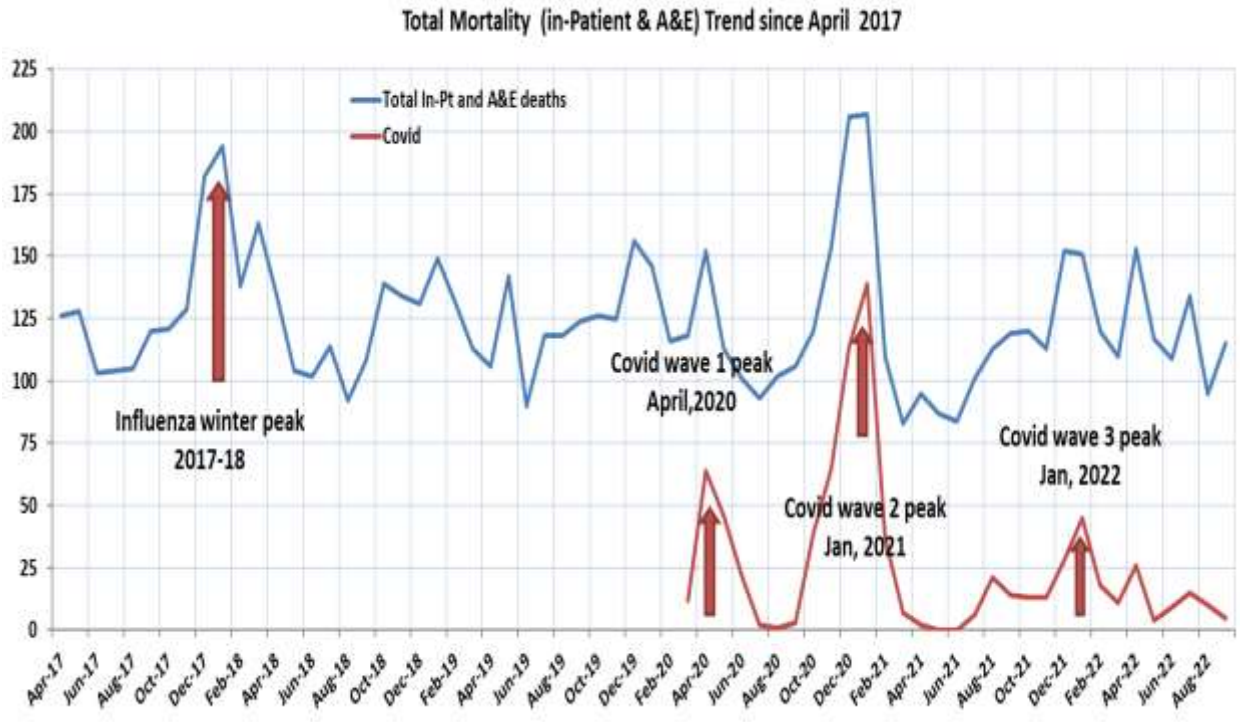
3. Mortality reviews

3.1 The Trust policy currently identifies that all in-patient deaths and those in the Accident and Emergency department are included in the scope of the mortality reviews. The chart below shows the total numbers of deaths since April 2019 to the end of September 2022.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	106	142	90	118	117	124	126	125	157	146	116	118
2020/21	152	113	101	93	102	106	120	154	206	207	110	83
2021/22	95	87	84	100	113	112	120	113	152	151	120	110
2022/23	153	117	111	134	95	115	0	0	0	0	0	0

3.2 The following chart shows the monthly trend and fluctuations in mortalities since April 2017 to June 2022. The red markers represent key areas of peak deaths linked with influenza over the winter of 2017-18 and Covid-19 from March 2020. The red line represents the numbers of Covid deaths logged by the Trust over the last 2 years.



3.3 All patient deaths are scrutinised by the Medical Examiners (ME) team, part of this involves contacting the patient's family or carers to discuss their death. This provides the opportunity for family's / carers to raise any concerns they might have but also for them to discuss with the ME, the medical cause of death or if there has been a referral to the Coroner, and why.

3.4 Mortality case reviews can be requested following the ME discussions, but are also undertaken for the following cases, which are linked to specific national review processes:

- All deaths where a patient has a registered Learning Disability (LD) – in conjunction with the Learning Disability Mortality Review Programme (LeDER).
- All maternal deaths – in conjunction with M-BRRACE-UK.
- All deaths where the patient has a severe mental illness – in conjunction with local Mental Health Trusts as required.
- All child deaths (up to 18th birthday) – in conjunction with the Child Death Overview Panel (CDOP) process, this may also link into Perinatal Mortality or LeDeR reviews.
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool; (these figures are not included within overall mortality data provided in the tables above).

3.5 The Trust is currently reviewing its processes for mortality case reviews; there will continue to be the required reviews as outlined above, however, these will be linked closely with learning from other complex cases where a patient may not have died or also any relevant thematic reviews that are identified. Cases will then be considered at a variety of speciality mortality and morbidity (M&M) meetings; the learning from these review sessions will then be shared at a Trust wide group to allow identification of overarching issues that may require local or more significant quality improvement work. These changes are based around the national "Better Tomorrow Programme: learning from deaths, learning for lives"; which is a national programme

providing support and tools for Trusts to use. As the Trust work develops, more detail will be provided in future reports, currently 14 members of staff have been trained in the use of the review tool being used as part of the pilot, and this will support completion of SJRs.

3.6 The following table provides a summary of the data, by financial quarters, to date for 2022-23. The numbers of mortality cases given scrutiny by the Medical Examiners team has been included in the chart below to demonstrate the integration of the two approaches to reviewing the care of our patients. The ME team can refer any cases into the overall mortality review system for further interrogation of clinical care or if necessary into the established governance structures.

To date in 2022-23, there are four cases that have been as Serious Incidents, all have been investigated and it is possible that the overall outcome may have been different with different care provision. There is one further case still being investigated and the outcome of this investigation will be reported in future reports.

2022-23	Q1	Q2	Q3	Q4	Total
Total deaths in scope	388	349			**737**
Deaths in compulsory criteria	49	51			**100**
Compulsory case reviews completed (no.)	27	32			**59**
Compulsory case reviews completed (%)	55%	63%			**57%**
Compulsory reviews pending	22	19			**41**
Reviews & ME scrutiny completed	375	350			**725**
Review/ Scrutiny completed of all deaths (%)	96%	99%			**98%**
Reviewed Deaths considered avoidable (no.)	2	2			**4**
Reviewed Deaths considered avoidable (%)	0.1%	0.1%			**0.1%**
Reviewed Deaths considered not preventable (no.)	373	348			**721**
Reviewed Deaths considered not preventable (%)	99.9%	99.9%			**99.9%**

3.7 Where a patient's death immediately raises concern, this is reported, and then escalated through the Trusts incident reporting and investigation process, implementing Duty of Candour procedures as required. The details of the case will then be considered in line with the national Serious Incident framework to ensure any lessons learned are identified and reported to the Trusts commissioners. A case record review is completed as part of the investigation process. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.

3.8 Over quarter 2, 99% of mortalities have been given either scrutiny by the ME team, or where the patient passed away on ITU, reviewed by the clinical team involved. Stillbirths are reviewed using the Perinatal Mortality Review Tool and have been added to the overall mortality numbers. There has been a low number of other SJRs completed for those cases identified as requiring further review. As the ME team are now identifying cases where they consider additional learning can be obtained, they are requesting SJRs are completed, the relevant clinical teams are being asked to complete these. The Trust Mortality Lead will be progressing this requirement in order to collate the learning from these reviews; the output from these will then be utilised to enhance the content of future reports.

3.9 The Trusts Safety Panel receives summary reports giving details of thematic learning from the following groups:

- Cardiac arrest reviews
- Intensive Care deaths
- Medical Examiner scrutiny
- Emergency Department deaths

These areas provide a monthly summary providing details of the number of cases reviewed; these provide information to help identify trends in "real time" so that actions and improvements are generated and initiated promptly. Details of thematic issues raised are included in the and will be in future reports as the relevant services provide updates on lessons learned, improvements made and overall evaluation of impact.

4. Learning from Deaths

4.1 Specialist Palliative Care Team update

The Specialist Palliative Care team (SPCT) undertake reviews of cases within their weekly multidisciplinary team (MDT) meetings; these may be randomly selected or identified as a case where learning may have been highlighted. The team also undertake case reviews as part of the National Audit of Care at the End of Life (NACEL), which supports benchmarking of inpatient care of people who died in hospital. The output and themes identified are presented at the SPC Team meeting, the End of Life Steering Group and the Trust Safety Panel meeting. The SPCT have provided some details of themes, learning and the resulting actions being implemented, they are summarised below but have also been shared at a variety of trust groups "huddles" and are also included in educational sessions.

Following discussions of case reviews and thematic learning at Safety panel, it has been identified through incidents presented at Safety Panel that some patients may not have Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed in a timely manner, and that there may be a lack of appropriate Advance Care Planning, including Emergency Health Care Plans (EHCPs).

Audit results have shown some specific areas of improvement that are to be addressed using a variety of approaches to raise awareness, not only for healthcare professionals but also for the public themselves. The team have issued overarching communications to all senior medical staff and are using the innovative "Medical Bites" approach to cascade brief learning videos to a wide range of staff in the Trust. This approach uses a closed group approach to sharing information around lessons learned across a range of learning activities; initially set up in the Responsive Care Group but now being utilised by wider teams in the organisation. The SPCT are planning to evaluate the impact of this increased awareness through future audits, case reviews or any safety events being reviewed.

The SPCT are also planning to initiate an audit of EHCPs, to examine the use and quality of plans, with an initial focus on Care Home residents. Once this has been completed, the results will be shared at the End of Life Steering Group in order to develop a robust improvement plan alongside any relevant stakeholders within Primary Care. Details will be shared in future reports.

The NACEL audit has highlighted that use of the Trusts "Care of the Dying Patient Document" (CFDPD) has been below what would be expected; and feel that this has impacted on the opportunities to provide gold standard care to our dying patients. In order to influence this an End of Life Facilitator has been appointed to champion the use of this document through education and support of front line staff. This is a fixed term appointment, the impact of the role

will be evaluated as part of future audit and through staff feedback; if the evaluation is positive then the role could be extended further.

Another key theme from case reviews and audits, as well as incident reporting, is in relation to the appropriate prescribing end of life medications (anticipatory medicines). In order to try and reduce errors in prescribing or incomplete prescribing, the SPCT have developed an “order set” in the Trusts electronic prescribing system to support safe prescription of these medications, this also provides a direct web link to the regional Palliative and End of Life Guidelines. The team are confident this will have an impact but will be monitoring through audit and incident reporting, and will provide an evaluation of the impact in future reports.

4.2 Maternity update

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 by Trusts 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.

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 peer staff; having external reviewers supports the provision of an 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.

The national requirements are that Trusts should complete the initial notification of cases to MBRRACE-UK within seven days of a death. During quarter two, all cases were submitted within the required time scales, confirming that the Trust is complaint with this standard.

There is an established process, coordinated through the Local Maternity and Neonatal System (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 evaluated each year as part of the multidisciplinary mandatory training.

Furthermore, any babies that show signs of life are also reviewed under CDOP processes. This is a Teeswide Multidisciplinary group that review all child deaths from birth for to 18 years; the group reviews cases and identifies actions that can be taken Teeswide to prevent future deaths.

The Maternity service also refers cases to the HSIB (Health Safety Investigation Branch) which meet the following requirements:

- Intrapartum stillbirth
- Early Neonatal death
- Potential severe brain injury

The maternity team works closely with families and health care staff affected by Patient Safety events, using a standardised approach to maternity investigations without attributing blame or liability. Working with families ensures that the patient’s perspective is understood in relation to

the care they have received. The service also work with other Trusts to ensure they support them to improve maternity investigations; this also extends opportunities for shared learning and improvement by bringing together findings from a range of investigation reports to identify wider themes and influence change across the national maternity health care system.

Of the cases reviewed during this quarter the presence of known risk factors such previous preterm labour and previous fetal loss, raised body mass index; have been identified; these are all factors which can increase the risk of fetal loss. This increases the importance of completing risk assessments at each Antenatal attendance; the service have identified through an audit process that staff appeared to be more compliant in documenting the completion of risk assessments if this was completed by using a stamp in the hand held notes rather a questionnaire.

Smoking in pregnancy continues to be a theme in the PMRT case reviews; this can be a more complex issue when there are other risk factors, as described above. During pregnancy Carbon Monoxide (CO) monitoring is offered to all pregnant women as part of ongoing assessments; it can lead to discussions around smoking cessation but also around how to be aware of, and avoid, passive smoke inhalation, it is recognised that this can also have an impact on pregnancy and outcome. In order to assess their ongoing work around smoking cessation the service undertake monthly audits in the relation to documentation of CO monitoring at time of booking; the current compliance is 100%. The Maternity Smoking Cessation lead is currently developing a Data Outcome system to assist with auditing; this will be initially specific to the Tobacco Dependency Treatment Service. Further feedback will be provided in future reports as this work progresses.

In previous reports, the service have given details of the ongoing work in relation to the recognition and management of reduced fetal movements (RFM); this is a key area of focus as 55% of women report RFM prior to a stillbirth. The midwifery team continue to screen for the presence of RFM at each antenatal contact and women are encouraged to sign on their records if they have received the information related to RFM. The most recent audit undertaken by the service, in August 2022, identified 100% of women know when to report concerns however, work still needs to be undertaken to ensure women sign to say they have received the advice.

The audit also showed that 100% of women who attended the maternity unit with history of RFM received a computerised cardiotocograph (CTG), an electronic recording of the baby's heart rate pattern. This forms an important element of the national Saving Babies Lives Care Bundle, which is a group of actions identified through research to have a positive impact on reducing stillbirths. The maternity services are currently compliant with all but one element of this care bundle; the one element of non-compliance is in relation to the provision of Uterine Doppler scanning at 24 weeks' gestation. A uterine artery doppler measurement is used to check the blood flow of the uterine arteries; this uses sound waves to check if the blood is flowing easily (low resistance) or whether it is having to work harder (raised resistance). This can help inform the team if additional appointments and scans are needed to monitor the growth of the baby or other pregnancy complications, such as raised blood pressure (pre-eclampsia). The maternity services have initiated a quality improvement project to support ultrasound staff with the additional training to provide these scans whenever they are required; updates in relation to the progress of the project and roll out of the service will be given in future reports.

The maternity services utilise a variety of opportunities to share learning across the multidisciplinary / multiprofessional teams involved in the provision of maternity care; the service have an extensive mandatory training programme which is responsive to learning identified from case reviews and any safety events identified. Case summaries and learning are also shared

via a range of Patient Safety Boards in staff areas. Details of any reports published by HSIB are also used to identify key learning from incidents these can be local or national reviews. The services a Bereavement session as part of their mandatory training programme; this is an opportunity to share the learning from case reviews, but also to support staff in relation to providing care to bereaved families.

4.3 Intensive Care Unit update

The Intensive Care Unit (ITU) team undertake case reviews for all patients who have died in their care; the learning from the reviews is shared with staff at the weekly multidisciplinary team meeting. A monthly summary is also provided to the Trusts Safety Panel in order to share themes, learning and actions taken with a wider audience from across all services.

The ITU team have worked collaboratively with the Surgical team to enhance the care given to patients undergoing emergency laparotomy; as a result of this joint work there is now a preoperative discussion prior to each emergency laparotomy involving the consultant surgeon, consultant anaesthetist and critical care consultant. All cases are reviewed on a monthly basis to assess compliance, which is currently 100%. The teams are also aiming to review any deaths linked to emergency laparotomy.

As part of the Trusts overarching Deteriorating patient work, the referral processes to ITU have been expanded to support increased access to the unit; alongside senior clinical staff the Critical Care Outreach Team members can directly refer patients to the unit. As part of this work, the ITU team have set up an MDT focused group to develop a treatment escalation plan, which can inform and further enhance clinical decision making around the management of patients. Updates around progress and impact will be provided in future reports as this work progresses.

5. Conclusion/Summary

5.1 The Trust HSMR value is 94.08 (September 2021 to August 2022), this is an increase from the previous reported value of 94.03 (August 2021 to July 2022). The latest SHMI value has increased slightly to 98.26 (June 2021 to May 2022) from the previously reported value of 97.50 (May 2021 to April 2022). Both statistics remain “within expected” ranges.

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

5.3 There is summary information in the report relating to actions initiated as a result of learning from deaths in patients in relation to the Specialist Palliative Care Team, Maternity Services and Intensive Care team.

5.4 To date in 2022-23, there are four cases that have been as Serious Incidents, all have been investigated and it is possible that the overall outcome may have been different with different care provision. There is one further case still being investigated and the outcome of this investigation will be reported in future reports.

6. Recommendations

6.1 The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover.

6.2 The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation.

6.3 The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

Dr D Dwarakanath

Medical Director / Deputy Chief Executive

North Tees and Hartlepool NHS Foundation Trust
2023 Board of Directors, Board Seminars, Council of Governors and AGM Meetings

BoD Meeting 10.30 am – public 12.30 pm – In committee	**Group Board of Directors** 9.30am	**Board Seminars** 1.00pm	**Council of Governors' Meeting** 9.00am – 1.00pm including a development session	**Annual General Meeting** 1.00pm – 3.00pm	**CoG Pre-Meetings** Venue tbc 9.30am – 11.30am
Thursday, 26 January Boardroom, UHNT	Thursday, 26 January – Q3 Boardroom, UHNT	Thursday, 12 January Boardroom, UHNT			
		Thursday, 23 February Boardroom, UHNT	Thursday, 16 February Venue, TBC		Wednesday, 8 February Boardroom, UHNT
Thursday, 23 March Boardroom, UHNT					
Thursday, 27 April Boardroom,	Thursday, 27 April – Q4 Boardroom,	Thursday, 13 April Boardroom,			
Thursday, 25 May Boardroom, UHNT		Thursday, 11 May Boardroom, UHNT	Thursday, 18 May Venue, TBC		Wednesday, 10 May Boardroom, UHNT
Thursday, 27 July Boardroom, UHNT	Thursday, 27 July – Q1 Boardroom, UHNT	Thursday, 13 July Boardroom, UHNT			
					Wednesday, 30 August Boardroom, UHNT
Thursday, 28 September Boardroom, UHNT		Thursday, 28 September Boardroom, UHNT, time tbc Lunch provided	Thursday, 7 September Venue, TBC	Thursday, 7 September Lecture Theatre	
Thursday, 26 October Boardroom,	Thursday, 26 October – Q2 Boardroom,	Thursday, 12 October Boardroom,			
Thursday, 23 November Boardroom, UHNT		Thursday, 9 November Boardroom, UHNT			
		Thursday, 7 December Boardroom, UHH	Thursday, 14 December Lecture Theatre		Wednesday, 6 December Boardroom, UHNT