North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 27 May 2021
at 1pm

Boardroom
University Hospital of North Tees

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
Stockton on Tees
TS19 8PE
Telephone: 01642 617617
www.nth.nhs.uk

20 May 2021

Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 27 May 2021 at 1.00pm** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely

Neil Mundy
Chairman

Agenda

			Led by
1.	(1.00pm)	Apologies for Absence	Chairman
2.		Declaration of Interest	Chairman
3.		Patient Story (verbal)	K Sheard
4.	(1.20pm)	Minutes of the meeting held on, 29 April 2021 **(enclosed)**	Chairman
5.		Matters Arising / Action Log **(enclosed)**	Chairman
Items for Information			
6.	(1.30pm)	Report of the Chairman **(enclosed)**	Chairman
7.	(1.45pm)	Report of the Chief Executive **(enclosed)**	J Gillon
Strategic Management			
8.	(2.00pm)	Annual Report and Accounts 2020/21 **(to follow)**	B Bright & N Atkinson
Performance Management			
9.	(2.10pm)	Integrated Corporate Report **(enclosed)**	L Taylor, K Sheard A Sheppard & N Atkinson

Neil Mundy
Chairman

Julie Gillon
Chief Executive

Governance

10.	(2.25pm)	Guardian of Safe Working Hours Report **(enclosed)**	D Dwarakanath
11.	(2.35pm)	Annual Operating Plan 2021/22 and Annual Self-Certifications **(enclosed)**	L Taylor & N Atkinson
12.	(2.45pm)	NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Progress Update **(enclosed)**	K Sheard

Items to Receive

13	(2.55pm)	Annual Report of the Vulnerability Unit, Safeguarding Adults, Children and Young People **(enclosed)**	K Sheard
14.		Director of Infection Prevention and Control Report 2020/21 **(enclosed)**	K Sheard
15.	(3.20pm)	Any Other Notified Business	Chairman

16. Date of Next Meeting
(Thursday, 29 July 2021 Boardroom, University Hospital of North Tees)

Neil Mundy
Chairman

Julie Gillon
Chief Executive

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing People

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

Transforming Our Services

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

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors held on Thursday, 27 May 2021 at 1 pm at the University Hospital of North Tees / Via Video Link

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

These minutes represent a formal record of the meeting.

Present:-

Neil Mundy, Interim Joint Chairman*	Chairman
Steve Hall, Vice-Chair/Non-Executive Director**[via video link]*	SH
Ann Baxter, Non-Executive Director**[via video link]*	AB
Philip Craig, Non-Executive Director*	PC
Jonathan Erskine, Non-Executive Director* *[via video link]*	JE
Kevin Robinson, Non-Executive Director*	KR
Rita Taylor, Non-Executive Director**[via video link]*	RT
Julie Gillon, Chief Executive*	CE
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Barbara Bright, Director of Corporate Affairs and Chief of Staff	DoCA&CoS
Neil Atkinson, Director of Finance*	DoF
Levi Buckley, Chief Operating Officer* *[via video link]*	COO
Gillian Colquhoun, Deputy Chief Information and Technology Officer *[via video link]*	DCITO
Karen Sheard, Deputy Chief Nurse/Deputy Director of Patient Safety and Quality*	DCN/DDoPS&Q
Alan Sheppard, Chief People Officer *[via video link]*	DCPO
Lynne Taylor, Director of Performance and Planning	DoP&P

In attendance: -

Tony Horrocks, Lead Governor / Elected Governor for Stockton *[via video link]*
Gavin Morrigan, Elected Governor for Stockton *[via video link]*
Aaron Roy, Elected Governor for Hartlepool *[via video link]*
Alan Smith, Elected Governor for Hartlepool *[via video link]*
Angela Warnes, Elected Governor for Rest of England [via video link]
Alex Metcalfe, Local Democracy Reporter, Teesside Gazette/Teesside Live *[via video link]*
Posmyk Boleslaw, Chair, Tees Valley CCG [via video link]
Sarah Hutt, Assistant Company Secretary (note taker)

BoD/4526 Apologies for Absence / Welcome

Apologies for Absence were reported by Graham Evans, Chief Information and Technology Officer, Lindsey Robertson, Chief Nurse / Director of Patient Safety and Quality, and Angela Seward, Lead Governor, South Tees Hospitals NHS Foundation Trust.

The Chairman welcomed members to the meeting which included Governors of the Trust, Posmyk Boleslaw, and members of the press.

BoD/4527 Declaration of Interests

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

* voting member

BoD/4528 Patient Story

The DCN/DDoPS&Q read out a positive patient story from a gentleman who had recently attended the Trust and was very complimentary about the care he had received, as well as describing other aspects of his experience including the food and ward environment.

It was agreed to share the story with the relevant members of staff and to formally thank the patient for taking the time to share their experience.

Resolved: that, the patient story be noted.

BoD/4529 Minutes of the meeting held on, Thursday, 29 April 2021

Resolved: that, the minutes of the meeting held on Thursday, 29 April 2021 be confirmed as an accurate record.

BoD/4530 Matters Arising / Action Log

a. BoD/4461 NHS Regulation Bill – White Paper: Integration and Innovation – Working together to improve health and social care for all

Joint sessions to be scheduled with the Board and Council of Governors of both Trusts to look at how the ICS would function in the future in light of the recently published White Paper. This was being progressed; however, the date of 1 July remained tentative. It was hoped that there would be senior representation from the ICS at the sessions.

Resolved: that, the update be noted.

BoD/4531 Report of the Chairman

The Chairman placed on record his thanks on behalf of the Board to the CE and all staff for their continued effort in caring for patients in the recovery phase from the pandemic. Although reductions in cases continued during May in most areas, thoughts were also with those dealing with the emerging variants that were causing a spike in cases in affected areas.

Work was continuing to resume services to pre-COVID-19 levels working in partnership across the region to reduce waiting lists. The case for further investment in the Tees Valley and North Yorkshire to address the needs of the population and address the health inequalities continued to be made.

The Joint Strategic Board held its second meeting on 18 May, which was attended by the ICS Medical Director and the Chief Officer of the Tees Valley Clinical Commissioning Group and focused on the Clinical Services Strategy for the Tees Valley and North Yorkshire. An event was scheduled for July facilitated by Cap Gemini to further discuss the Clinical Services Strategy and would be attended by the various workstream leads.

In respect to the recruitment process for a substantive Joint Chair, the closing date for applications was 24 May and interviews were planned for 30 June. The Nominations Committee with representatives from both North Tees and South Tees trusts were supporting the process. A second Board to Board meeting took place between the two trusts, with presentations regarding areas of collaboration through the Durham Tees Valley Research Alliance (DVRA) and the importance of working together to address health inequalities from Public Health colleagues.

The Chairman was pleased to report he had visited a number of departments and clinical services during May including Medicine and Respiratory, Breast Services, IT & Allied Services, and the Elective Theatres at the University Hospital of Hartlepool. It was noted that a Celebrating Excellence event was taking place the following day on 28 May, showcasing the fantastic work

being done across the Trust. In respect of external meetings, the Chairman, Chief Executive and Vice Chair had met with the Chair of the Health and Wellbeing Board for Hartlepool to discuss population health and wider health services.

The Trust's Council of Governor meeting had taken place on 6 May, and in the spirit of collaboration a number of Governors from South Tees were also in attendance.

At the Board Seminar on 13 May board members were apprised of the future ambitions of North Tees and Hartlepool Solutions LLP, a subsidiary company of the Trust, as well as its achievements operating during the pandemic, progress of testing against the new emergency care metrics, the development of Care Scan +, and the transformational plans to develop integrated sustainable services.

Resolved: that, the information be noted.

BoD/4532 Report of the Chief Executive

The CE reported that the Trust currently only had one positive COVID-19 patient, which was a phenomenal improvement compared to the positon in January when there were over 200 patients accounting for 40% of occupied beds, and the immense pressure the Trust had been under. This was as a result of the continuing vaccination programme, and the public maintaining social distancing measures. The Trust continued to work with system partners to minimise the impact of any future surges.

Progress continued to be made in respect of service recovery across diagnostics, outpatients, elective and community care. The Trust had committed to stretch targets for recovering performance which would support timely access for patients for the local population and the wider Tees Valley with a particular focus on waits over 52 weeks. Both North Tees and South Tees trusts were working with primary care colleagues to streamline clinical pathways and reduce a variation in access to services for patients.

The planning guidance recently published set out a roadmap for recovery of services across the NHS, building on lessons learnt during the pandemic, addressing health inequalities, developing services to support both physical and mental needs of the population and returning services to pre-COVID-19 levels. The Trust had submitted recovery trajectories to address the services with back-logs over and above the minimal requirements included within the Annual Operating Plan, and was also supporting an Accelerator proposal which would further increase activity and provide support to partner organisations in addressing waiting list back-logs.

There was a continued focus on the health and wellbeing of staff with a renewed Health and Wellbeing Strategy being embedded and a wide range of support mechanisms available for staff. The CE had opened the virtual People Week, which provided the opportunity to engage with staff about the People Plan and the People Promise. Other forums were held during the week providing the opportunity for staff to give feedback and make suggestions for future changes. Plans were progressing to develop outside spaces for staff to recharge and relax, in addition to the internal Rainbow Rooms. The Trust's Listening into Action staff engagement tool would be relaunched on 18 June providing a bespoke way to communicate with staff and ensuring cultural engagement. To support this valuable work a number of 'leaders' and 'pack leaders' had been identified. A Faculty of Leadership and Improvement would also be launched to empower future and current leaders to support health and care provision for the populations served.

The Trust had made good progress in contributing to the national vaccination programme, having delivered 150,000 vaccines. The on-site vaccine hub was now closed, however patients were signposted to local facilities. The success of the Durham Tees Valley Research Alliance (DTVRA) regarding the Novavax vaccine trial and the RECOVERY trial was noted. Led by the Palliative Care Team, a new large picture name badge had been developed so that patients would be able to see the faces of those staff caring for them, helping with the restricted view

when wearing a facemask.

The Rainbow Pledge was launched on 13 May with staff being invited to sign up to show support for those staff who identified themselves as LGBTQ+ in the spirit of openness and inclusion within the organisation. Those staff who signed up were given a rainbow badge to wear. On 5 and 12 May it was the International day of Midwives and Nurses respectively, with a range of celebratory activities that were featured in the local media.

The Trust continued to lead a campaign against violence to emergency staff in the line of duty, and worked with colleagues in the fire service, police force and ambulance service to represent emergency services across the whole of the North East and North Cumbria. As part of the campaign hard-hitting videos were published telling individual stories and the impact of the violent incidents.

The NENC ICS continued to be a proactive partner in the development and architecture of the Government's new white paper: Integration and Innovation – working together to improve health and social care for all. There was a focus on how partner organisations could work together to deliver a population health based approach. The CE reported that a Public Health Consultant had been appointed working across the Trust and key stakeholders to focus on tackling health inequalities and the prevention agenda. NHSE/I had prepared proposals for a new approach to NHS system oversight with the proposed approach aligning with the vision set out in the white paper. The Trust as part of the ICS had contributed to the consultation, which closed at midnight on 14 May 2021.

NHS England published the 2021 /22 NHS Operational Planning Guidance in March setting out the priorities for the coming year. Work continued to plan accordingly and monitor progress and delivery. At an ICP level, good progress was being made in the development and delivery of the Clinical Services Strategy to support the managed clinical network approach.

The Tees Valley and North Yorkshire Provider Collaborative was progressing to provide the best services possible for the populations served. A Joint Board to Board meeting had taken place on 10 May, and a Joint Strategic Board meeting on 18 May. The focus of the Joint Strategic Board was to add pace to the development of the Clinical Services Strategy, and a further event was scheduled in July facilitated by Gap Gemini to progress the work further.

The North East and North Cumbria Population and Health Prevention Board met on 13 May with discussions centring around tackling health inequalities in the region. The CE reported that she had been appointed as the Senior Responsible Officer (SRO) for this work.

Since the last meeting a Dr Rebecca Dunn, Consultant Gastroenterologist with a specialist interest in Liver Medicine had been appointed.

The Chairman congratulated the CE on her SRO role, and also thanked Posmyk Boleslaw, Governing Body Chair, Tees Valley CCG for their support.

JE, Chair, Patient Safety and Quality Standards Committee (PS & QS) welcomed the campaign to highlight the instances of violence against emergency staff, and reported that a Violence Strategy was being rolled out by the Trust. It was noted that an internal audit had been commissioned by the PS and QS Committee for early 2022 to review the implementation of the Strategy.

In response to a query from JE regarding the Active Hospital Programme, the CE explained that the Trust were one of only two trusts regionally who had been selected as a pilot site to be part of the programme, which endorsed the benefits of physical activity in patients specifically within a secondary care setting.

Resolved: that, the contents of the report and the pursuance of strategic objectives

amongst the COVID-19 recovery and restoration programme be noted.

BoD/4533 Annual Report and Accounts 2020/21

The DoCA&CoS presented the draft Annual Report and Accounts for 2020/21. Members were reminded that it was a statutory requirement for trusts to produce an annual report and accounts, in a recognised format in line with the NHS Foundation Trust Annual Reporting Manual guidance and the Department of Health and Social Care Group Accounting Manual.

The Annual Report and Accounts 2020/21 had been developed in line with the statutory guidance and would be submitted to NHS Improvement, prior to being laid before parliament. It was noted that revised guidance had been issued during 2019/20 in response to the COVID-19 pandemic and continued for 2020/21 with the aim of reducing the burden on providers. The annual report and final audited accounts were due for submission on 15 June and the Quality Account was due on 30 June, however the Quality Account and Quality Report were not required to be audited this year.

Each year, the Annual Report and Accounts were subject to a robust audit process, which this year was undertaken by Deloitte, the Trust's new external auditor. Following scrutiny by the Auditors, the draft Annual Report and Accounts had been presented to the Trust's Audit Committee on 24 May. The DoF reported that it had been a positive audit process with the new Auditors. It was noted that the date to lay the documents before Parliament had not yet been confirmed, however, once this had occurred they would be formally presented to the Council of Governors at an Annual General Meeting, following which the documents would be publically available.

PC, Chair, Finance and Audit Committees commended the overall performance and financial position of the Trust following an extraordinary year.

Resolved: (i) that, the draft Annual Report and Accounts 2020/21 be noted; and
(ii) that, draft Annual Report and Accounts had been audited by Deloitte; and
(iii) that, the final Annual Report and Accounts 2020/21 would be submitted to NHS Improvement in line with guidance, and would be laid before parliament.

BoD/4534 Integrated Compliance and Performance Report

The DoP&P presented the Integrated Compliance and Performance Report, which outlined compliance against key access standards included in the Single Oversight Framework and the Foundation Trust Terms of Licence for April 2021. Trend analysis was provided against key compliance indicators, operational efficiency and productivity, quality, workforce and finance.

The overall position for the majority of key standards, including RTT, cancer and diagnostics remained largely comparable to national and regional positions. Focus continued on reducing the overall waiting list position in line with the published Annual Operating Plan requirements, which set out a roadmap for recovery of NHS Services.

The final RTT position for April was 85.2%, which continued to demonstrate recovery with a focus on waiting list reduction. Reducing the number of patients waiting 52 weeks was also a key focus and the validated position for April was 130, a reduction of 46% from the March position. This represented less than 1% of the overall waiting list. A reduction in the backlog was continuing to be supported by additional weekend sessions and the utilisation of Independent Sector facilities.

Pressures continued to impact on delivery of the cancer standards, with the Trust achieving three out of the eight standards in March, the latest validated position. It remained a key priority to reduce the 62-day standards and the 62-day referral to treatment standard reported an improved

position at 78.1%. The regional average was reported at 77.5%.

The diagnostic pathways continued to maintain good recovery against planned trajectories, however there were some capacity issues in April, which saw a slight increase in the number of patients waiting over 6 weeks.

The Efficiency and Productivity standards were all reporting an improved position with the exception of readmission rates. Readmission audits to understand avoidable and unavoidable admissions had re-commenced, following a pause during COVID-19, and the findings would be monitored by the Planning, Performance and Compliance Committee (PPC).

Although a downward trend was reported for Electric Discharge Summaries the issues were being addressed and were largely due to the move from paper based clinical notes to electronic 'Active Clinical' notes. It was noted that the Theatre metrics were under review and therefore would be removed from board reports until the work was complete.

In respect of the Safety and Quality metrics, HSMR was reporting at 97.78, which was an improvement on the previous position. Both the HSMR and SHMI were reporting within the as expected range, however, SHMI had seen a slight increase to 100.88 since the last position. A positive position was reported overall for the Dementia and Pressure Ulcer standards.

It was noted that communication remained the highest reported issue for complaints. A new communication plan had been introduced incorporating virtual visiting, regular telephone updates for relatives, and a property and letter drop service, which was helping to reduce the number of concerns in this area. The Trust was reviewing options to allow some on-site visiting in a safe and secure way and would be piloted in the coming months. This was separate to the current visiting arrangements for those patients at end of life and those with dementia.

The VTE compliance rate reported slightly below the 95% standard at 94.89%. A trust wide quality improvement programme was in place to improve compliance and processes.

A positive position was reported for the three Friends and Family Test (FFT) metrics for April with all being above the 75% standard. Work continued to promote the FFT particularly from inpatient areas. Nursing fill rate levels were indicative of the workforce pressures being faced, with three out of the four metrics reporting below the standard, however, it was noted that safe staffing levels had been maintained at all times. Successful recruitment drives and a reduction in COVID-19 sickness absence saw the Trust's nursing resource position improve during March.

The Chairman sought to understand the challenges around achieving the 62-day referral to treatment standard, which had been highlighted as a risk in the Trust's Annual Self Certifications as part of the Annual Operating Plan 2021/22. The DoP&P explained that although the number of patients being treated had remained relatively stable, the continuous impact of patient choice remained, as well as dealing with backlogs due to COVID-19, complex pathways, and system pressures beyond the control of the Trust could affect consistent delivery of the standard.

In respect of the theatre metrics currently being removed from reporting, the DoP&P explained that this was due to a requirement for more IPC measures to be incorporated into the flow of patients, therefore, the stretch targets were being assessed through the Perioperative Steering Group. The new metrics would be reported from July 2021.

The DoP&P reported that the Diabetic Retinopathy Screening reduction in capacity was due to all screening services paused during the first wave of COVID-19 in line with national guidance. The national focus was now on recovery and work was on-going to address the backlog of invites.

Following a query by RT, Non-Executive Director and Chair, Workforce Committee regarding patient delays on the 62-day referral to treatment pathway, the DoP&P provided assurance that every patient on the pathway was tracked real time so any issues could be flagged quickly. In

the event a patient were to breach the 62 day standard then a full root cause analysis was undertaken to ensure there were no themes.

JE, Chair, PS & QS Committee sought to understand whether the Trust was prepared for the expected surge of cancer referrals and were able to support primary care colleagues following the easing of lockdown restrictions. The DoP&P explained that support was being provided across the Integrated Care Partnership (ICP) as well as making the best use of resources to release capacity, such as virtual consultations with patients.

The sickness absence rate for March (latest validated position) was 4.94%, which was a decrease of 0.65% compared to the previous month. The cost of sickness absence was reported at £481,553, which was an increase of £33,274 compared to the February position. It was noted that there were 30 further cases of COVID-19 related staff absence during April. The Health and Wellbeing of staff remained a focus with a wide range of support mechanisms in place. A dedicated health and wellbeing newsletter was issued to staff on a monthly basis.

Appraisal compliance remained unchanged at 81.32% from the previous month and mandatory training compliance had increased by 1% to 87.76%. Managers encouraged staff to complete any outstanding training. The Trust's volunteers continued to return to the Trust and at the end of April, there were 146 active and 34 applications in progress. A new pilot was being launched for an end of life companion role to be able to provide support for patients and their families. Training was due to commence in May. Volunteers were active in the Orthopaedic Outpatient Department to assist with the reintroduction of appointment screens and to help with the flow of patients. The Home But Not Alone project would recommence on 1 June 2021. A number of celebrations were planned to mark National Volunteers Week which was 1 – 7 June.

The Trust had agreed a £3m surplus for the first half of 2021/22, which was being called 'H1'. At Month 1, the Trust reported a surplus of £961K, which was £461K ahead of plan. The Group's income position was £28.45m, and the block contract element for H1 largely mirrored the payments received in H2 of 2020/21, including the non-recurrent system funding and COVID-19 top-up funding. The cash position at Month 1 was 54.6m. The pre-commitment capital spend was reported at £0.6m, against a year to date plan of £0.2m.

SH, Vice Chair commended the report and the success of the committee structures to provide scrutiny and challenge. SH also provided positive feedback he had received from staff as to their keenness to assist with the programme of recovery. The Chairman added that he had also been in receipt of positive feedback from staff, and highlighted the important part staff play in the success of the Trust. KR, Chair of the PPC and Transformation Committees invited the CPO to give members an update on the various support mechanisms being offered to staff. The CPO reported that the Trust had been successful in obtaining some funding to provide psychological support for staff, as part of the staff survey action plan. The Trust's Listening into Action communication tool was being re-launched and 100 'pack leaders' had been recruited.

Resolved:
(i) that, the Trust's performance against the key operational, quality and workforce standards, delivered against the backdrop of associated pressures of the COVID-19 pandemic be noted; and
(ii) that, the ongoing operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that was being undertaken to address these going forward be acknowledged; and
(iii) that, the positive financial position be noted; and
(iv) that, the pending measures associated to the Annual Operating Plan be noted.

BoD/4535 Guardian of Safe Working Hours Report

The MD presented the Guardian of Safe Working Hours Report for the period December 2020 to March 2021. The COVID-19 pandemic continued to impact the working lives of the Doctors in

Training (DiTs) at the Trust, and as part of the support being provided the doctors' forums had been increased to bi-monthly, which enabled feedback to be obtained and also to address or escalate any concerns raised.

It was noted that initially during Wave 1 of COVID-19 there was a reduction in exception reports, however, subsequently reporting levels had returned to pre-pandemic levels and compared to the regional position, the Trust still had relatively low numbers of exception reports with 10 reports from 7 doctors over the reporting period.

Exception reports were the mechanism used to highlight non-compliance with safe working hours, lack of support and missed educational opportunities. Flexible and remote working options had increased including virtual teaching sessions being offered to allow trainees to continue learning. Rest rooms and re-charge hubs had also been developed as a result of the pandemic to ensure the welfare of the trainees. The Trust was relaunching its Listening into Action app, which allowed the staff the opportunity to provide feedback or raise any concerns.

There were no major concerns relating to safe working hours reported and no significant exceptions resulting in new fines. Where concerns had been raised work was on-going to ensure they were addressed.

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

BoD/4536 Annual Operating Plan 2021/22 and Annual Self Certifications

The DoP&P presented the Trust's final Annual Operating Plan for 2021/22 and the Annual Self-Certifications, which were required in support of a number of compliance requirements.

The planning requirements for 2021/22 included supporting the health and wellbeing of staff and taking action on recruitment and retention; delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19. In addition, building on lessons learnt during the pandemic to transform the delivery of services, accelerating the restoration of elective and cancer care and managing the increasing demand on mental health services; expanding primary care capacity to improve access, local health outcomes and address health inequalities; transforming community services and urgent and emergency care to prevent inappropriate attendance at emergency departments, improving timely admission to hospital for ED patients and reducing length of stay; working collaboratively across systems to deliver on these priorities.

An overview of each of the declarations was provided and it was noted that due consideration has been given based upon performance in 2020/21, the forecast pressures for 2021/22 and the mitigating actions put in place to improve the position in 2020/21. The key risks to delivery were highlighted which included consistent delivery of the 62 day cancer referral to treatment standard; and the continued impact of COVID-19 on the delivery of elective and non-elective pathways.

Compliance against all the declarations was confirmed and delegated responsibility was given to the Chairman and Chief Executive to sign the statements of self-certification on behalf of the Board.

Resolved: (i) that, due diligence had been paid by the Board of Directors in assessing on-going compliance with governance requirements, specifically those illustrated in regular seminars and committee discussion, in line with the NHS Provider Licence Conditions; and
(ii) that, the Board of Directors delegate responsibility to the Chairman and Chief Executive to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board; and
(iii) that, the final Operating Plan 2021/22 which will be submitted to form part of the ICP Plan and the overarching ICS Annual Operating Plan be

noted.

BoD/4537 NHS Resolution Clinical Negligence Scheme for Trusts (CNST)

The DCN/DDoPS&Q presented the outcome of the Trust's self-assessment from the NHS Resolution's Maternity Incentive Scheme - Year 3. The Trust was compliant with seven of the ten requirements and work was on-going to achieve the three remaining actions, however, partial compliance was not formally acknowledged.

It was noted that the scheme required trusts to pay an additional 10% premium on top of the CNST payment, however once trusts demonstrated they were compliant with all ten actions they were eligible to have the additional contribution reimbursed, as well as receiving a share of any unallocated funds. No partial repayment was available for only partial achievement of the ten actions; however, trusts not achieving the full ten actions could be eligible for a small discretionary payment to help them make progress against the actions not achieved. This would be a much smaller sum than the additional 10% premium.

Although three of the actions remained outstanding, the DCN/DDoPS&Q confirmed that the Trust's maternity services were safe and requested delegated authority be granted to the CE to sign the declaration on behalf of the Board to confirm that the evidence provided demonstrated compliance against seven of the ten maternity safety actions.

The DCN/DDoPS&Q explained that AB had been appointed as the Non-Executive Director Maternity Champion and would meet with the Trust's Maternity and Neonatal Safety Champions on a bi monthly basis, in addition to regularly meeting with the Head of Midwifery. Monthly walkarounds had been scheduled for AB in clinical areas to enable direct communication with staff and patients.

SH, Vice Chair highlighted the Trust's openness and transparency to learn from incidents such as the Ockendon Report with gap analysis being undertaken. In addition, any maternity based issues were raised at the weekly Safety Panel meetings. The CE further added that the Trust were often cited as being open and transparent by NHSE/I in respect of incidents and investigations.

RT, Non-Executive Director and Chair, Workforce Committee suggested that regular updates regarding the Trust's maternity services be given to Governors, and perhaps it could be in the form of a marketplace style event to showcase the great work being done. The Chairman agreed this was a good idea to be taken forward.

AB reported that as the newly appointed Maternity Champion it was important to raise the profile of maternity services and being able to listen to mothers and fathers about the services the Trust provided.

Resolved:
(i) that, CE be given delegated authority to sign the declaration on behalf of the Board to confirm the Trust's compliance in seven out of the ten maternity safety actions of the NHS Resolution's Maternity Incentive Scheme – Year 3; and
(ii) that, the content of the declaration be shared with Commissioners and be submitted to NHS Resolution by 15 July 2021; and
(iii) that, a market place event be considered to showcase the great work being done within Maternity Services.

BoD/4538 Annual Report of the Vulnerability Unit, Safeguarding Adults, Children and Young People 2020/21

The DCN/DDoPS&Q presented the Annual Report of the Vulnerability Unit, Safeguarding Adults, Children and Young People for 2020/21 highlighting key achievements. Despite the COVID-19

pandemic, safeguarding training had continued and staff were not deployed to other areas. A renewed focus has been placed on domestic abuse, which now had a separate category on the adult safeguarding data base. Following the involvement of the Trust in a domestic homicide review a poster had been created and placed in clinical areas using the 'Think Family Approach' to raise awareness and provide signposting for help. The Trust had been recognised nationally for its multi-disciplinary approach when contributing to external safeguarding adult reviews.

It was noted that there had been a rise in the number of concerns raised against the Trust, however, this was in line with the number of safeguarding concerns being reported, and was consistent across all of the local authorities.

A new named doctor had been appointed, Dr Shashwat Saran. Dr Saran has set up a National Fabricated or induced illness special interest group (FII SIG), which included over 65 other named and designated doctors from across the UK to discuss complex cases and share learning. A series of E-conferences had also been delivered by the Paediatric Department to provide low cost high quality education to doctors, nurses and partner agencies.

AB, Non-Executive Director commended the annual report and the contribution of the teams involved to present the information in a way that made sense to people. It was a great achievement that safeguarding training had been able to continue during the pandemic. The 'Think Family Approach' was very positive and forward looking as abuse affects people of all ages. The rise in the number of safeguarding concerns being reported could be seen as positive, as it indicated there was an increase in awareness.

RT, Non-Executive Director and Chair, Workforce Committee concurred that an increase in reporting was positive, as it was good that issues were being raised and not kept hidden. RT further enquired whether it would be possible to review the NCPOD report into patient outcomes and deaths, specifically related to young people and to share the information with mental health colleagues as it was known that COVID-19 had impacted on young people as well as adults, which was agreed.

The Chairman expressed that young people had suffered in so many ways during the pandemic and would require compassionate care over the next 12 months. It was good to see that photos of the team members were included in the report and placed on record thanks to those staff.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a review of the NCPOD report specifically related to young people, and the outcome to be shared with mental health colleagues.

BoD/4539 Director of Infection Prevention and Control Report 2020/21

The DCN/DDoPS&Q presented the Director of Infection Prevention and Control Report for 2020/21 and highlighted key points.

The last 12 months had been a time of unprecedented challenge, and the support of Infection Prevention Control teams had been crucial. New ways of working were created to keep patients and staff safe in very difficult circumstances. It was noted that the majority of infections that formed part of the mandatory surveillance programme either remained low or had seen improvement from the previous year. This could be attributed to the heightened awareness of hand hygiene, environmental cleanliness and the correct use of personal protective equipment (PPE). It was acknowledged that staff had been required to work collaboratively and imaginatively to overcome difficulties and adapt to new guidance.

There had been a reduction in the number of Clostridium difficile infection (CDiff) for the second year running; however, unfortunately the Trust had reported its first case of MRSA in 34 months, which was disappointing. During 2020/21, there had been fewer patients than in previous years

admitted with flu, although the focus had continued to vaccinate as many staff as possible, with 85% staff vaccinated.

During 2020/21 monthly self-audits of hand hygiene for clinical staff were introduced, with quarterly assurance audits being undertaken by the IPC Team. Although not all areas were able to complete the monthly audits due to the pressures of COVID-19, the overall compliance target of 95% had been achieved each month.

During the pandemic guidance changed very rapidly and working groups were developed both within the Trust and with local authority colleagues to ensure that clinical decision in relation to any new guidance was understood and implemented as appropriate and as timely as possible. The IPC Team were also involved in the training of staff around the usage of PPE as well as assisting with a comprehensive screening service for staff. In April 2020, PPE Safety Officers were introduced across the Trust to be able to ensure new guidance and recommendations were embedded quickly. Teams were often required to be creative with solutions having to adapt with an ageing estate. The IPC Team increased their working hours to provide a seven-day service for 7 months during the year in order to fully support frontline staff.

Enhanced care continued to be provided to care homes during the first wave of the pandemic. During the second wave the Trust saw a significant increase in the amount of nosocomial infections, which was when patients became infected having been in hospital for 8 days or more. Practices were then reviewed and adapted to maintain the safety of patients and staff. Through these additional measures, the Trust continued to report low hospital onset cases of COVID-19. Outbreak management of the COVID-19 virus was also undertaken by the IPC Team and by collaborating with the regional IPC teams vital learning was shared. There had been no COVID-19 outbreaks in the Trust since April 2021.

JE, Non-Executive Director and Chair, PS & QS Committee commended the work of the IPC team and enquired whether the enhanced support provided to community colleagues and care homes would continue. The DCN/DDoPS&Q confirmed that the work would continue as it was vital to work together for the benefit of the population.

KR, Non-Executive Director and Chair of PPC and Transformation Committees reported that a tool was being developed to support care homes in identifying COVID-19, and was part of working together for the benefit of the communities served.

The Chairman commended the work being undertaken and requested to visit them personally to be able to thank staff.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a visit be arranged for the Chairman to visit the IPC Team.

BoD/4540 Any Other Notified Business

There was no other business reported.

The Chairman invited questions from the observers.

Tony Horrocks, Lead Governor, was complimentary about the Board meeting and on behalf of the Council of Governors thanked the Board for its ongoing commitment to progressing the ICP. It was noted that the Council of Governors and Nominations Committee were involved with the recruitment of the joint chair.

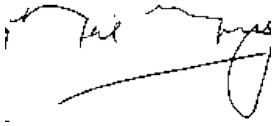
Posmyk Boleslaw, Chair, Tees Valley CCG thanked the Chairman for being invited to attend the meeting, and extended a reciprocal invitation to attend a Board meeting of the CCG. Posmyk also highlighted that it was important for the CCG to understand the work of trust staff during the pandemic and the requirement to operate differently.

The Chairman accepted the invitation to attend the Tees Valley CCG board meeting, and thanked Posmyk for the ongoing support afforded by the CCG during his tenure.

BoD/4541 Date and Time of Next Meeting

Resolved: that, the next meeting be held on Thursday, 29 July 2021 in the Boardroom at the University Hospital of North Tees

The meeting closed at 2.50pm.

Signed:  Date: 29 July 2021

Board of Directors

North Tees and Hartlepool NHS Foundation Trust

Title of report:	Chairman's Report										
Date:	27 May 2021										
Prepared by:	Neil Mundy, Interim Joint Chairman										
Executive Sponsor:	Neil Mundy, Interim Joint Chairman										
Purpose of the report	This purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss		Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing 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:

Introduction

In introducing my report, I offer on behalf of my Non-Executive colleagues and myself our grateful thanks to Julie and the teams within the Trust for their remarkable efforts on behalf of our patients in the recovery stage from the pandemic. We have seen during May a continued reduction in cases, but we, as in other areas, are mindful of the risks linked to COVID-19 variants which are affecting some areas so seriously.

Working with our partners within an Integrated Care System

You will hear in the reports later in the meeting the strong progress being made to return to the levels of services pre-COVID-19 and how waiting lists are being reduced which is the priority of our Trust and other Trusts in the region. The Integrated Care System (ICS) in the North East and North Cumbria is working collectively with the support of additional funding to address those pressures.

We have worked with our partners in the Tees Valley and North Yorkshire to present our compelling case for future funding to be administered by the ICS that fully takes account of the needs of our area and the health inequalities that are present within our population. This situation has been accentuated by COVID-19 and I am able to say that this priority for pressing resources is being recognised and the Trust and its partners are actively working together to secure a satisfactory outcome.

Developing our partnership and joint working

Our Joint Strategy Board held its second meeting on 18 May at which we were joined by the Medical Director of the ICS and the Chief Executive of our Commissioners which enabled us to hold a broad based discussion on taking forward a Clinical Strategy for the Tees Valley and North Yorkshire which as I mentioned earlier, will enable us to attract more resources to our area. Discussions will continue in July within the broader partnership within the Health and Care System to agree the way forward.

Regarding the recruitment and appointment of the substantive Joint Chair for North Tees and Hartlepool and South Tees Hospital NHS Foundation Trusts, the recruitment process is well underway with the closing date for applications 24 May. The Nominations Committee of both Trusts are working closely together to take this process forward. The Governors have appointed the independent recruitment consultants to support the process and have coproduced the

recruitment pack which has resulted in strong interest for this important role. Shortlisting and stakeholder engagement will be carried out during June with the aim of interviews at the end of June with the aim of appointing a substantive Joint Chair by July.

A second joint Board to Board Meeting was held in May to enable members to join together to discuss areas of current collaboration and mutual priority. The Team from the Durham and Tees Valley Research Alliance which undertakes outstanding joint research projects and clinical testing, presented to the meeting. The Alliance Team has been prominent during the Pandemic in supporting the national programme to tackle COVID-19. We also received a powerful presentation on Health Inequalities from Public Health Consultants on the priorities for addressing health inequalities and the importance of working together with our Local Authority, Voluntary Sector and other partners urgently to support our communities .

Visiting and thanking staff
May for me has been another very rewarding month which provided the opportunity to visit a number of departments in the Trust including Medicine and Respiratory, Breast Services, our IT and Allied Services and the Elective Operating Theatres in Hartlepool. It was a great privilege to meet those dedicated staff and to thank them on behalf of us all. The services at Hartlepool in elective care are so impressive and present further opportunities for the Trust.

External meetings
I was delighted to join the Chief Executive and Vice Chair in meeting with the Chair of the Health and Wellbeing Board for Hartlepool and the opportunity to share thoughts on the future of Health Care and Population Health in Hartlepool and the wider Tees Valley and North Yorkshire.

Council of Governors Meeting
The Council of Governors met on the 6 May with a busy agenda covering the various aspects of the Trust's performance both clinical and financial. It was a very constructive meeting at which Governors participated strongly and I was delighted that we were joined by a number of Governors from South Tees Hospitals NHS FT.

Board Development
The Board was most fortunate to receive presentations at a seminar on 13 May on the future ambitions of NTH Solutions, the Trust's very successful arm's length company which carries out a range of activities for the Trust and other public Sector organisations. We received an important presentation on Urgent and Emergency Care models of care and measurement and on CareScan+ which enabled the tracking of equipment and devices throughout the Trust. The session was concluded with a powerful presentation from the Chief Executive on the transformation of services in integrated care.

Next month
I am looking forward to supporting Governors in the next stage of recruitment and appointment of the substantive Joint Chair and further developing partnership and collaborative relationships with South Tees Hospitals NHS FT and our other partners within the ICP and ICS.

How this report impacts on current risks or highlights new risks:	
Consideration will be given to the information contained within this report as to the potential impact on existing or new risks.	
Committees/groups where this item has been discussed	Items contained in this report will be discussed at Executive Team and other relevant Committees
Recommendation	The Board of Directors is asked to receive and note the content of this report

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Chief Executive Report												
Date:	27 May 2021												
Prepared by:	Julie Gillon, Chief Executive Barbara Bright, Director of Corporate Affairs and Chief of Staff												
Executive Sponsor:	Julie Gillon, Chief Executive												
Purpose of the report	The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.												
Action required:	Approve		Assurance		Discuss	X	Information	X					
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X					
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X			

Executive Summary and the key issues for consideration/ decision:

The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level from the main statutory and regulatory organisations of NHS Improvement, NHS England, Care Quality Commission and the Department of Health and Social Care.

In addition, information is provided on strategic delivery and positioning and operational issues not covere elsewhere on the agenda. Key issues for Information:

- COVID-19 update, annual operating plan, recovery including vaccination roll out
- Research team leading the way in COVID-19 treatment nationally
- Palliative care team badge campaign success
- Listening in Action (LiA) Strategic Relaunch
- NHS People Plan Engagement Week
- Rainbow Pledge
- International day of the Nurse and Midwife
- Trust leads on awareness campaign for violence against emergency workers
- Integrated Care System
- Integrated Care Partnership (ICS/ICP) update including Clinical Services Strategy and NENC Population Health and Prevention Board – 13 May 2021
- NENC Provider Collaborative
- Tees Valley and North Yorkshire Provider Collaborative
- NENC Population Health
- Consultant Appointments

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

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

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 May 2021

Report of the Chief Executive

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Strategic Objective: Putting our Population First

2.1.1 COVID-19 Current Position and Phase 3 Recovery

As at 18 May 2021, the Trust is caring for three COVID-19 positive patients. This is a major indication that the easing of lockdown measures, the rollout of vaccinations and the continued efforts of the public to maintain social distancing measures is having a real impact on the transmission of infections. While this remains a positive position, it is important that the organisation continues to follow Infection Prevention and Control guidance to ensure a Covid secure working environment for staff, including regular reviews of personal risk assessments in line with Government guidance.

In the populations served by the Trust, the rates of infection have now reduced significantly with a corresponding reduced impact across community and hospital services.

The focus of the organisation continues to be on the recovery of normal service provision across diagnostics, outpatient, elective and community care. The Trust has committed to stretch targets for recovering performance, which will support both timely access to services for our communities as well as providing support to the wider Tees Valley. In particular, the Trust is working closely with colleagues at South Tees Hospitals NHS Foundation Trust to review the support that can be provided to address elective waiting list pressures, with a particular focus on over 52 week waits. Both Trusts are working with colleagues in Primary Care to streamline clinical pathways with the aim of reducing variation in access to services. This work supports both the Tees Valley Clinical Services Strategy and the Tees Valley and North Yorkshire Provider Collaborative ambition.

The planning guidance sets out the roadmap for recovery of NHS services, building on lessons learnt during the pandemic, addressing health inequalities, developing services that support both the physical and mental health of the population and returning services to pre-Covid levels.

The Trust has submitted recovery trajectories for addressing activity backlogs in elective care, emergency activity, diagnostics and outpatient activity, over and above the minimal requirements contained within the Annual Operating Planning guidance. In addition, the Trust has supported an Accelerator proposal to further increase activity and provide support to partner organisations in addressing waiting list backlogs. The accelerator proposal specifically identifies actions intended to:

- Reduce unwarranted variation in patient care and productivity of diagnostics, treatments and follow-ups.
- Deliver increased productivity in collaboration with the GIRFT clinical team and ICS clinicians.
- Focused/increased capacity in priority pathways within and across teams and sites.
- Re-engineer demand and supply across sites to achieve the same clinical outcome in a less resource intensive way.
- Harness strong clinical engagement; focus on innovation; implementation of new models of delivery.

The rolling seven-day positive incidence of COVID-19 per 100,000 population continues to stabilise, resulting in a reduction of hospital admissions.

The culmative position/impact on the Trust is included below in Table 1:

Table 1: Culmative COVID position

Total COVID-19 Admissions	2,760
Total Admissions Base Wards	2,573
Total Admissions ITU	187
Number of Discharges	2,231
% Discharged	80.83%
Number of Deaths Positive COVID-19	526
% Deceased	19.06%

Position as at 18 May 2021

2.1.2 Health and Wellbeing

The renewed health and well-being strategy continues to be embedded as a priority in the Trust.

As part of the Trust-wide People Week, a number of virtual engagement sessions were hosted, covering a range of topics including health and wellbeing. During these sessions, participants were able to give feedback on current health and wellbeing support and make suggestions for future provision.

Work has also begun on developing the outside spaces attached to the recharge rooms, identified as the Rainbow Rooms, with the intention of creating fit for purpose areas for staff and volunteers to enjoy in the summer weather.

2.1.3 Vaccination Rates

The Trust has made good progress on COVID vaccinations in the contribution to the national effort to contain the pandemic and support the NHS and Care sector.

Staff vaccination rates are consistent with other providers across Cumbria and the North East. This approach includes some individual support for colleagues who have vaccine hesitancy to assure the organisation that staff have had access to all of the latest and relevant information to help them make an informed choice. Vaccination reports are monitored on a weekly basis by the Executive Team to capture the impact of this approach and identify any additional work to support uptake and the safety of our patients.

In line with other organisations, we have now closed the vaccination hub; staff will be signposted to the primary care networks and mass vaccination sites in line with the national and regional vaccination strategy.

2.1.4 Research Team leading the way in COVID-19 treatment nationally

The mobilisation of clinical and research teams to support the emerging Covid-19 research programme has been exemplary receiving national and regional praise.

2.1.4.1 Recovery Study

The Trust has been selected as a site for MHRA inspection in May in relation to the RECOVERY trial due to high levels of patient recruitment. Dr Prudon recently presented information on the study at the COVID-19 research symposium in collaboration with the National Horizons Centre.

2.1.4.2 Novavax Covid Vaccine Trial

The NOVAVAX COVID vaccination trial has been an immense success. The Trust volunteers have provided invaluable support as "Greeters" at the entrance to UHH; a firm example of multi-disciplinary team working success and the value of volunteers both now and in the future.

2.1.5 Palliative Care Team Badge Campaign Success

Led by John Sheridan, Macmillan lead nurse for end-of-life care – the Trust has launched a new picture badge for patient facing staff to ensure that barriers between staff and patients are broken down whilst PPE remains in place. The team decided to create picture ID badges to ensure the personal touch remains in place despite the infection prevention requirements.

2.2 Strategic Objective: Valuing our People

2.2.1 Listening Into Action – Strategic Re-launch

The Trust will be re-launching the 'Listening into Action' engagement strategy on 18 June 2021. This strategic re-launch will focus on a more bespoke, dedicated ambition to ensure cultural engagement is optimum by utilising key influencers and leaders across the organisation to communicate our vision, and to reflect on success and challenge to date.

2.2.2 NHS People Plan Engagement Week Launch

I had the honour of opening the virtual NHS People Plan engagement week within the Trust that was attended by over 140 members of staff, which provided a great opportunity to engage with staff about the major elements of the People Plan, the People Promise and what these mean to the Trust. I highlighted the need to make the NHS a better place to work, the importance of listening and how staff adapted to the rapid changes brought about by the COVID-19 pandemic.

This was followed by a series of events, on topics that matter to staff. Discussion forums were held on themes such as leadership, health and wellbeing and flexible working with feedback to be used to influence policy and future changes in culture and inclusivity.

2.2.3 Rainbow Pledge

The Trust is committed to being an open, non-judgmental and inclusive place for people that identify as LGBTQ+. LGBTQ+ stands for lesbian, gay, bisexual, transgender, queer and the + simply means that we are inclusive of all identities, regardless of how people define themselves. The Trust has signed up to the Rainbow Badge initiative to promote a message of inclusion, raise awareness of issues and to help improve the experiences of healthcare for LGBTQ+ patients and staff.

On 13 May 2021, staff were invited to make a pledge to be an ally to LGBTQ+ colleagues and patients. All pledgers were offered a specially designed NHS badge with the LGBTQ+ rainbow proudly adorned on it, which when worn is a simple way to show support.

2.2.4 International Day of the Nurse and Midwife

The International day of the Midwife was celebrated on Wednesday 5 May 2021, with the International day of the Nurse being held on Wednesday 12 May 2021. The celebration involved a high-energy engagement campaign with colleagues still in their role as midwife or nurse, and those who had progressed through to new challenges. This was featured in local media, and across the Trust, social media accounts and received well by both the public, and indeed our staff.

2.2.5 Trust leads on Awareness Campaign for Violence against Emergency Workers

As the first bank holiday post the lifting of restrictions arrived in May, the Trust issued a campaign about the ongoing violent attacks emergency staff suffer in the line of duty. Working with colleagues from the fire, police and ambulance service, North Tees and Hartlepool represented the entire

emergency services across the North East and North Cumbria in a number of hard-hitting videos featuring colleagues telling their stories with the theme 'it happened to me'. The videos were featured in local and regional media outlets and opened rich discussion and support to staff.

2.3 Strategic Objective: Transforming our Services

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

2.3.2 Integrated Care System

The Integrated Care System continues to plan the development and transition work in line with the requirements of the White Paper '*Integration and Innovation – working together to improve health and social care for all'*. A programme management team is in place with the objective to explore how the system and structures will best deliver the outcomes required at system and place.

2.3.2 Integrated Care Partnership

Despite the pressures of COVID-19, there has been good progress in the development and delivery of the Clinical Services Strategy, with a third clinical workshop in the process of being developed to support ambitious progress in the Managed Clinical Network approach to sustainability.

2.3.3 North East and North Cumbria Provider Collaborative

An extra-ordinary North East and North Cumbria Provider Collaborative meeting was held in May to discuss the Elective Recovery/Accelerator bid. The programme is ambitious and forward thinking with the Trust contributing proactively to the system approach.

2.3.4 Tees Valley and North Yorkshire Provider Collaborative

The Trust continues to progress the development of full ambitions for collaborative arrangements with South Tees Hospitals NHS Foundation Trust to deliver the best benefits for the population of the Tees Valley and North Yorkshire. A Joint Board to Board meeting was held on 10 May 2021, which enabled discussion in respect to population health and health inequalities, specifically on how this is impacting and affecting the population served; and the work of the Durham Tees Valley Research Alliance and how collaboration has benefited the Tees Valley during COVID. In addition, a Joint Strategic Board was held on 18 May 2021 where focus was on the Clinical Strategy, the ambition and vision that is collectively shared, the progress to date and the plans for future development and delivery.

The recruitment process for the appointment of the substantive Joint Chair was launched on 30 April 2021 with a closing date of 24 May 2021. Hunter Healthcare Resourcing are the partner working with the Trusts to facilitate the recruitment and selection process, working closely with the Nominations Committee and Governors of both organisations to ensure alignment with constitutional requirements. The Board of Directors and Council of Governors will be involved in the selection process, with the Council of Governors holding ultimate responsibility for the appointment of the Joint Chair.

2.3.4.1 North East and North Cumbria Population Health and Prevention Board – 13 May 2021

Discussion at the NENC Population Health and Prevention Board centred around the approach for the North East and North Cumbria to tackle health inequalities. I have been appointed Senior Responsible Officer for this work, which builds on the expectations included in the third phase NHS response to COVID-19. A high-level summary of the NENC ICS digital inclusion plan was discussed along with the challenges to manage digital technology in the direction of tackling health inequalities within the North East and North Cumbria.

2.3.6 Consultant Appointments

Interviews have taken place over the last month for one Consultant position with a successful appointment made as follows:

Dr Rebecca Dunn, Consultant in Gastroenterology with Specialist Interest in Liver Medicine.

3. Recommendation

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

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Annual Report and Accounts 2020/21										
Date:	27 May 2021										
Prepared by:	Neil Atkinson, Director of Finance Barbara Bright, Director of Corporate Affairs and Chief of Staff										
Executive Sponsor:	Barbara Bright, Director of Corporate Affairs and Chief of Staff										
Purpose of the report	It is a statutory requirement for the Trust to produce an annual report and accounts, which is required to be in the format as laid down within the NHS Foundation Trust Annual Reporting Manual 2020/21 (FT ARM). In addition, trusts are also required to follow the Department of Health and Social Care Group Accounting Manual 2020/21 (DHSC GAM 2020/21) for detailed requirements for their accounts. The Trust's Annual Report and Accounts 2020/21 have been developed in preparation for submission to NHS Improvement within agreed timelines, following which they will be laid before Parliament at a date to be confirmed.										
Action required:	Approve	X	Assurance	X	Discuss		Information				
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 document is provided in accordance with the requirements as detailed within the NHS Foundation Trust Annual Reporting Manual 2020/21 (FT ARM) and the guidance issued by NHS Improvement (NHSI) initially in response to the pandemic crisis for 2019/20 and continued for 2020/21 The revised guidance aims to reduce the burden on providers, however, the Trust has prepared all the reports working to the original deadlines.

As previously reported the following changes have been made for this year by NHSI:

- Final Audited accounts will be due on 15 June;
- Annual Report will be due on 15 June;
- Quality Accounts will be subject to the 30 June deadline specified in the regulations;
- Auditor and other assurance work on Quality Accounts and Quality Reports is not required for 2020/21
- Quality Accounts are not required to be included in the Annual Report
- Providers will no longer be required to submit hard copy documents to NHSE/I for annual report and accounts
- The date for submission to Parliament is to be confirmed

The annual report and accounts 2020/21 provides compliance with the guidance and Annual Reporting Manual and consists of: -

- Shortened opening statement from Chair and Chief Executive;
- Overview of the Trust's strategic direction;
- Performance Summary (Headlines only);
- Accountability Report (Table form with summary narrative);
- Staff report (Highlights only);
- Auditors report;
- Foreword to the accounts; and
- 4 Primary financial statements of comprehensive income, financial position, changes in taxpayers' equity and cash flows, and notes to the accounts

The annual report and annual accounts are subject to a full and robust audit process which has been undertaken over the last couple of months. The external auditors Deloitte have worked with key leads in the trust to ensure that all of the information contained within the report and accounts complies fully with requirements of the FT ARM and other guidance.

The external auditors have scrutinised information in the annual report and accounts, and information was presented at the Audit Committee on 24 May 2020.

In respect to the Quality Accounts and Report for 2020/21 there is no requirement for an external audit assurance review, however, they will be subject to 30 June submission date as specified in the regulations. The draft Quality Report/Account was issued to key stakeholders in May 2021 with the Third Party Declarations to be received by June 2021. Stakeholders have been consulted commencing in January 2021 and concluding in March 2021; the stakeholders were requested to review the Quality Accounts document and comment on whether they felt it accurately reflected their understanding of the Trust position in relation to quality. All the key stakeholder 3rd Party Statements are due back into the Trust by early June 2021, to meet the 30 June 2021 deadline.

Once the report has been laid before parliament, it will be presented to the Council of Governors at the Annual General Meeting, following which it will be made publically available.

How this report impacts on current risks or highlights new risks:
The areas within the Annual Report and Accounts are covered within the Board Assurance Framework in respect to quality, safety, performance, finance and leadership, therefore are managed through this process.

Committees/groups where this item has been discussed	Executive Team Audit Committee Board of Directors
Recommendation	The Board of Directors is invited to review the attached document, note the work undertaken to produce this within the timelines, note the scrutiny on compliance by the external auditors, and note submission in line with guidance to NHS Improvement in readiness for submission to Parliament on a date to be confirmed.

North Tees and Hartlepool NHS Foundation Trust
Board of Directors

Title of report:	Integrated Compliance and Performance Report										
Date:	27 May 2021										
Prepared by:	Lindsey Wallace, Head of Planning, Performance and Development										
Executive Sponsor:	Lynne Taylor, Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Alan Sheppard, Chief of Workforce Neil Atkinson, Director of Finance										
Purpose of the report	To provide an overview of the integrated performance for compliance, quality, finance and workforce.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing our People	x	Transforming our Services		Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

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

Key issues

- Covid-19 pressures have eased significantly with only two patients remaining.
- Elective recovery plans fully implemented.
- Focus will remain on reducing the overall waiting list in relation to cancer, RTT and Diagnostics.

Summary

- The pandemic continues to affect delivery against a number of operational standards and overall efficiency and productivity however; performance continues to be monitored closely through the established internal governance structures.
- The operational Planning and Recovery Group is overseeing delivery of the agreed recovery plans, which are currently under review.
- Effective uses of resources remains a priority, with good progress made across a number of operational efficiency indicators.
- The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI, infection control measures and dementia standards.
- Lateral Flow testing continues to be utilised as a rapid testing process for both staff and patients.

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.

Committees/groups where this item has been discussed	Executive Team Meeting Audit and Finance Committee Planning, Performance and Compliance Committee

Recommendation	The Board of Directors is asked to note: • 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 intense mitigation work that is being undertaken to address these going forward. • Pending measures associated to the Annual Operating Plan.

North Tees and Hartlepool NHS Foundation Trust

Integrated *Corporate* Report

May 2021

Responsible Directors

North Tees and Hartlepool NHS Foundation Trust

Lynne Taylor
Director of Planning & Performance

- Single Oversight Framework
- Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

- Safety & Quality

Alan Sheppard
Chief People Officer

- Workforce

Neil Atkinson
Director of Finance

- Finance

Introduction

North Tees and Hartlepool NHS Foundation Trust

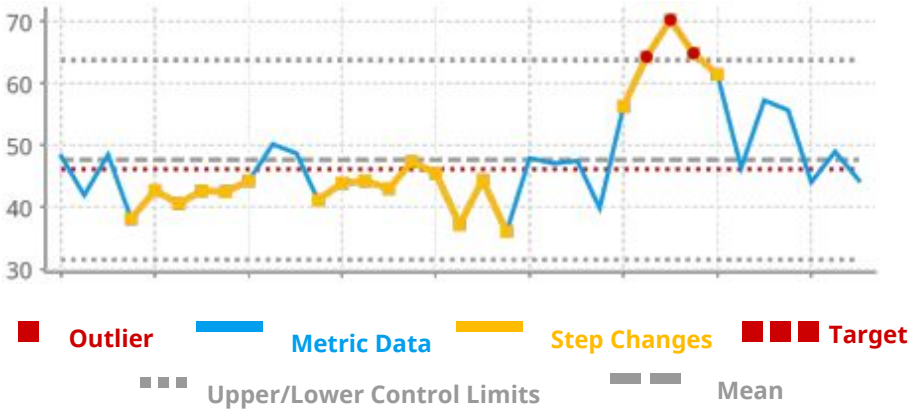
The Integrated Corporate Dashboard and Board report has been reviewed, redesigned and transformed into the Trusts new Business Intelligence tool, 'Yellowfin'. Performance highlights against a range of indicators including the Single Oversight Framework (SOF) and the Foundation Trust terms of licence remains. The report is for the month of April 2021 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

Statistical Process Control (SPC) Charts

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

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

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



Contextual Information

4

North Tees and Hartlepool NHS Foundation Trust

The Trust has seen a significant reduction in the number of patients with COVID, with planning and recovery plans in full implementation and a return to business as usual.

The Trust has continued to deliver the safest, quality and timely services to its population, reviewing and transforming pathways to accommodate the challenges that have arisen.

The Trust continued with its successful rollout of the COVID vaccination plan.

Going forward, the Trust is considering the Annual Operating Plan recommendations, with revised and additional metrics featuring future reports, and similarly, the implications of the System Oversight Framework, which is currently in consultation with a revised framework expected in June 2021.

Executive Summary

SOF and Efficiency & Productivity

Key Messages

The Trust embarked on its recovery journey with robust plans for all routine services fully effective from 22 March 2021, with pre covid levels of capacity resumed. The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position; however with evidence of the impact of the Covid pressures now reflected in the overall position. Whilst some recovery is noted against the standards, the focus has been, and will continue to be on reducing the overall waiting list position in line with the recently published Annual Operating Plan requirements.

Despite these pressures, clinical teams are working hard to maintain business as usual alongside recovery, with strong oversight and management through the Trust's governance structures.

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

Changes to metrics

No standards have been amended in this month's report however future reports will reflect;

- Criteria to Reside to comply with the latest discharge sitrep.
- Emergency Care standards to comply with the Annual Operating Plan.
- 28-day faster diagnosis cancer standard.

Safety & Quality

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

Whilst HSMR has shown a decrease from the rebased previous value of 98.62 to 97.78 (March 2020 to February 2021) it remains within control limits with the same trend evident in the latest SHMI value.

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

Stage 1 Informal complaints have seen an increase in April 2021 from the previous reporting period, whilst Stage 2 - Meeting and Stage 3 Formal Letter have both seen a slight reduction from the previous reported period.

Changes to metrics

The falls metrics have changed from 'Fall No Injury', 'Fall Injury, No Fracture' and 'Fall with Fracture' to the following: Fall No Harm, Fall Low Harm, Fall Moderate Harm, Fall Severe Harm and Fall Resulting in Death. This now meets the National reporting standards

The standard for the metrics that were previously *accumulative* are now set to the *mean* of the previous 2 years.

Executive Summary

Workforce

Following the updated Government guidance relating to shielding, effective 31st March, 150 of our 165 CEV staff have returned to work, 9 continue to work from home, 5 are on long term sick and 1 has left the Trust. The Workforce Department is working with Care Groups to facilitate 1:1's with staff members who have not been vaccinated to date to identify any additional support needed. Lateral flow testing continues, with the coordinated distribution of second kits to frontline staff and promoting the opportunity for all staff to be tested.

The OD Team continue to work collaboratively with Occupational Health, Psychology, Chaplaincy and the wellbeing team to provide a variety of opportunities for staff support. 'Appreciation April' took place during the month, providing a space for reflection, and the covid vaccination programme pushed ahead with the delivery of 2nd doses. Regular updates on support available are provided through the monthly Engagement, Development and Wellbeing newsletter. In April the team focused on stress, providing tools and support mechanisms, with a stand available to encourage staff to remember it's okay to 'have a wobble' occasionally (and take a jelly).

The number of active volunteers has increased to 146 at 30 April 2021, with 34 applications currently in progress. As restrictions ease there has been an increase in numbers of volunteers showing an interest in returning to the Trust; as they re-join they will be placed with an existing volunteer to support transition back into the organisation. Volunteers who have supported the vaccination centre will be re-allocated to alternative roles as activities reduce.

In addition, the service continues to develop and grow in scope as follows:

- training for the end of life support companion role will commence on 17 May 2021, this pilot will enable volunteers to provide support to identified patients in a ward setting, providing presence and a listening ear to the patient and their families.
- volunteers have started to support in the Orthopaedic Outpatient Department to assist with the re-introduction of the appointment screens and to help with the flow of patients through the outpatient area.
- work with the responder and comfort call pilot continues as numbers and usage increase.
- the 'Home but Not Alone' project will restart on 1 June 2021.
- work continues to support the team delivering the Active Hospital pilot and will deploy volunteers where they can best support this initiative.
- National Volunteers' Week will take place 1-7 June. Trust volunteers will be celebrated by various means throughout the week.

Finance

For 2021/22, the Trust has agreed to a financial plan of a £3m surplus for the first half of the financial year (H1).

At month 1, the Trust is reporting an in month and year to date surplus of £0.961m, which is £461k ahead of plan.

Total Group income in Month 1 is £28.45m and the block contract element for H1 2021 /22 largely mirror the payments received in H2 2020/21 including the non-recurrent system and Covid-19 top-up funding.

Pay expenditure totalled £18.855m of which £0.270m is additional spend relating to the Covid-19 response and includes costs associated with Covid-19 testing.

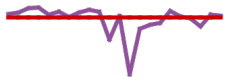
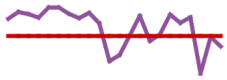
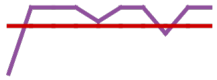
Month 1 non-pay expenditure totalled £7.51m of which £0.191m is additional spend related to the Covid-19 response and includes costs associated with Covid-19 testing.

At Month 1, the Group cash balance is £54.6m and is supported by an improvement in the surplus position and a further increase in income paid in advance in April 2021.

The Trust has spent capital of £0.6m of pre-commitments against a year-to-date plan of £0.2m.

Single Oversight Framework 7

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*2 Year Trend*	
New Cancer Two Week Rule	✓	Mar-21	96.87%	93.00%		
Breast Symptomatic Two Week Rule	✓	Mar-21	93.88%	93.00%		
New Cancer 31 Days	✗	Mar-21	94.53%	96.00%		
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	Mar-21	100.00%	98.00%		
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	Mar-21	87.50%	94.00%		
New Cancer 62 Days	✗	Mar-21	78.10%	85.00%		
New Cancer 62 Days (Screening)	✗	Mar-21	76.47%	90.00%		
New Cancer 62 Days (Consultant Upgrade)	✗	Mar-21	73.33%	85.00%		

Cancer

Pressures continue to impact on delivery of the cancer standards, with some delays to pathways unavoidable. Capacity, patient choice and swabbing requirements continue to affect pathways. The Trust has continued to monitor and manage cancer pathways within the operational management structure, with a focus on the reduction of longer waiters alongside recovery of the waiting times standards.

Despite the increased scrutiny and management the March position indicates a number of the cancer standards were not achieved.

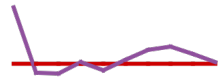
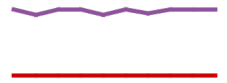
An improvement is noted against the 62-day Referral to Treatment standard compared to the previous month, reporting at 78.10%, with 53.5 out of 68.5 patients treated within the 62 day timescale. Similar performance is evident across the region, with only one Trust achieving the standard. Performance ranged between 65.5% to 89.06% reporting a regional average of 77.5%.

The SPC charts indicates a number of points outside the statistical control ranges in year, reflective of the pressure points of the pandemic. The 62-day standard within SPC is indicating an overall downward trend, resulting in increased internal escalation processes. This is being monitored through robust daily/weekly operational meetings and strategically through dedicated tumour level cancer pathway groups.

The 28-day faster diagnosis standard will be included in the report from June onwards.

Single Oversight Framework 8

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	2 Year Trend
Referral To Treatment Incomplete Pathways Wait (92%)	✗	Mar-21	84.57%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	✓	Mar-21	24.40	28.00	
Incomplete Pathways Wait (Median)	✗	Mar-21	7.40	7.20	
Incomplete Pathways Wait (>52 Week Wait)	✗	Mar-21	241	0	
Diagnostic Waiting Times and Activity	✗	Apr-21	95.06%	99.00%	
Community Information Datset - Referral Information	✓	Mar-21	100.00%	50.00%	
Community Information Dataset- Referral to Treatment Information	✓	Mar-21	98.05%	50.00%	
Community Information Dataset - Treatment Activity Information	✓	Mar-21	100.00%	50.00%	
Community Information Dataset - End of Life	✓	Mar-21	86.49%	50.00%	

Narrative

RTT

The elective recovery plan continues.

April validated RTT position was unavailable at the point of reporting due to technical issues, however the un-validated position indicated circa 84.62% of patients were waiting less than 18 weeks. A verbal update will be presented at Board.

The Trust continues to show recovery against this standard with a focus on waiting list reduction. The most recent national benchmark position (March 2021), indicates the regional average reported at 72%, the national average at 59%. Reducing 52-week waits remains a key focus, with the Trust reporting an unvalidated position of 135. However, in comparison, the region reported circa 17,825 over 52 week waiters (7% of the overall waiting list) at the end of March, with a number of organisations reporting up to 12% of their waiting list waiting over 52 weeks.

A reduction in backlog is being supported through both additional weekend sessions and the utilisation of Independent Sector facilities, available as part of the national recovery programme. Validation and prioritisation of the waiting list continues, based on clinical review.

Diagnostics

The diagnostic pathways continue to maintain good recovery against planned trajectories, however some capacity issues in April which saw a slight increase in the number of patients waiting over 6 weeks. The SPC indicates a positive trend. The longest delays are evident within Endoscopy and MRI.

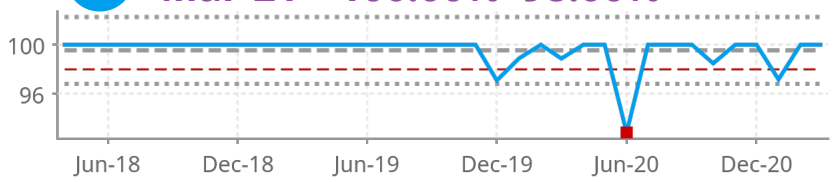
Single Oversight Framework

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

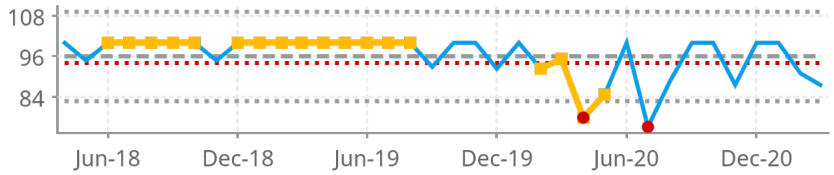
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
Mar-21	100.00%	98.00%



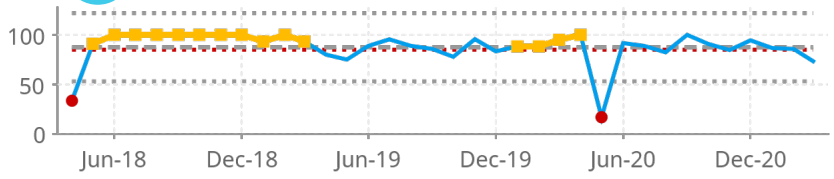
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
Mar-21	87.50%	94.00%



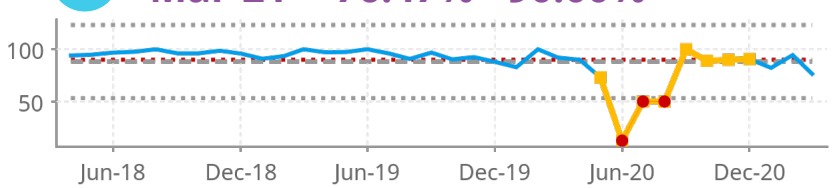
Cancer - 62 Consultant Upgrade

Month	Performance	Standard
Mar-21	73.33%	85.00%



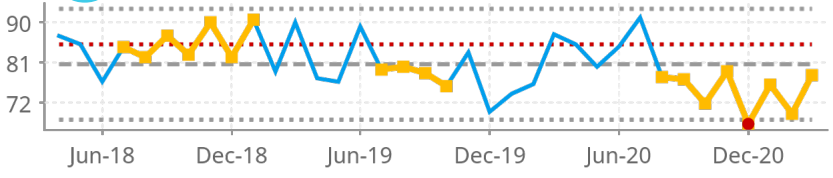
Cancer - 62 Days Screening

Month	Performance	Standard
Mar-21	76.47%	90.00%



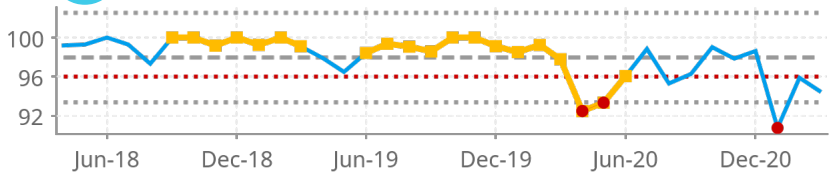
Cancer - 62 Days

Month	Performance	Standard
Mar-21	78.10%	85.00%



Cancer - 31 Days

Month	Performance	Standard
Mar-21	94.53%	96.00%



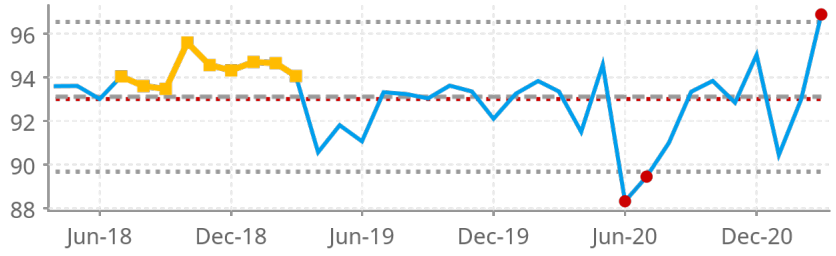
Single Oversight Framework 10

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

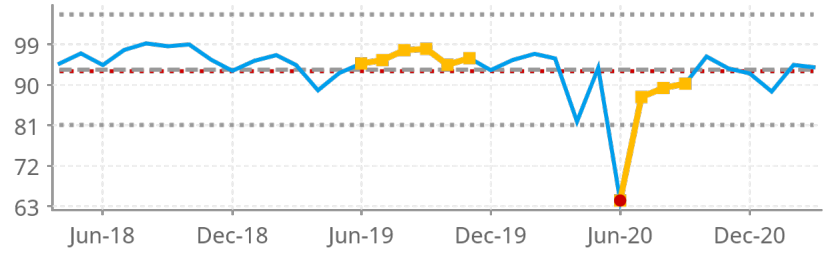
Cancer - 2 Week Rule

Month	Performance	Standard
Mar-21	96.87%	93.00%



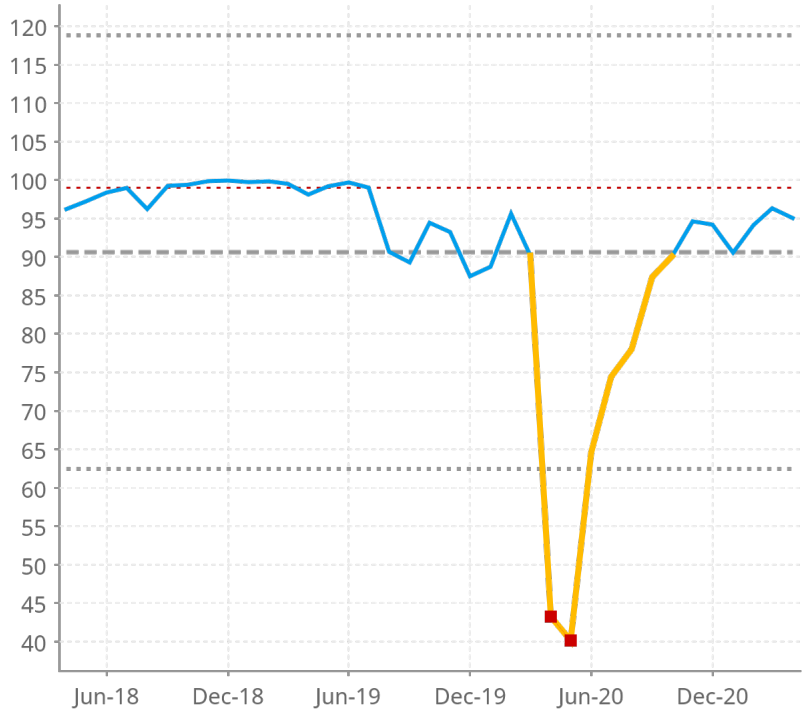
Cancer - Breast Symptomatic

Month	Performance	Standard
Mar-21	93.88%	93.00%



Diagnostic Waiting Times

Month	Performance	Standard
Apr-21	95.06%	99.00%



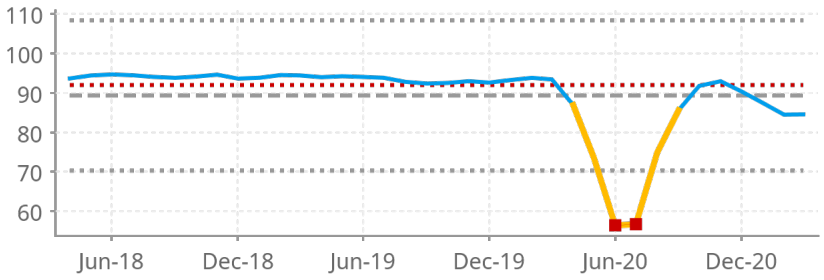
Single Oversight Framework 11

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

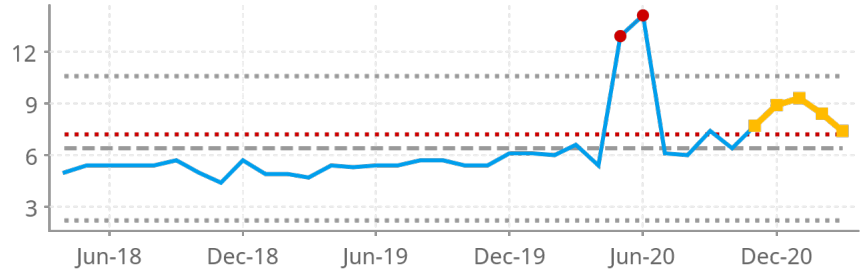
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Mar-21	84.57%	92.00%



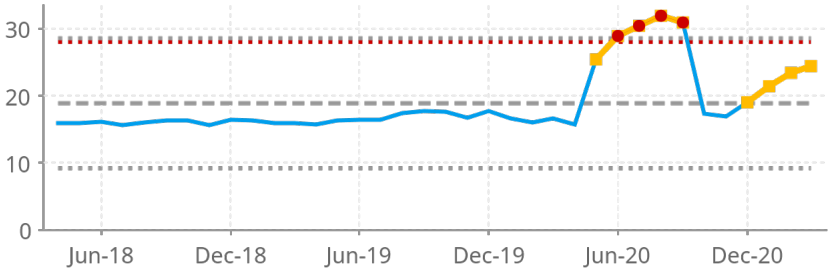
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Mar-21	7.40	7.20



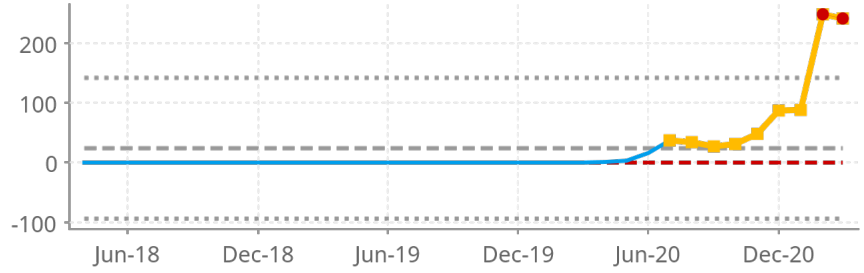
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Mar-21	24.40	28.00



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

Month	Performance	Standard
Mar-21	241	0



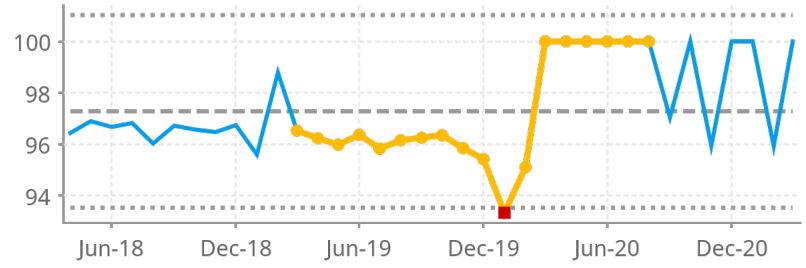
Single Oversight Framework

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

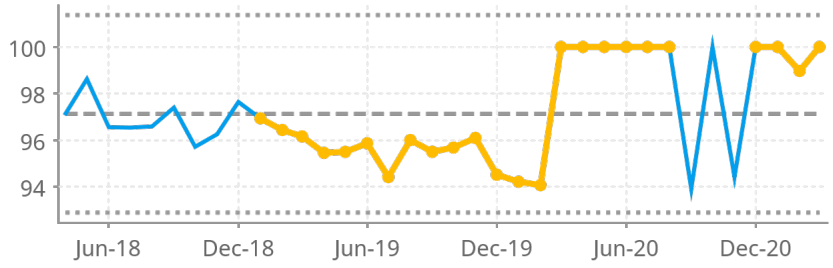
Community Information Dataset - Referral Information

Month	Performance	Standard
Mar-21	100.00%	50.00%



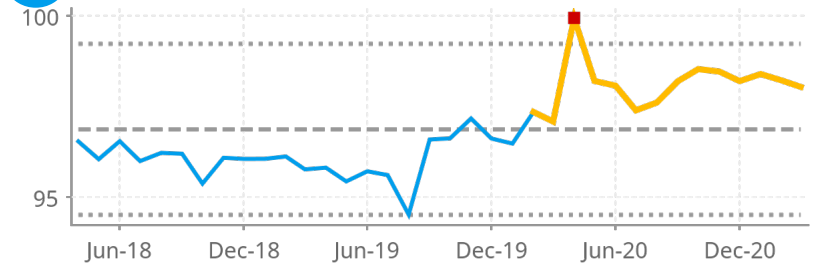
Community Information Dataset - Treatment Activity Information

Month	Performance	Standard
Mar-21	100.00%	50.00%



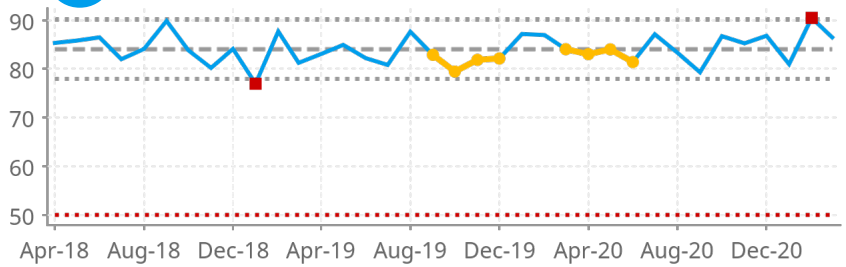
Community Information Dataset - Referral to Treatment Information

Month	Performance	Standard
Mar-21	98.05%	50.00%



Community Information Dataset - End of Life

Month	Performance	Standard
Mar-21	86.49%	50.00%



Efficiency & Productivity

13

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	2 Year Trend
Outpatient Did Not Attend (New)	Apr-21	6.12%	7.20%	
Outpatient Did Not Attend (Review)	Apr-21	6.81%	9.00%	
Average Depth of Coding	Apr-21	7.01	3.01	
Length of Stay - Elective	Apr-21	1.94	3.14	
Length of Stay - Emergency	Apr-21	2.80	3.35	
Day Case Rate	Apr-21	84.23%	75.00%	
Pre-op Stays	Apr-21	1.87%	4.50%	
Trust Occupancy	Apr-21	83.75%	85.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	Feb-21	11.08%	7.70%	

Narrative

Efficiencies

An overall reduction in DNA rates has been evident throughout the year, potentially aligned to the positive impact of virtual appointments.

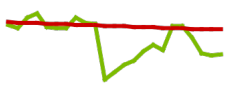
Despite the operational pressures, lengths of stay remain on track across both emergency and elective pathways, with an improved Day Case rate also evident.

Readmissions

Readmission audits had been paused during the pandemic however, these have now been reinstated as part of the Trusts Journey to Excellence (JTE). The Audits are reviewed by the clinical teams, to understand avoidable and unavoidable admissions, with the aim to undertake improvement actions to reduce the risk of readmission. Findings are monitored via the Planning, Performance and Compliance Committee and JTE operational group.

Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Month	Performance	Standard	2 Year Trend
Electronic Discharge Summaries	Apr-21	76.76%	95.00%	
Cesarean -Section Rates	Apr-21	12.36%	15.60%	
Trolley Waits (over 12 hours)	Apr-21	0	0	
Time to Initial Assessment (mean) Type 1 & 3	Apr-21	8.67	15.00	
Number of Ambulance Handovers waiting more than 30 Mins	Apr-21	40	0	
Number of Ambulance Handovers waiting more than 60 Mins	Apr-21	5	0	
Super Stranded	Apr-21	37	61	

Narrative

Ambulance handover - Internal validation of the NEAS reports saw a reduction in the number of handover waits. In comparison, based on NEAS reports, the regional over 30 minute delays reported an average of 125 (range 8-270), with the average over 60 minutes reporting at 8 (range 0–42).

Electronic Discharge Summaries (EDS) -
The recent decline in performance is aligned to recent changes in process, with the move from paper based clinical notes to electronic 'Active Clinical' notes, which is being addressed through a Task and Finish group established in May. Reports and processes are under review with improvements expected in June reports.

Efficiency & Productivity

15

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved	Narrative
Operation Time Utilisation		
Run Time Utilisation		*Under review - To be reported in July 2021*
Cancelled on Day of Operation		
Late Start %		
Early Finishes %		

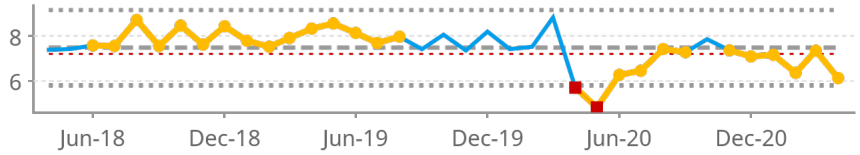
Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

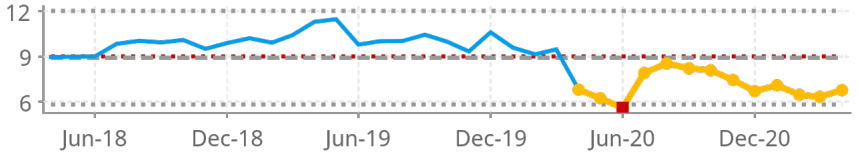
Outpatient Did not Attend (New)

Month	Performance	Standard
Apr-21	6.12%	7.20%



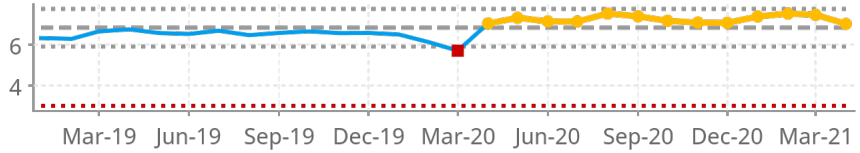
Outpatient Did Not Attend (Review)

Month	Performance	Standard
Apr-21	6.81%	9.00%



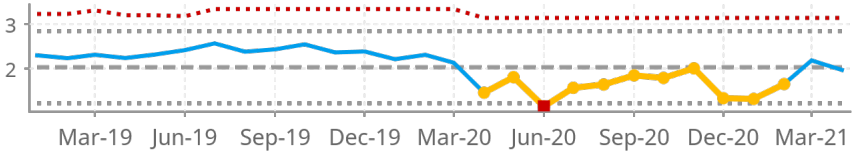
Average Depth of Coding

Month	Performance	Standard
Apr-21	7.01	3.01



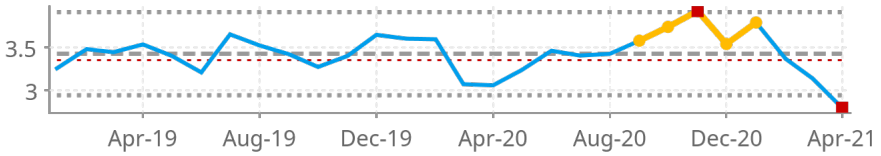
Length of Stay - Elective

Month	Performance	Standard
Apr-21	1.94	3.14



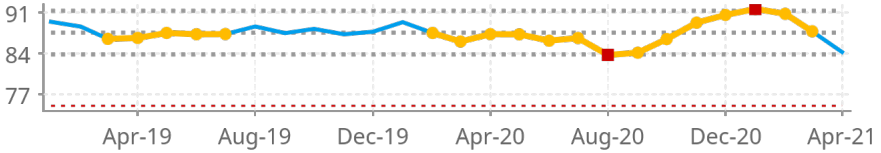
Length of Stay - Emergency

Month	Performance	Standard
Apr-21	2.80	3.35



Day Case Rate

Month	Performance	Standard
Apr-21	84.23%	75.00%



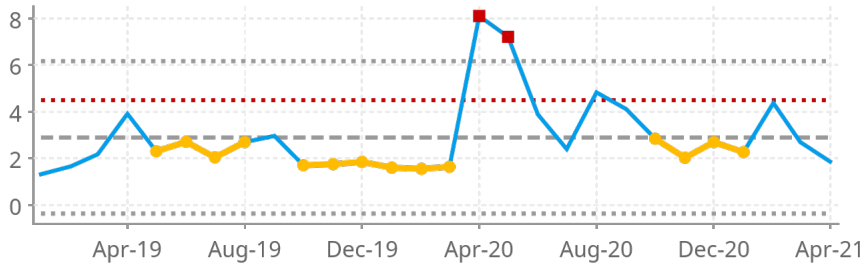
Efficiciency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

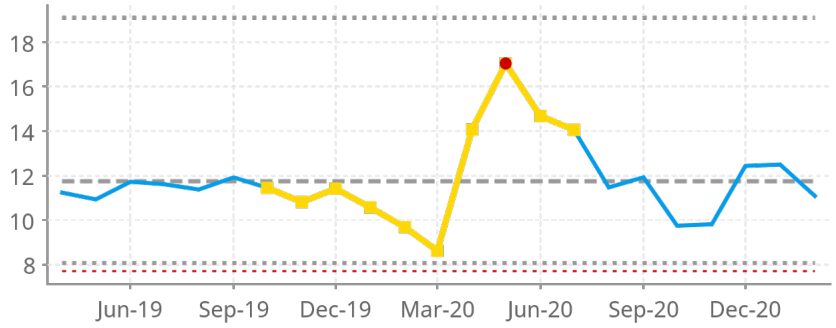
Pre-op Stays

Month	Performance	Standard
Apr-21	1.87%	4.50%



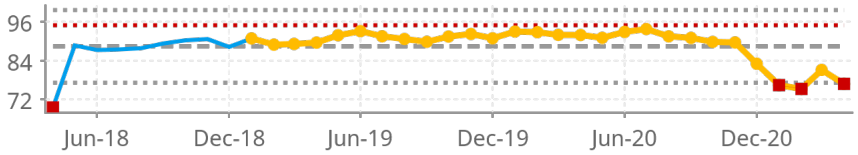
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Feb-21	11.08%	7.70%



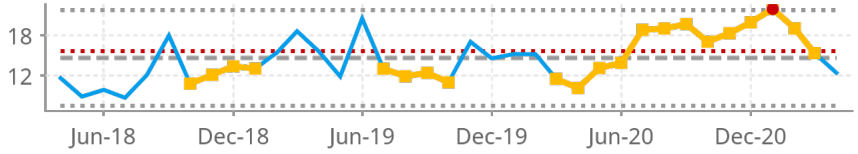
Electronic Discharge Summaries

Month	Performance	Standard
Apr-21	76.76%	95.00%



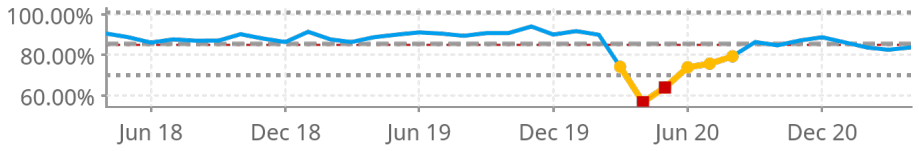
Cesarean-Section Rates

Month	Performance	Standard
Apr-21	12.36%	15.60%



Trust Occupancy

Month	Performance	Standard
Apr-21	83.75%	85.00%



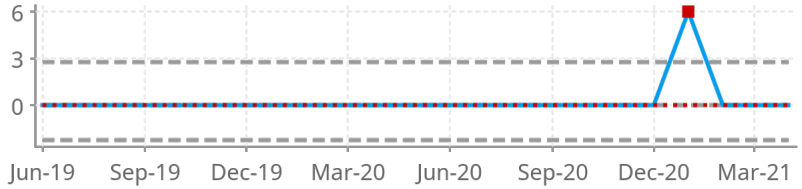
Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

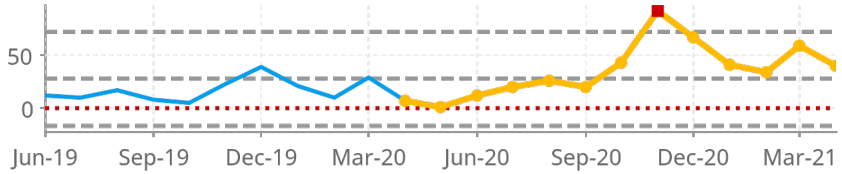
Trolley Waits over 12 hours

Month	Performance	Standard
Apr-21	0	0



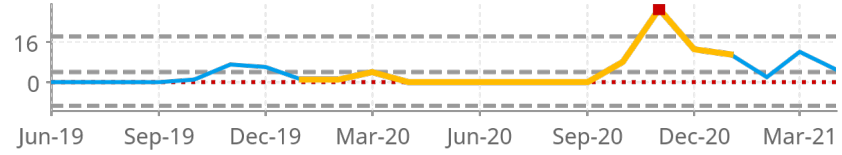
Number of Ambulance Handovers waiting more than

Month	Performance	Standard
Apr-21	40	0



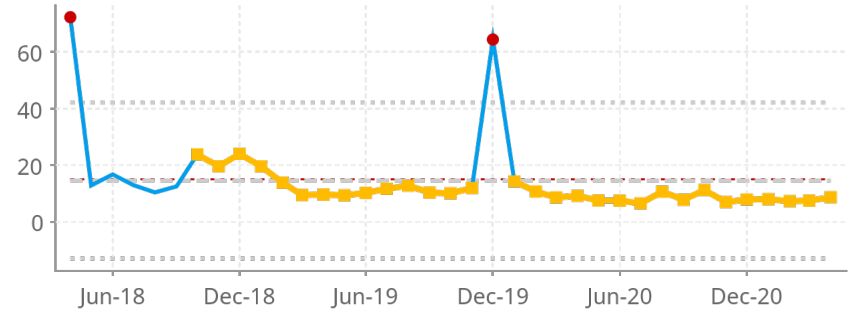
Number of Ambulance Handovers waiting more than

Month	Performance	Standard
Apr-21	5	0



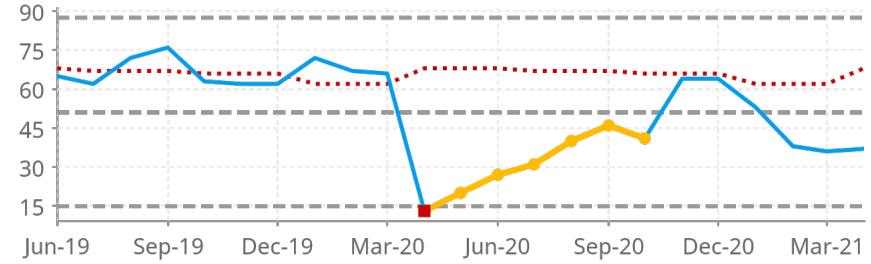
Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Apr-21	8.67	15.00



Super Stranded

Month	Performance	Standard
Apr-21	37	61



Statistical Process Control (SPC) Charts

Theatre metrics are under review

Efficiency & Productivity

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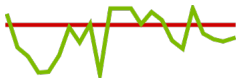
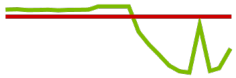
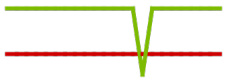
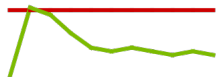
Standard	Standard Achieved				Narrative
	Month	*Performance*	*Standard*	*2 Year Trend*	
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool	Mar-21	97.20%	93.50%		
TCS35b - % of Wheelchair referrals not completed within 5 weeks but completed within 18 weeks	Apr-21	81.91%	90.00%		
Diabetic Retinopathy Screening	Apr-21	78.43%	95.00%		
The % of Patients treated within 18weeks of referral to Audiology	Apr-21	100.00%	95.00%		
Audiology non-admitted wait (92nd Percentile)	Apr-21	6.00	18.30		

Diabetic Retinopathy Screening

Diabetic retinopathy screening has been affected by the pandemic, with all screening services paused during the first wave, in line with national guidance. Work is now on-going to address the backlog of invites, with the national focus shifting from achievement of the current standard to recovery. This will be achieved through a phased approach based on capacity.

TCS Standards

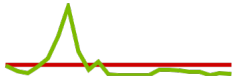
TCS35b - This standard has been affected by staffing in a relatively small team, however recruitment is underway.

TCS24 - This standard has been affected by the availability of residential rehabilitation beds within the community settings

Efficiency & Productivity

21

North Tees and Hartlepool NHS Foundation Trust

Standard	Month	Performance	Standard	2 year Trend
PHQ - Emergency Admissions for Acute Conditions that should not usually require hosptial admission	Apr-21	84.50	116.03	
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Apr-21	8.90	13.06	
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Apr-21	53.50	56.68	
PHQ - Unplanned hospitalision for respiratory tract infections in under 19s	Apr-21	3.34	18.17	
Stroke admisisons - 90% of time spent on dedicated stroke unit.	Apr-21	93.10%	80.00%	
High Risk Trans Ischaemic Attack assessed and treated within 24hrs	Apr-21	0.00%	75.00%	

Narrative

PHQ Indicators

The PHQ indicators are a set of metrics, which monitor the impact of community services on avoidable admissions for a set of key conditions. A year on year improvement is monitored against these indicators as a measure of avoidable admissions.

No exceptions to report within the SPC charts, with controlled variation across all the standards, however recognising the impact of the Covid pandemic and associated changes in pathway management, which is evident in the drop in activity from March 20 onwards.

High Risk Trans Ischaemic Attack

There were no high risk TIA patients for the month of April 2021.

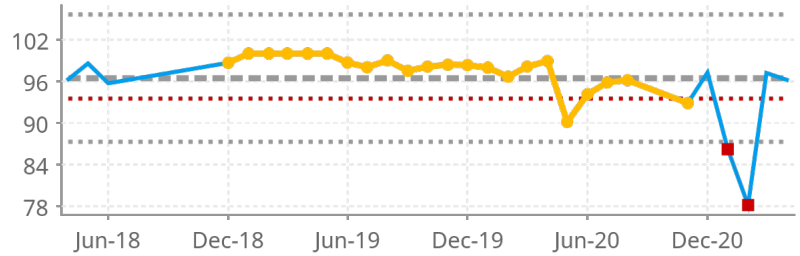
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

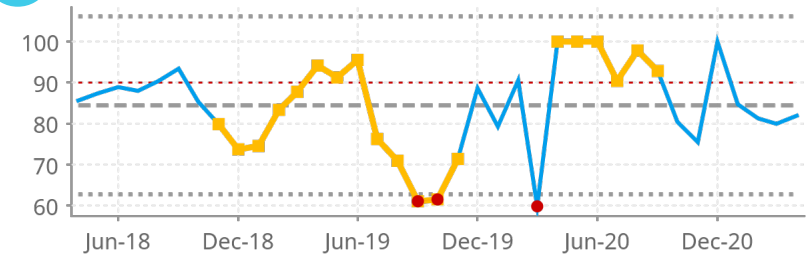
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool

Month	Performance	Standard
Mar-21	97.20%	93.50%



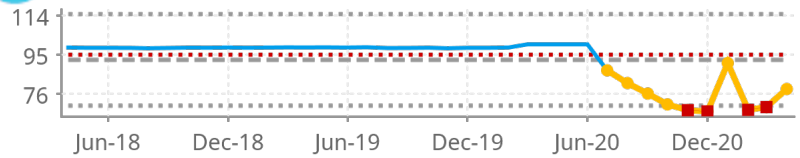
TCS35b - % of Wheelchair referrals not completed within 5 weeks but completed within 18 weeks

Month	Performance	Standard
Apr-21	81.91%	90.00%



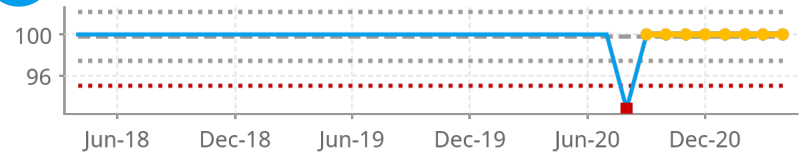
Diabetic Retinopathy Screening

Month	Performance	Standard
Apr-21	78.43%	95.00%



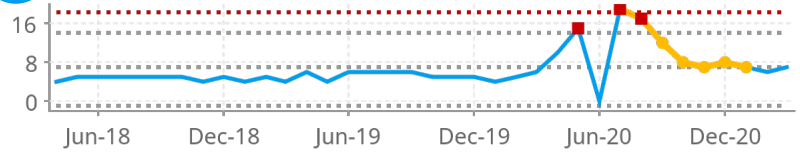
The % of Patients treated within 18weeks of referral to Audiology

Month	Performance	Standard
Apr-21	100.00%	95.00%



Audiology non-admitted wait (92nd Percentile)

Month	Performance	Standard
Apr-21	6.00	18.30



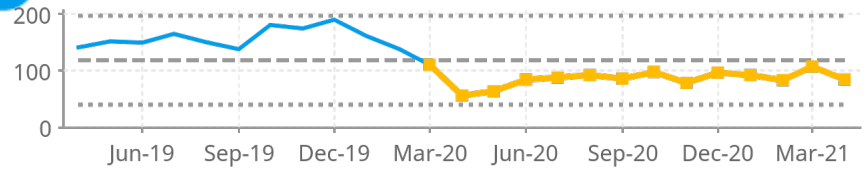
Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

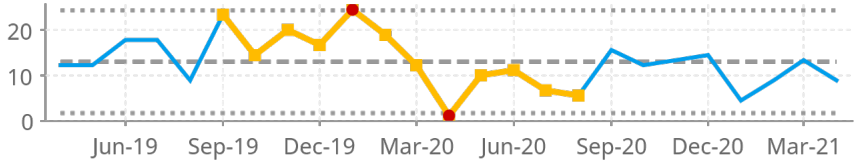
PHQ - Emergency Admissions for Acute Conditions that should not usually require hosptial admission

Month	Performance	Standard
Apr-21	84.50	116.03



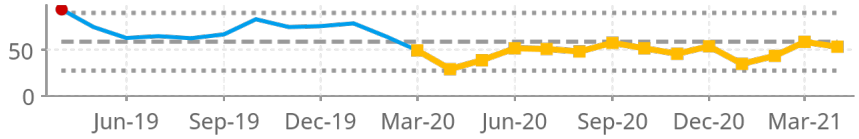
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in unders 19s

Month	Performance	Standard
Apr-21	8.90	13.06



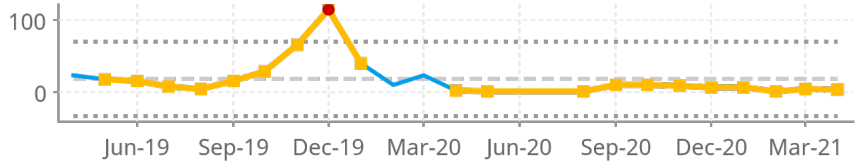
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

Month	Performance	Standard
Apr-21	53.50	56.68



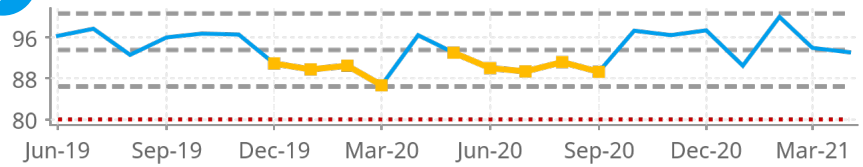
PHQ - Unplanned hospitalision for respiratory tract infections in under 19s

Month	Performance	Standard
Apr-21	3.34	18.17



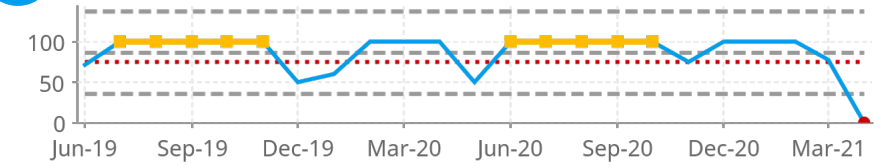
Stroke admisisons - 90% of time spent on didicated stroke unit.

Month	Performance	Standard
Apr-21	93.10%	80.00%



High Risk Trans Ischaemic Attack assessed and treated within 24hrs

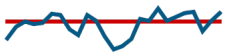
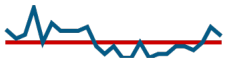
Month	Performance	Standard
Apr-21	0.00%	75.00%



Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Mar 20 - Feb 21	97.78	
Summary Hospital-Level Mortality Indicator (SHMI)	✗	Dec 19 - Nov 20	100.88	
Dementia KPI 1	✓	Apr-21	100.00%	
Dementia KPI 2	✓	Apr-21	100.00%	
Dementia KPI 3	✓	Apr-21	100.00%	

		Month	Performance	Standard	Trend
Stage 1 Complaint	✗	Apr-21	100	87	
Stage 2 Complaint	✗	Apr-21	6	4	
Stage 3 Complaint	✓	Apr-21	6	12	

Narrative

Mortality

The latest HSMR value is currently reporting at 97.78 (March 2020 to February 2021) which has decreased from the previous rebased value of 98.62 (February 2020 to January 2021). The latest SHMI value is now 100.88 (December 2019 to November 2020) which has increased from the previous rebased value of 99.83 (November 2019 to October 2020).

Complaints

Due to Covid-19 restrictions, visiting remains limited, to reduce the transmission of Covid, whilst supporting families through Johns Campaign and those at end of life. However, following the reduction in the local Covid-19 transmission rate, the trust is reviewing options to allow some on-site visiting whilst ensuring this is undertaken in a safe a secure way for our patients, visitors and staff. The aim is to pilot this in the next few months. Communication continues to be the highest reported issue for concerns. However, following the introduction of a communication plan which incorporates virtual visiting, regular telephone updates, property and letters of love drop off service, there continues to be a reduction in the number concerns raised in relation to communication. The profile for complaints types had changed during Covid, due to restriction on visiting, now more stage 2 resolutions are being completed virtually.

- The Trust is reporting 100 stage 1, which is slightly higher than the mean of 87.
- The Trust is reporting 6 stage 2 and is above the mean of 4.
- The Trust is reporting 6 stage 3 complaints and is below the mean of 12.

Compliments

The Trust records the compliments received onto the Greatix platform. For April 2021 the number of compliments received is 279, compliments consistently remain higher than complaints. It is recognised that work still needs to be done to increase the recording of compliments across the Trust.

Safety & Quality

NHS
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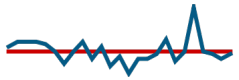
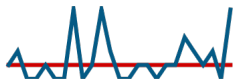
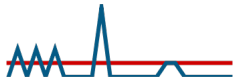
NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Red Risks	Apr-21	1	5	
Never Events	Apr-21	0	0	
VTE %	Apr-21	94.89%	95.00%	
Fall No Harm	Apr-21	64	75	
Fall Low Harm	Apr-21	16	17	
Fall Moderate Harm	Apr-21	5	1	
Fall Severe Harm	Apr-21	0	0	

Narrative

Venous Thromboembolism Compliance %

The Trust is reporting that 94.89% of patients admitted to hospital were risk assessed for venous thromboembolism (VTE) during April 2021; this is slightly below the National Standard of 95.00%. There is a Trust wide quality improvement work in progress to improve compliance, process and built upon to sustain the improvement.

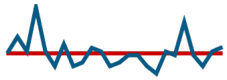
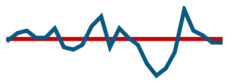
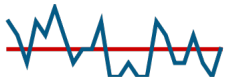
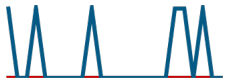
Falls

The trust has recently appointed a new lead for falls who is reviewing the current falls prevention and management system; this is being developed using an assurance framework approach. The development of this assurance framework will lead to the development of a risk mitigation plan that can be supported with the use of a project methodology to drive forward specific areas of improvement.

The Trust reporting of falls has changed from the previous three metrics of Falls No Injury, Fall Injury,No Fracture and Fall with Fracture to the following four harms of: None, Low, Moderate and Se vere.

- The Trust is reporting 64 Falls resulting in No Harm for April 2021. The 64 is below the mean of 75 and remains within the upper Control Limit.
- The Trust is reporting 16 Falls resulting in Low Harm for April 2021. The 16 is below the mean of 17 and remains within the upper Control Limit.
- The Trust is reporting 5 Falls resulting in Moderate Harm for Ap ril 2021. The 5 is above the mean of 1 and is outside the upper Control Limit.
- The Trust is reporting 0 (zero) Falls resulting in Severe Harm for April 2021.

Safety & Quality

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*Trend*	
Pressure Category 1 (inpatient)	✖	Mar-21	8	7		**Pressure Ulcers** In the March 2021 reporting period, all four categories of Pressure Ulcers fall within the control limits. A pressure ulcer assurance framework is currently under development to further support pressure ulcer management.
Pressure Category 2 (inpatient)	✔	Mar-21	22	24		
Pressure Category 3 (inpatient)	✔	Mar-21	2	2		
Pressure Category 4 (inpatient)	✔	Mar-21	0	0		

Safety & Quality

NHS
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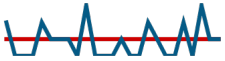
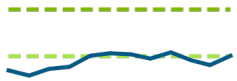
NHS Foundation Trust

Standard	Standard Achieved				Narrative
		Month	*Performance*	*Standard*	*Trend*	
Hand Hygiene	✓	Apr-21	97%	95%		**Hand Hygiene** The overall Trust compliance score for hand hygiene is 97% for April 2021; this has remained the same from the previous reported period. Clinical areas carry out monthly audits with a quarterly assurance check by the IPC team
Clostridium difficile	✗	Apr-21	5	4		**Infections** For April 2021, the Trust is reporting 5 Trust attributed case of Clostridium difficile infection (3 HOHA - Hospital Onset Healthcare Associated and 2 COHA - Community Associated Healthcare Associated). The 5 cases for April 2021 is greater than the mean for the past two years for Clostridium difficile which is 4. All seven infections continue to display natural cause variation and remain in their respective upper and lower control limits. The number of hospital onset Covid-19 cases (positive test > 8days after admission) has reduced significantly with only 2 cases reported in April 2021. There was one on-going outbreak with no new cases and was closed on the 10th April 2021. The Trust remains on zero outbreaks to-date.
MRSA	✓	Apr-21	0	0		
MSSA	✓	Apr-21	1	2		
Ecoli	✓	Apr-21	3	3		
Klebsiella	✓	Apr-21	1	1		
Pseudomonas	✓	Apr-21	0	0		
CAUTI	✓	Apr-21	21	22		

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	Apr-21	86.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	Apr-21	92.00%	75.00%	
Friends and Family Test (FFT) - Maternity	Apr-21	100.00%	75.00%	
UNIFY - RN Day	Apr-21	80.27%	>=80% and <=109.99%	
UNIFY - RN Night	Apr-21	84.08%	>=80% and <=109.99%	
UNIFY - HCA Day	Apr-21	84.51%	>=80% and <=109.99%	
UNIFY - HCA Night	Apr-21	92.57%	>=110% and <=125.99%	

Narrative

Friends and Family Test

The FFT process changed in April 2020 to a single question with more focus on the narrative that is supplied with the feedback. This has created a wealth of patient and family feedback that is available for all clinical teams

The Emergency Care (Accident & Emergency and Urgent Care) Friends and Family position for rating the service 'Very Good or Good' was 86% for April 2021.

The In-patient Friends and Family position for rating the service 'Very Good or Good' was 92% for April 2021.

The Maternity (Delivery) Friends and Family position for rating the service 'Very Good or Good' was 100% for April 2021.

All three metrics April FFT 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

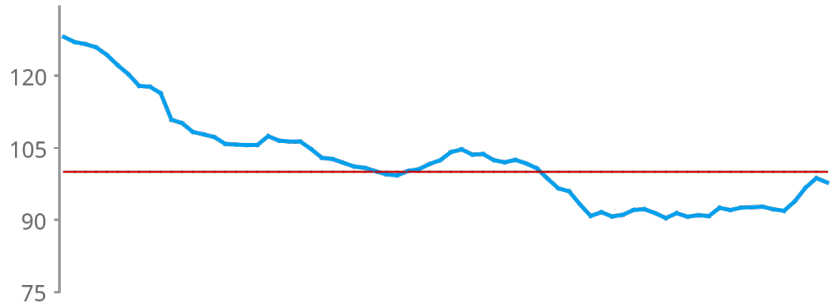
Nursing fill rate reflects the increased demand on the workforce during Covid-19 to safely meet the needs of patients with a higher acuity. In April 2021, 3 out of the 4 metrics reported below the standards reflective of the workforce pressures within the period, however noting safe staffing levels have been maintained at all times.

Successful recruitment drives and the reduced Covid sickness absence has seen the Trust's nursing resource position improve during March.

Additional Detail Charts

Hospital Standardised Mortality Ratio

Month	Performance
Mar 20 - Feb 21	97.78



Summary Hospital-Level Mortality Indicator

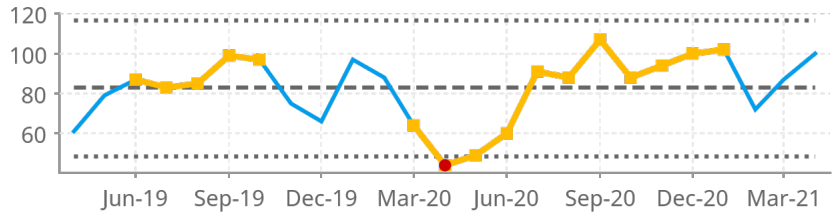
Month	Performance
Dec 19 - Nov 20	100.88

	Month	Performance
Dementia KPI 1	Apr-21	100.00%
Dementia KPI 2	Apr-21	100.00%
Dementia KPI 3	Apr-21	100.00%

Statistical Process Control (SPC) Charts

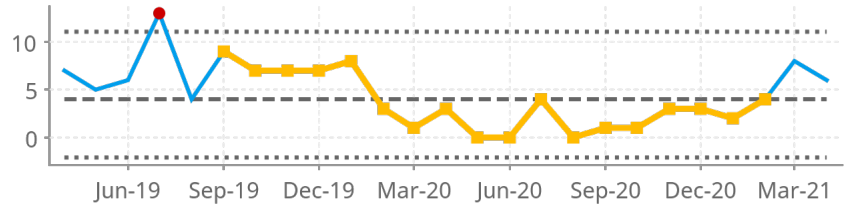
Stage 1 - Informal

Month	Performance	Standard
Apr-21	100	87



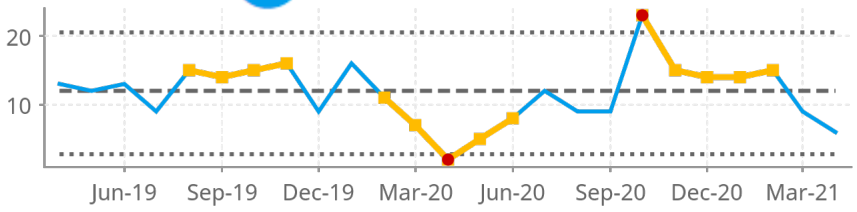
Stage 2 - Meeting

Month	Performance	Standard
Apr-21	6	4



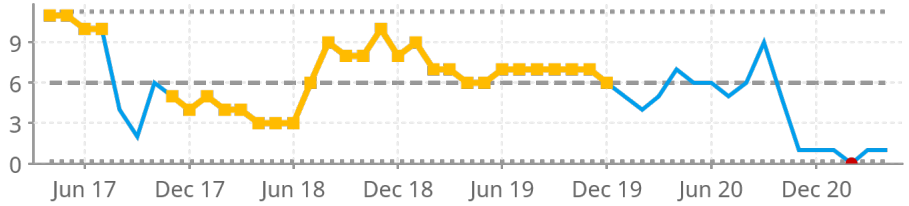
Stage 3 - Formal

Month	Performance	Standard
Apr-21	6	12

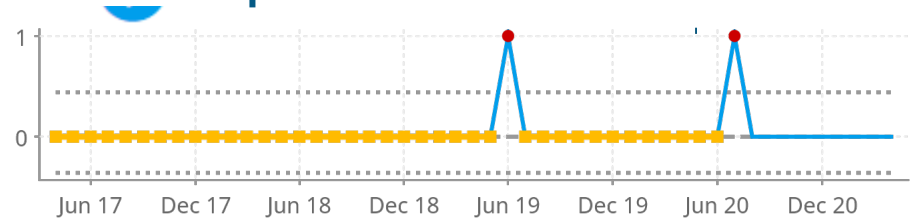


Red Risks

Month	Performance	Standard
Apr-21	1	5

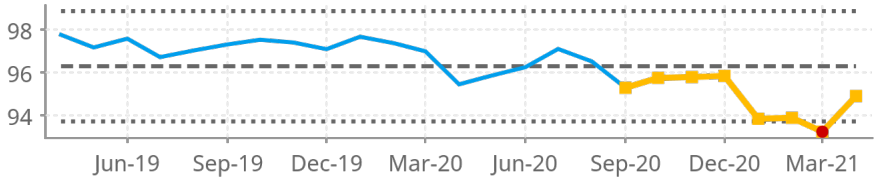


Month	Performance	Standard
Apr-21	0	0



VTE %

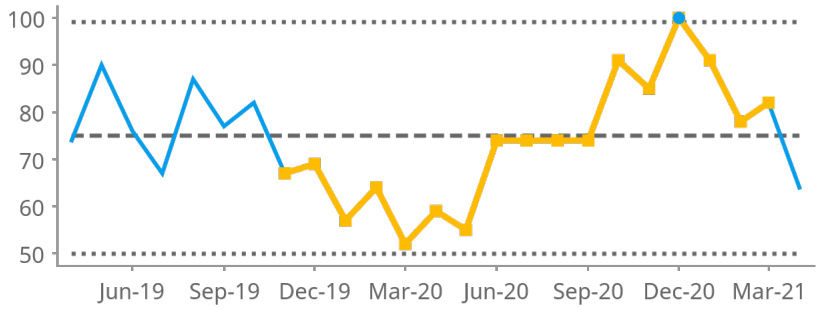
Month	Performance	Standard
Apr-21	94.89%	95.00%



Statistical Process Control (SPC) Charts

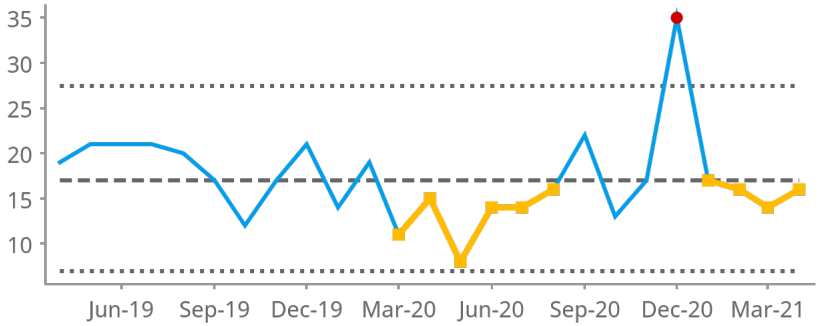
Fall No Harm

Month	Performance	Standard
Apr-21	64	75



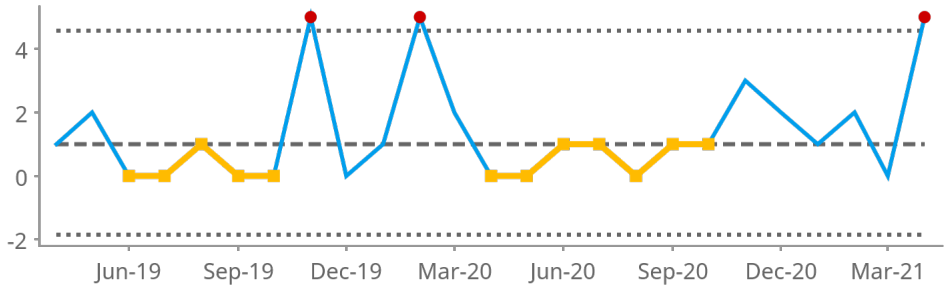
Fall Low Harm

Month	Performance	Standard
Apr-21	16	17



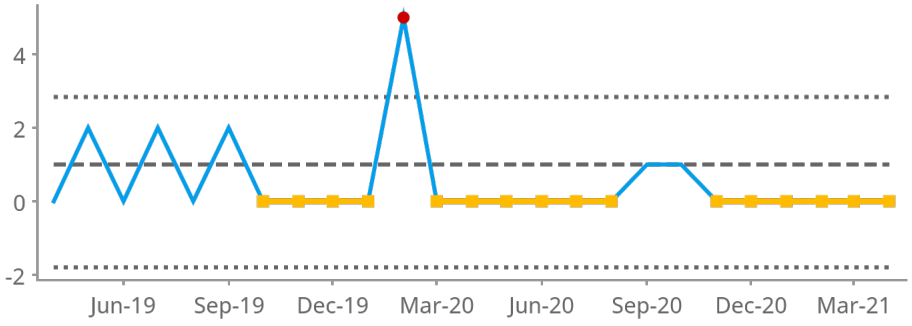
Fall Moderate Harm

Month	Performance	Standard
Apr-21	5	1



Fall Severe Harm

Month	Performance	Standard
Apr-21	0	0



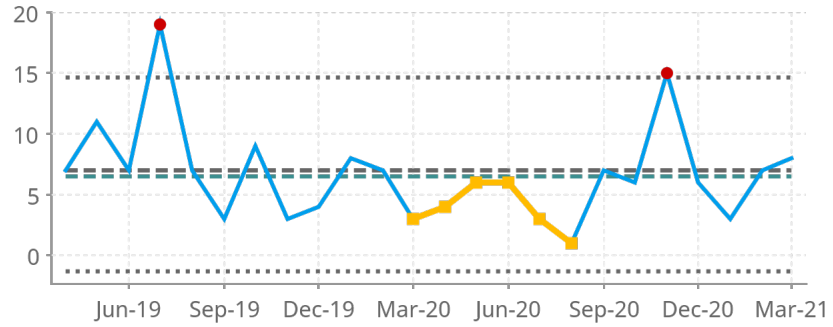
Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

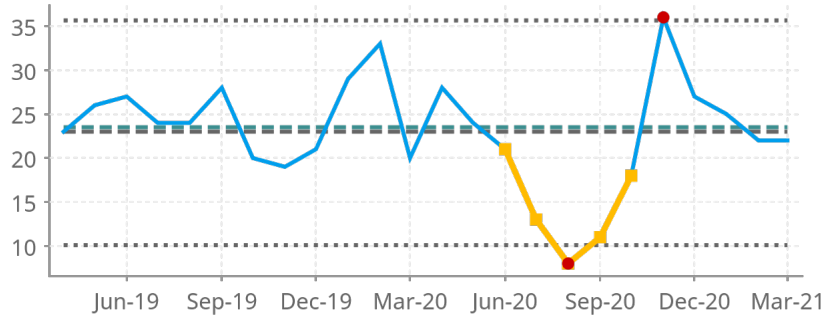
Pressure Ulcer Cat 1

Month	Performance	Standard
Mar-21	8	7



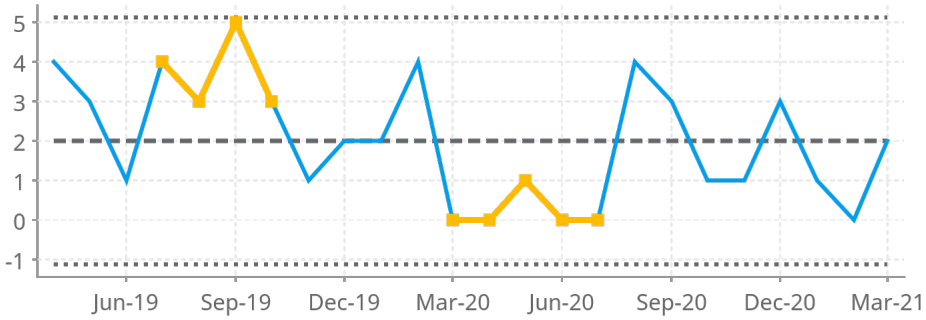
Pressure Ulcer Cat 2

Month	Performance	Standard
Mar-21	22	24



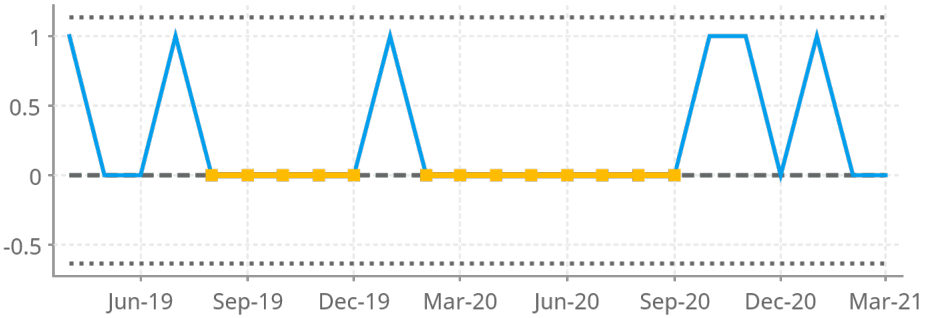
Pressure Ulcer Cat 3

Month	Performance	Standard
Mar-21	2	2



Pressure Ulcer Cat 4

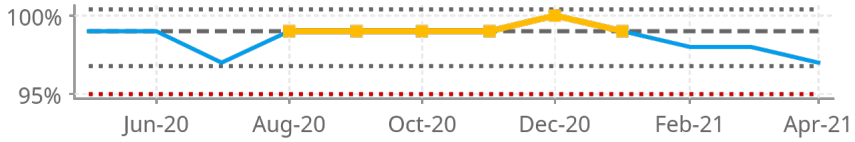
Month	Performance	Standard
Mar-21	0	0



Statistical Process Control (SPC) Charts

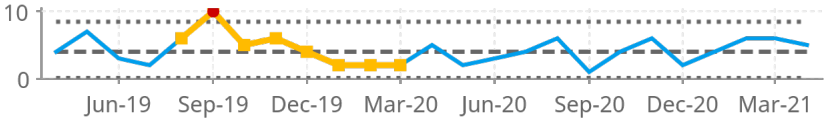
Hand Hygiene

Month	Performance	Standard
Apr-21	97%	95%



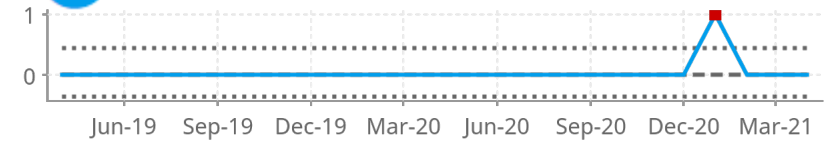
Cdiff

Month	Performance	Standard
Apr-21	5	4



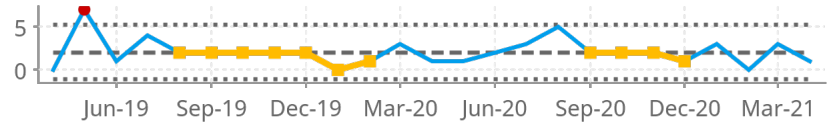
MRSA

Month	Performance	Standard
Apr-21	0	0



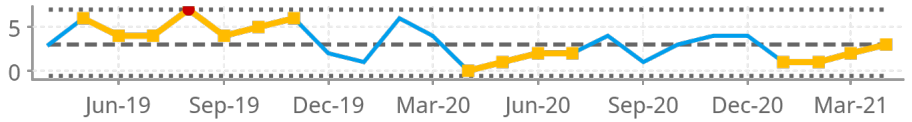
MSSA

Month	Performance	Standard
Apr-21	1	2



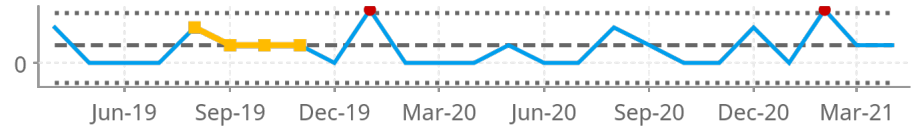
Ecoli

Month	Performance	Standard
Apr-21	3	3



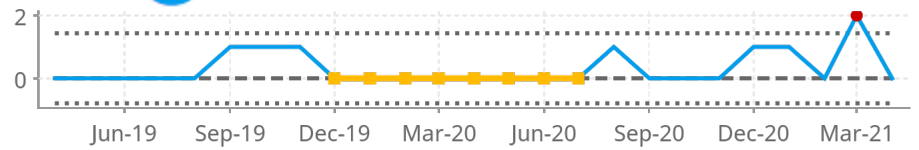
Klebsiella

Month	Performance	Standard
Apr-21	1	1



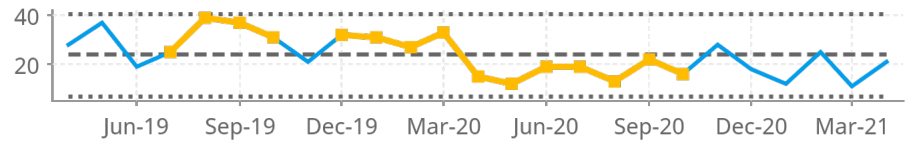
Pseudomonas

Month	Performance	Standard
Apr-21	0	0



CAUTI

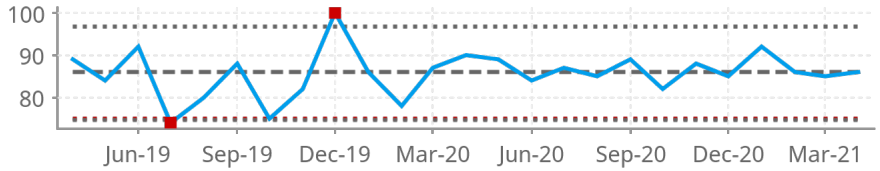
Month	Performance	Standard
Apr-21	21	22



Statistical Process Control (SCP) Charts

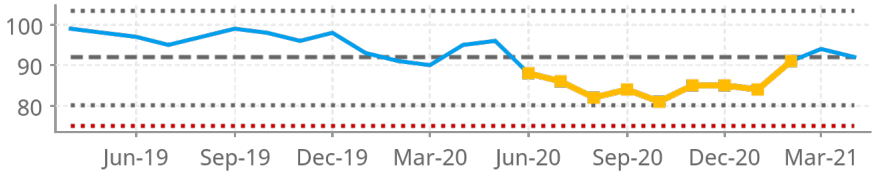
FFT Emergency Care

Month	Performance	Standard
Apr-21	86.00%	75.00%



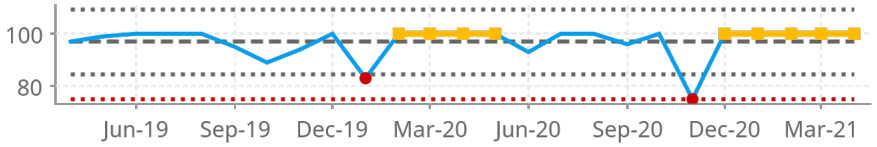
FFT Inpatient

Month	Performance	Standard
Apr-21	92.00%	75.00%



FFT Maternity

Month	Performance	Standard
Apr-21	100.00%	75.00%

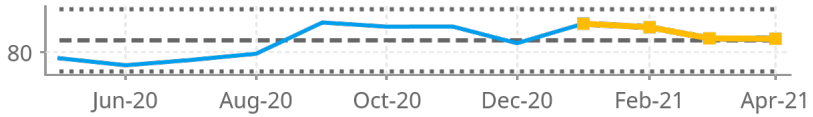


UNIFY RN Day

Month	Performance	Standard
Apr-21	80.27%	>=80% and <=109.99%

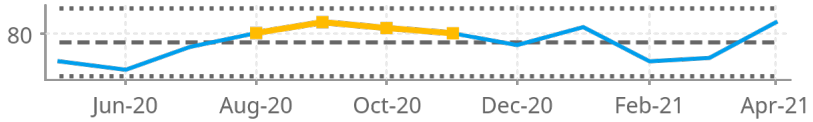
UNIFY RN Night

Month	Performance	Standard
Apr-21	84.08%	>=80% and <=109.99%



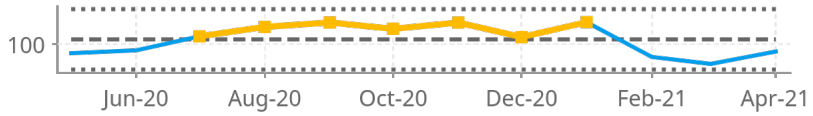
UNIFY HCA Day

Month	Performance	Standard
Apr-21	84.51%	>=80% and <=109.99%



UNIFY HCA Night

Month	Performance	Standard
Apr-21	92.57%	>=110% and <=125.99%



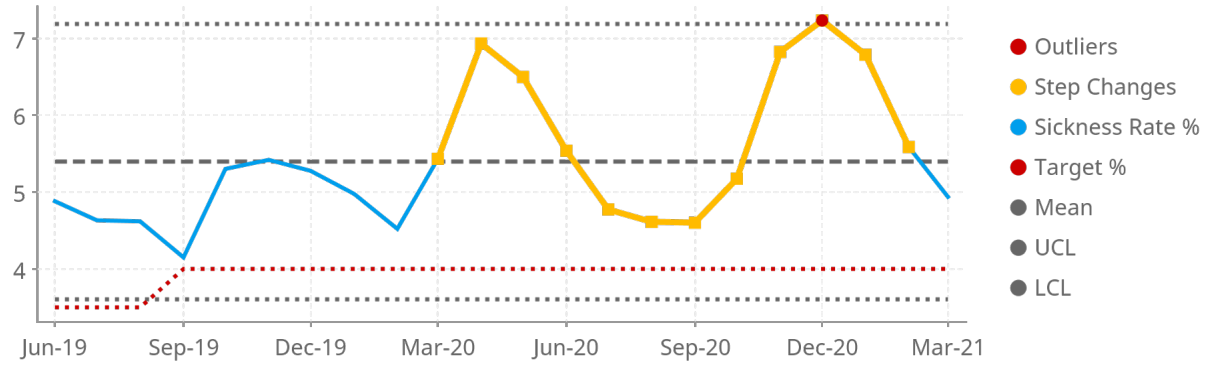
Workforce

Standard	Standard Achieved				Narrative
	Month	*Performance*	*Standard*	*2 Year Trend*	
Sickness					The sickness absence rate for March 2021 is reported at 4.94%, a decrease of 0.65% compared to the previous month. This is broken down into 0.61% attributable to Covid-19 related sickness and 4.33% attributable to other sickness. The cost of sickness absence is reported as £481,533, an increase of £33,274 compared to February (£448,259). There were 30 further cases of Covid-19 related staff absence in April 2021, broken down into 15 staff absent for 10 days and 15 who self-isolated for 14 days.
✗	Mar-21	4.94%	4.00%		
Appraisals					The sickness absence rate for quarter 4 was 5.75%, of which 1.21% was attributable to covid-related sickness and 4.53% attributable to other causes.
✗	Apr-21	81.32%	95.00%		
Turnover					'Anxiety/stress/depression' was the top sickness reason in March, accounting for 31% of all sickness absence during the month. 'Chest & respiratory problems' (under which Covid-related sickness is recorded) was the second highest reason, accounting for 14% of sickness absence.
✓	Apr-21	7.75%	10.00%		
Mandatory Training					Other workforce metrics for April 2021 are:
✓	Apr-21	87.76%	80.00%		• Appraisal compliance reported as 81%, unchanged from the previous month • Mandatory Training compliance reported as 88%, a 1% increase on the previous month • Staff Turnover reported as 7.75%, a increase of 0.25%

Statistical Process Control (SPC) Charts

Sickness

Month	Performance	Standard
Mar-21	4.94%	4.00%



Appraisal

Month	Performance	Standard
Apr-21	81.32%	95.00%

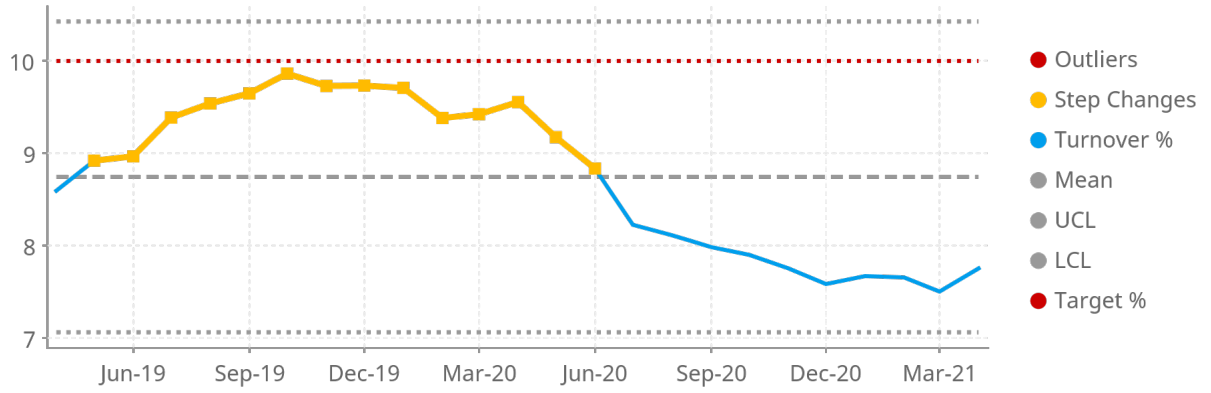
Workforce

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

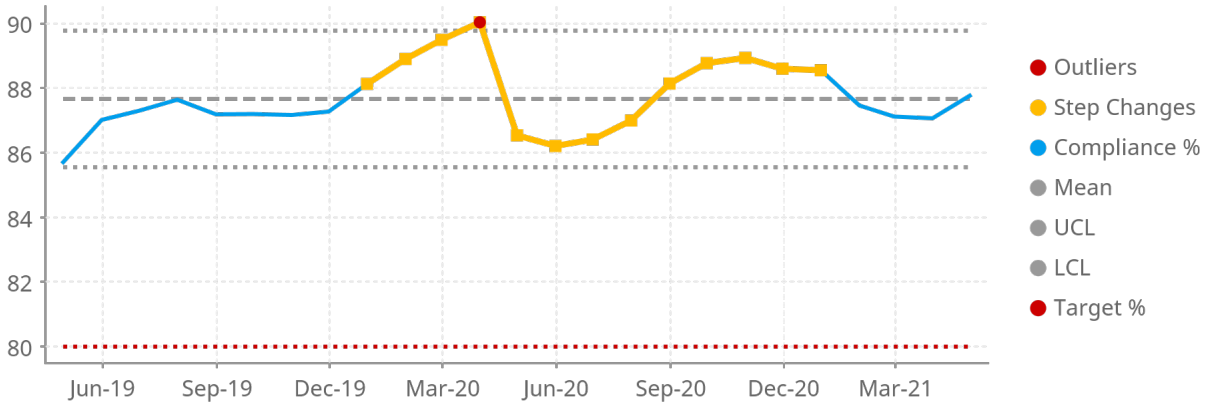
Turnover

Month	Performance	Standard
Apr-21	7.75%	10.00%



Mandatory Training

Month	Performance	Standard
Apr-21	87.76%	80.00%



Finance Overview - Month 1

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	500	961	☺
Year to Date	500	961	☺

Balance Sheet

£m

Cash Actual	54.6
Cash Forecast*	41.8

*Ahead of forecast due to improved I&E and additional advanced income

Capital

	Plan (£m)	Actual (£m)	
In Month	0.2	0.6*	☺
Forecast	17.0	17.0	☺

*This includes pre-commitments

Use of Resources*

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

*UOR suspended in 2020-2021 - manual calculations

** Rating will only improve with increased cash reserves

Appendix 1

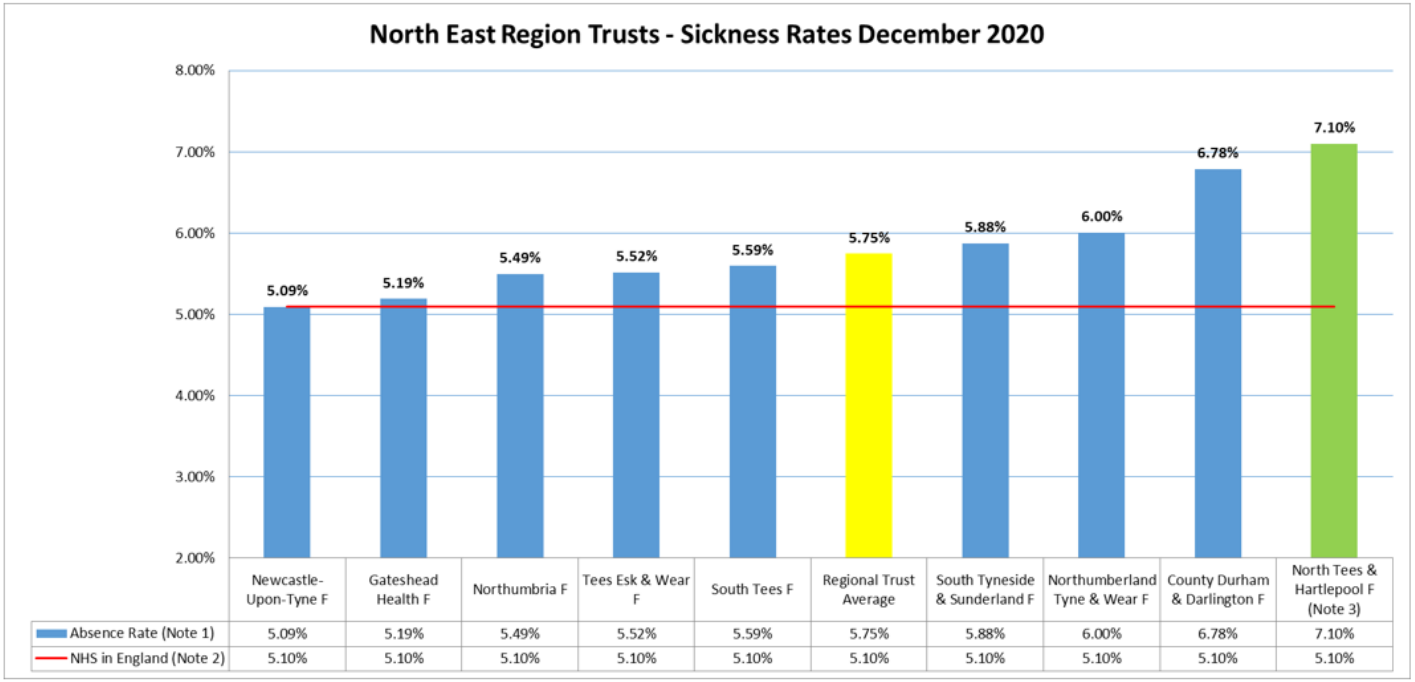
RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - March 21										
Incomplete Pathways waiting <18 weeks	64.4%		84.6%	85.5%	N/A	76.1%	70.3%	85.7%	62.1%	67.3%
Half of incomplete patients wait less than	12		7	6	N/A	8	10	8	12	10
Half of admitted patients wait less than	9		9	15	N/A	13	8	10	4	6
19 out of 20 admitted patients wait less than	52+		52+	35	N/A	52+	52+	50	38	52+
Half of Non admitted Pathways waited less than	5		2	4	N/A	3	6	5	4	4
19 out of 20 non admitted patients wait less than	45		24	21	N/A	27	42	30	32	30

Cancer 62 Day Standard - March 21	National	North East	North Tees & Hartlepool	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
Breast	Data not available	88.16 (134/152)	100 (19.5/19.5)	100 (2/2)	63.16 (12/19)	94.12 (32/34)	89.74 (17.5/19.5)	92.45 (24.5/26.5)	82.61 (9.5/11.5)	85 (17/20)
Lung		73.97 (54/73)	90 (9/10)	88.46 (11.5/13)	69.57 (8/11.5)	50 (1.5/3)	57.89 (5.5/9.5)	90 (4.5/5)	71.43 (10/14)	57.14 (4/7)
Gynae		58.97 (23/39)	60 (1.5/2.5)	100 (2.5/2.5)	60 (1.5/2.5)	22.73 (2.5/11)	55.56 (2.5/4.5)	100 (7/7)	66.67 (4/6)	50 (1.5/3)
Upper GI		66.67 (52/78)	100 (4/4)	75 (6/8)	60 (3/5)	100 (6/6)	47.83 (11/23)	79.17 (9.5/12)	77.27 (8.5/11)	44.44 (4/9)
Lower GI		56.14 (64/114)	47.37 (4.5/9.5)	72 (9/12.5)	45.45 (5/11)	72 (9/12.5)	60.87 (7/11.5)	65.31 (16/24.5)	46.88 (7.5/16)	36.36 (6/16.5)
Uro (incl testes)		72.32 (122/168)	62.16 (11.5/18.5	98.53 (33.5/34)	44.44 (8/18)	61.11 (6/9)	50 (12/24)	86.44 (25.5/29.5)	73.53 (25/34)	50 (0.5/1)
Haem (incl AL)		80.39 (41/51)	100 (2.5/2.5)	90 (9/10)	86.67 (6.5/7.5)	80 (4/5)	100 (3/3)	100 (2/2)	52.63 (5/9.5)	78.26 (9/11.5)
Head & Neck		77.36 (41/53)	50 (1/2)	76.47 (6.5/8.5)	50 (1/2)	0 (0/1)	81.82 (13.5/16.5)	0 (0/0)	94.44 (17/18)	40 (2/5)
Skin		97.62 (164/168)	0 (0/0)	100 (4.5/4.5)	96.97 (16/16.5)	0 (0/0)	94.57 (61/64.5)	100 (7/7)	100 (38/38)	100 (37.5/37.5)
Sarcoma		100 (2/2)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	100 (1/1)	0 (0/0)	100 (1/1)	0 (0/0)
Brain/CNS		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Children's		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Other		75 (6/8)	0 (0/0)	100 (1/1)	0 (0/0)	0 (0/0)	100 (2/2)	100 (1/1)	0 (0/0)	50 (2/4)
All		77.54 (703/906)	78.1 (53.5/68.5)	89.06 (85.5/96)	65.59 (61/93)	74.23 (61/81.5)	75.98 (136/179)	84.72 (97/114.5)	78.93 (125.5/159)	72.93 (83.5/114.5)

Appendix 2

Workforce



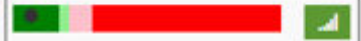
North East Region Trusts - Sickness Rates December 2020 (*latest available)

The chart above shows the sickness absence figures for Acute and Mental Health Trust's in the North East region for December 2020. North Tees and Hartlepool NHS Foundation Trust is represented by the green column. The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column. The red line is the average rate for the whole of the NHS in England.

The sickness rate for North Tees and Hartlepool is 7.10%, which is the highest in the north east region this month.

Newcastle-upon-Tyne Hospitals NHS Foundation Trust report the lowest sickness absence rate for November 2020 at 5.09%.

Standard Indicator Set: Operational Efficiency	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2021)	9.51% (Feb 2020 - Jan 2021)	9.47% (Jan 2020 - Dec 2020)	0.04 ↑	7.72%	8.01%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2021)	2.48% (Feb 2020 - Jan 2021)	2.43% (Jan 2020 - Dec 2020)	0.05 ↑	2.21%	2.11%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2021)	5.31% (Feb 2020 - Jan 2021)	5.23% (Jan 2020 - Dec 2020)	0.08 ↑	4.99%	4.52%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2021)	7.64% (Feb 2020 - Jan 2021)	7.57% (Jan 2020 - Dec 2020)	0.07 ↑	7.29%	6.41%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Apr 2021)	10.55% (Feb 2020 - Jan 2021)	10.46% (Jan 2020 - Dec 2020)	0.09 ↑	10.00%	8.60%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Apr 2021)	6.89% (Mar 2020 - Feb 2021)	7.05% (Feb 2020 - Jan 2021)	-0.16 ↓	7.51%	6.90%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Apr 2021)	2.57 (Mar 2020 - Feb 2021)	2.55 (Feb 2020 - Jan 2021)	0.02 ↑	2.45	2.30	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Apr 2021)	0.00% (Mar 2020 - Feb 2021)	0.00% (Feb 2020 - Jan 2021)	No Change	14.74%	13.09%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Apr 2021)	92.09% (Mar 2020 - Feb 2021)	92.22% (Feb 2020 - Jan 2021)	-0.13 ↓	76.82%	87.98%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Apr 2021)	96.29% (Mar 2020 - Feb 2021)	96.62% (Feb 2020 - Jan 2021)	-0.33 ↓	95.35%	95.15%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Apr 2021)	78.41% (Mar 2020 - Feb 2021)	78.69% (Feb 2020 - Jan 2021)	-0.28 ↓	76.76%	74.80%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Apr 2021)	78.76% (Mar 2020 - Feb 2021)	79.96% (Feb 2020 - Jan 2021)	-1.20 ↓	68.10%	63.52%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Apr 2021)	87.29% (Mar 2020 - Feb 2021)	88.19% (Feb 2020 - Jan 2021)	-0.90 ↓	83.25%	77.83%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Apr 2021)	85.96% (Mar 2020 - Feb 2021)	86.84% (Feb 2020 - Jan 2021)	-0.88 ↓	66.29%	58.62%	
Day case realisation rate (12 mth rolling) HES Inpatients (Apr 2021)	96.59% (Mar 2020 - Feb 2021)	96.56% (Feb 2020 - Jan 2021)	0.03 ↑	95.04%	95.57%	
Day case rate (12 mth rolling) HES Inpatients (Apr 2021)	82.88% (Mar 2020 - Feb 2021)	82.57% (Feb 2020 - Jan 2021)	0.31 ↑	84.64%	67.99%	

Average excess length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.08 (Mar 2020 - Feb 2021)	0.09 (Feb 2020 - Jan 2021)	-0.01 ↓	0.33	0.41	
Average length of stay (12 mth rolling) HES Inpatients (Apr 2021)	3.32 (Mar 2020 - Feb 2021)	3.32 (Feb 2020 - Jan 2021)	No Change	3.98	4.51	
Average elective length of stay (12 mth rolling) HES Inpatients (Apr 2021)	1.26 (Mar 2020 - Feb 2021)	1.30 (Feb 2020 - Jan 2021)	-0.04 ↓	3.74	4.68	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Apr 2021)	3.55 (Mar 2020 - Feb 2021)	3.56 (Feb 2020 - Jan 2021)	-0.01 ↓	4.01	4.47	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.22 (Mar 2020 - Feb 2021)	0.22 (Feb 2020 - Jan 2021)	No Change	0.24	0.25	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.01 (Mar 2020 - Feb 2021)	0.01 (Feb 2020 - Jan 2021)	No Change	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.35 (Mar 2020 - Feb 2021)	0.35 (Feb 2020 - Jan 2021)	No Change	0.42	0.46	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.94 (Mar 2020 - Feb 2021)	0.94 (Feb 2020 - Jan 2021)	No Change	1.02	0.98	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	0.16 (Mar 2020 - Feb 2021)	0.17 (Feb 2020 - Jan 2021)	-0.01 ↓	0.32	0.25	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Apr 2021)	1.45 (Mar 2020 - Feb 2021)	1.45 (Feb 2020 - Jan 2021)	No Change	1.64	1.68	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Apr 2021)	34.66% (Mar 2020 - Feb 2021)	34.76% (Feb 2020 - Jan 2021)	-0.10 ↓	34.82%	32.81%	
Elective stranded rate (12 mth rolling) HES Inpatients (Apr 2021)	3.42% (Mar 2020 - Feb 2021)	3.56% (Feb 2020 - Jan 2021)	-0.14 ↓	13.55%	12.86%	
Emergency stranded rate (12 mth rolling) HES Inpatients (Apr 2021)	18.12% (Mar 2020 - Feb 2021)	18.00% (Feb 2020 - Jan 2021)	0.12 ↑	18.81%	21.35%	
Elective super-stranded rate (12 mth rolling) HES Inpatients (Apr 2021)	0.29% (Mar 2020 - Feb 2021)	0.32% (Feb 2020 - Jan 2021)	-0.03 ↓	2.54%	3.52%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Apr 2021)	93.11% (Mar 2020 - Feb 2021)	93.31% (Feb 2020 - Jan 2021)	-0.20 ↓	76.15%	76.88%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Apr 2021)	0.23% (Mar 2020 - Feb 2021)	0.25% (Feb 2020 - Jan 2021)	-0.02 ↓	1.03%	0.98%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Apr 2021)	82.71 (Mar 2020 - Feb 2021)	83.54 (Feb 2020 - Jan 2021)	-0.83 ↓	101.73	100.10	Low (>95%)

Board of Directors

NHS North Tees and Hartlepool NHS Foundation Trust

Title of report:	Guardian of Safe Working Hours Report										
Date:	27 May 2021										
Prepared by:	Mr Pud Bhaskar, Guardian of Safe Working hours										
Executive Sponsor:	Deepak Dwarakanath, Medical Director and Deputy Chief Executive Officer										
Purpose of the report	The New Junior Doctor Contract (2016) requests that the Guardian of Safe Working Hours (GOSW) prepares a quarterly report to the Board of Directors. These reports contain information relating to the safe working of doctors within the Trust. This report covers the period December 2020 to March 2021.										
Action required:	Approve		Assurance	✓	Discuss	✓	Information	✓			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	✓	Transforming our Services	✓	Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well Led	✓	

Executive Summary and the key issues for consideration/ decision:

As with the wider NHS Workforce, COVID-19 continues to have a significant impact on the working lives of Doctors in Training (DiTs). Our workforce continues to work together as a team and flexibly to meet both service and training needs.

The Guardian of Safe Working Hours has increased the frequency of the doctors' forum to bi-monthly, in order to increase our level of support to our doctors, obtain feedback, and address or escalate concerns. From the end of Dec 2020, the Pfizer vaccine has been offered to the entire workforce.

Exception reporting continues to be the mechanism used to highlight non-compliance with safe working hours, lack of support, and missed educational opportunities. Following an initial reduction in exceptions, which is thought to be related to the first pandemic surge, the rate of exception reporting appears to be returning to pre-pandemic levels. Flexible and remote working has increased, allowing teams to meet virtually and continue training/teaching sessions. Rest rooms and recharge hubs are available to staff, in addition to a listening in action app and support line.

Concerns relating to the availability and location of equipment in clinical areas need further investigation so that they can be addressed. Other concerns relating to the approval of study leave will be conveyed to the Northern Foundation School.

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

- Issues relating to the availability of personal protective equipment have been addressed and no longer appears to be a concern amongst doctors in training. The situation should continue to be monitored.
- Possible disruption to educational and training opportunities due to subsequent pandemic surges.
- Possible breaches to safe working hours and rest requirements resulting in fines

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

Guardian of Safe Working Report
December 2020 to March 2021

Executive Summary

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

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

The most recent forums have given trainees the opportunity to express their thoughts around the recent redeployment between services, which has been done in line with service demands. Trainees were assured that training requirements would continue to be met and this had been considered when arranging redeployments. It was reported that all trainees had been appropriately supported through this period and no trainees had been redeployed for longer than a four week period. All arrangements included input from service rota administrators and the associated Dean and Schools. HEENE received weekly reports detailing the redeployment of trainees.

Trainees raised concerns around changes to funding arrangements regarding study leave, particularly where training courses are pre-paid. A number of trainees expressed concern relating to specialty courses no longer being funded, which could have detrimental impact on career progression. Information regarding these changes had been communicated to all supervisors in advance of any changes made. Trainees have been advised that this is not a Trust decision and decisions on funding are made by HEENE. Over-spend in previous years where funding has been uncapped, has now resulted in introduction of a spend cap, which is negatively impacting current trainees. The Junior Doctors Committee will be escalating these concerns to the Foundation School.

The introduction of the Team Support Worker (TSW) role across the organisation received excellent feedback from trainees, and the scheme was supported by the BMA. Notably, two of the new TSW cohort are Medical Students looking to gain further experience working in the NHS to support their development. Trainees have offered their support in generating feedback about the role, which will support the evaluation of this 6-month pilot scheme.

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

The following new recommendations are made to the board:

1. Continue to monitor personal protective equipment arrangements
2. Continue to encourage exception reporting

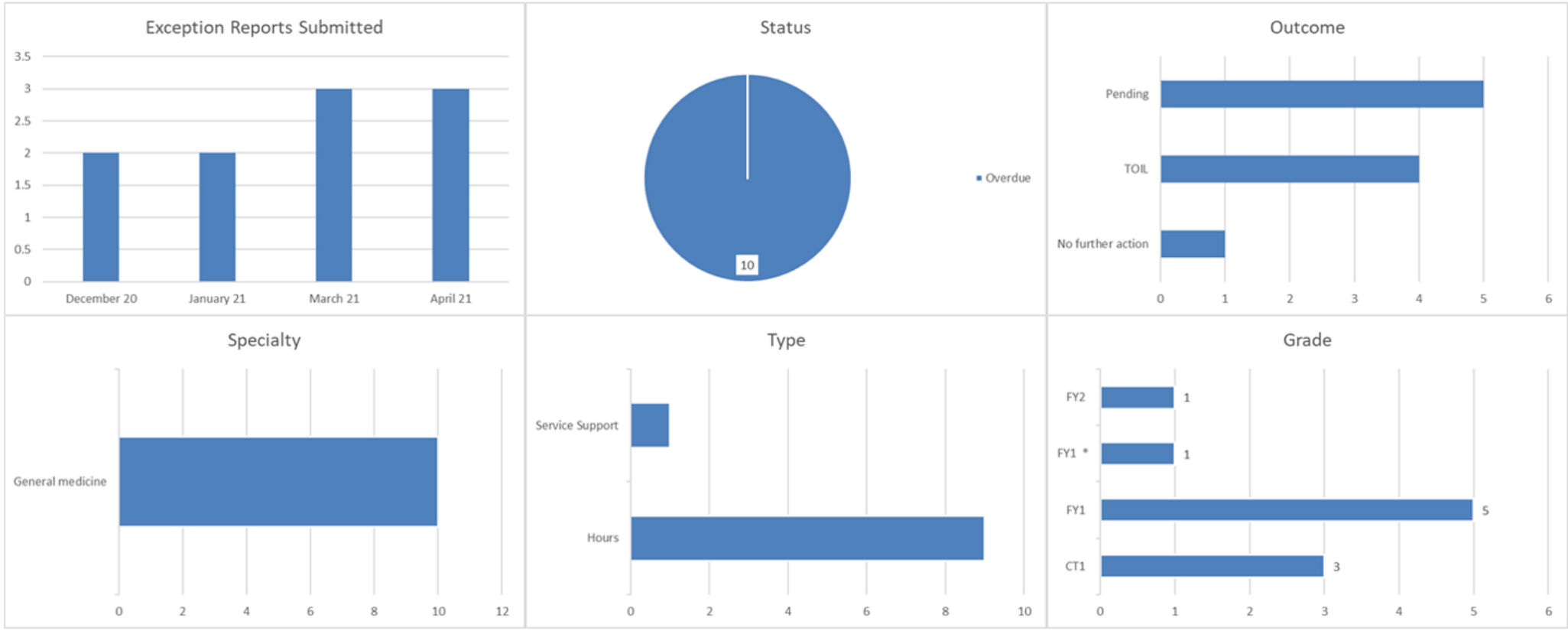
3. Exception reporting engagement sessions to be held with supervisors
4. Issues around availability of equipment in clinical areas to be addressed by ward matrons
5. Concerns relating to approval of study leave to be conveyed to the Foundation School.

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

Mr Pud Bhaskar, Guardian of Safe Working Hours

May 2021

Appendix One: Exception Reporting Dashboard Screenshot – December 2020-March 2021



10 Exception reports submitted by 7 doctors

Board of Directors

Title of report:	Annual Operating Plan 2021/22 and Annual Self Certifications										
Date:	27 May 2021										
Prepared by:	Neil Atkinson, Director of Finance Barbara Bright, Director of Corporate Affairs and Chief of Staff Lynne Taylor, Director of Planning and Performance										
Executive Sponsor:	Lynne Taylor, Director of Planning and Performance										
Purpose of the report	In line with NHS Improvement Annual Planning requirements and Licencing conditions, NHS Foundation Trusts and NHS Trusts are required to complete annual self-certifications of compliance against a number of governance requirements. This summary report provides an overview of the requirements and the Trust's position against each declaration.										
Action required:	Approve	x	Assurance	x	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

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

- Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence (Appendix 1, section 1&2)
- Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Appendix 1, section 3)
- Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Appendix 2)
- Corporate Governance Statement (Appendix 3 FT4 declaration)

The Board received an overview of the Trust's Annual Planning Programme at the April Board of Directors meeting, outlining the key requirements within the NHSE/I '2021/22 Priorities and Operational Planning guidance', the Trust's position against these requirements and future plans to meet any outstanding gaps. The 2021/22 planning requirements include:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.

The Trust Final Annual Operating Plan is attached for review and agreement. The Trust's plan will be submitted to the ICP for collation into the overarching ICS Annual Operating Planning submission, which will be submitted on 3 June 2021.

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

One area highlighted at risk within the Annual Operating Plan for 2021/22 includes the consistent delivery of the Cancer 62-day referral to treatment standard, due to the impact of COVID-19 and continuous impact of patient choice, complexity of pathways and system pressures outside the organisation's control, however recognising the robust governance structure the Trust has in place to monitor and manage pathways.

The COVID-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non-elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to, affect performance against key access standards in 2021/22.

The Trust has commenced work across the Integrated Care Partnership/Integrated Care System to address both recovery and overall performance delivery as a system, working collaboratively to address the capacity issues compounded by the backlog associated with the COVID pressure.

Following the interim financial management arrangements, which were implemented during 2020/21, the Trust reported a surplus position in 2020/21 and as a consequence, made a significant contribution to the financial position across both the ICP and ICS. These arrangements (system enevlopes) will continue for the first six months of 2021/22. The funding associated with the system envelopes has been agreed and subsequently, allocated to the four organsaitions within the ICP. In order to deliver a breakeven position across the ICP, the Trust is expected to deliver a £3m surplus in the first six months of 2021/22. With regards to the second half of the financial year, the ICP / Trust is awaiting further guidance / outcome of the financial settlement (between DHSC and Treasury).

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

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

27 May 2021

Annual Operating Plan 2021/22 and Annual Self-Certifications

Report of the Director of Planning and Performance

1. **Introduction/ Purpose**

1.1 In line with NHS Improvement Annual Planning requirements, NHS Foundation Trusts and NHS Trusts are required to complete annual self-certifications of compliance against a number of governance requirements, in line with Licencing conditions.

1.2 This summary report provides an overview of the requirements and the Trust's position against each declaration.

2. Key Highlights/ Issues/ Risks

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

- Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence (Appendix 1, section 1&2)
- Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Appendix 1, section 3)
- Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Appendix 2)
- Corporate Governance Statement (Appendix 3 FT4 declaration)

2.2 General Condition 6 requires the Board to review and declare that, in the financial year most recently ended, the Trust (Licensee) took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. See Appendix 1.

2.3 Condition 7, Continuity of Services, requires that the Board have a reasonable expectation that the Trust (Licensee) will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to within the declaration, 2020/21. See Appendix 1.

2.4 Certification on training of Governors requires the Board to review and declare compliance that it is satisfied that during the financial year most recently ended, 2019/20, that the Trust (Licensee) has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. See Appendix 2, Training of Governors.

2.5 The Corporate Governance Statement requires the Board to review and declare that it is satisfied that the Trust (Licensee) applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Corporate Governance Statement requires evidence of compliance against a number of key criteria, to support assurance of self-certification. See Appendix 3, FT4 declaration.

3. Key Challenges

3.1 One of the key areas highlighted at risk within the Annual Operating Plan for 2021/22 includes the consistent delivery of the Cancer 62-day referral to treatment access standard, due to the impact of COVID-19 and the continuous impact of patient choice, complexity of pathways and system pressures outside the organisation's control, however recognising the robust governance structure the Trust has in place to monitor and manage pathways.

3.2 The COVID-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non-elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to, affect performance against key access standards in 2021/22.

3.3 The Trust has commenced work across the Integrated Care Partnership/Integrated Care System to address both recovery and overall performance delivery as a system, working collaboratively to address the capacity issues compounded by the backlog associated with the COVID pressure.

3.4 Following the interim financial management arrangements, which were implemented during 2020/21, the Trust reported a surplus position in 2020/21 and as a consequence, made a significant contribution to the financial position across both the ICP and ICS. These arrangements (system enevlopes) will continue for the first six months of 2021/22. The funding associated with the system envelopes has been agreed and subsequently, allocated to the four organsaitions within the ICP. In order to deliver a breakeven position across the ICP, the Trust is expected to deliver a £3m surplus in the first six months of 2021/22. With regards to the second half of the financial year, the ICP / Trust is awaiting further guidance / outcome of the financial settlement (between DHSC and Treasury).

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

4. Annual Operating Plan 2021/22

4.1 The Board received an overview of the Trust's Annual Planning Programme at the April Board of Directors meeting, outlining the key requirements within the NHSE/I '2021/22 Priorities and Operational Planning guidance', the Trust's position against these requirements and future plans to meet any outstanding gaps. The 2021/22 planning requirements include:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.

4.2 The Trust Final Annual Operating Plan is attached for review and agreement. The Trust's plan will be submitted to the ICP for collation into the overarching ICS Annual Operating Planning submission, which will be submitted on 3 June 2021.

5. Conclusion

5.1 Due consideration has been given against each of the Self-Certifications, based on the 2020/21 performance and the forecast pressures for 2021/22, taking into account the on-going operational pressures, however alongside the mitigating actions that have been put in place to improve the position in 2020/21.

5.2 The individual Self Certifications have been completed, providing evidence of assurance where necessary, with the aim to declare compliance against each of the declarations for the periods of 2020/21 and 2021/22, as applicable.

5.3 The Final Annual Operating Plan will be submitted to the ICP in line with the agreed timescales, following which it will be collated into an ICP plan and submitted to the ICS for collation into the overarching ICS Annual Operating Plan by 3 June 2021.

6. Recommendations

The Board of Directors is asked to note:

- Due diligence has been paid by the Board of Directors in assessing on-going compliance with governance requirements, specifically those illustrated in regular seminars and committee discussion, in line with the NHS Provider Licence Conditions;
- the requirement for the Board of Directors to delegate responsibility to the Chairman to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board; and
- The Final Annual Operating Plan 2021/22 which will be submitted to form part of the ICP Plan and the overarching ICS Annual Operating Plan.

Prepared by:

Neil Atkinson	**Director of Finance**
Barbara Bright	**Director of Corporate Affairs and Chief of Staff**
Lynne Taylor	**Director of Planning and Performance**

Appendix 1

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2020-21

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

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

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

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

Confirmed — OK

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

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

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

OR

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

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

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

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

The Covid-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway, in line with the Annual Operating Planning requirements, to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to affect performance against key access standards in 2020/21.

The Trust has commenced work across the Integrated Care Partnership/Integrated Care System to address both recovery and overall performance delivery as a system, working collaboratively to address the capacity issues compounded by the backlog associated with the Covid pressure.

Following the interim financial management arrangements, which were implemented during 2020/21, the Trust reported a surplus position in 2020/21 and as a consequence, made a significant contribution to the financial position across both the ICP and ICS. These arrangements (system envelopes) will continue for the first six months of 2021/22. The funding associated with the system envelopes has been agreed and subsequently, allocated to the four organisations within the ICP. In order to deliver a breakeven position across the ICP, the Trust is expected to deliver a £3m surplus in the first six months of 2021/22. With regards to the second half of the financial year, the ICP / Trust is awaiting further guidance / outcome of the financial settlement (between DHSC and Treasury).

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

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

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

Signature		**Signature**	
Name	Neil Mundy	**Name**	Julie Gillon
Capacity	Interim Joint Chair	**Capacity**	Chief Executive
Date	27 May 2021	**Date**	27 May 2021

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

Appendix 2

Worksheet "Training of governors"

Financial Year to which self-certification relates | 2020-21 | Please Respond

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Neil Mundy	**Name**	Julie Gillon
Capacity	Interim Joint Chair	**Capacity**	Chief Executive
Date	27 May 2021	**Date**	27 May 2021

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

A

Appendix 3

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2020-21**

Corporate Governance Statement (FTs and NHS trusts)

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

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board of Directors certifies on-going compliance with the governance condition, via the Corporate Governance Statement, using performance against governance indicators, financial performance, exception reports and third party information to test the certification. The Board of Directors effectively planned and assessed risks for 2021/22, with the continued risk of underachievement against the 62 day referral to treatment cancer standard anticipated by the Board of Directors, linked to the on-going impact of the Covid Pandemic. The Trust has recognised the consistent delivery of cancer standards continues to present a risk and as such has declared this within the Annual Plan for 2021/22. The Trust is focussed on the recovery of activity across both elective and non-elective pathways, post the impact of the Covid pandemic, aiming to eliminate all long waiters by the end of March 2022. The recovery of all access standards remains a key priority of the organisation. The Trust is fully engaged in system working, with significant input into the development and delivery of the ICS Annual Operating Plan for 2021/22. Post the Covid pandemic, the Trust has developed robust recovery plans to ensure both elective and non elective pathways are delivered, taking into account the wider system pressures and the need to support equitable access to services for the local population, recognising the impact of the high levels of deprivation across the locality. The risk of financial delivery is on-going and has been captured within the 2021/22 Annual Plan. The Trust continues to work closely with partners across the ICP and ICS (as well as, representatives from NHSE/I), to ensure continued delivery of robust financial plans. The delivery of these plans will continue to be given appropriate scrutiny and oversight by the Board. The plan currently contains risk associated with the delivery of CIP, and the plan is aligned with system enevelope assumptions; however, the wider ICP plan does also include identified system risk. In order to address the system risk, the Trust, and its partners have agreed to work collaboratively to address these financial pressures and will work closely to identify system solutions that will enable both provider and commissioner to meet their financial obligations for 2021/22. This demonstrates the commitment of the Trust to work collaboratively within the Integrated Care Partnership and support the wider system returning to financial balance.
			The Board of Directors gains assurance from a number of sources and assurance mechanisms as follows: Internal and external audit plans which cover a full range of audits; Annual Governance Statement; Head of Internal Audit Opinion; Integrated performance report to the Board of Directors covering quality, performance, workforce and finance; Board Assurance Framework reported quarterly to the Board of Directors' Risk Management Strategy.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	There are no risks identified with this statement, the Trust has due regard to guidance when issued by NHS Improvement.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a robust governance structure with a locally agreed committee structure under the Board of Directors which are over and above those required in statute. This ensures that members of the Board are more closely involved in the governance of the organisation and are closer to assurance on the quality of services (clinical and non-clinical). Each committee has terms of reference which clearly articulate the purpose, responsibilities, accountabilities, reporting lines and delegated authority they have been given by the Board to carry out work on its behalf. Minutes of the individual sub-committees are reviewed within the Board of Directors meeting. The Board agenda focuses on the key areas of quality, strategy, performance and governance; reports, along with minutes of committee meetings are presented on a regular basis. The terms of reference are reviewed on a regular basis to ensure effectiveness and this will continue in 2021/22. Significant work has been undertaken during 2020/21, which will continue in 2021/22, in order to create the capacity, capability and leadership required to fulfil the future ambitions of the organisation through the Care Group Operating Model, with robust support from corporate services and functions. This will make the Trust sustainable and an enabler to drive the vision, deliver the strategy and the Long Term Plan. A number of documents outline the accountabilities, responsibilities and reporting lines including: Well led external review with on-going internal self-assessment CQC Inspection reports The Trust's Constitution Standing Financial Instructions Scheme of Delegation Sub-Committee terms of reference
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	This has been an unprecedented year due to COVID-19, during the year the Trust has continued to ensure robust governance in respect to financial decision-making in order to support the management, grip and control of expenditure, this will continue in 2021/22. The Trust was placed into segment 3 within the Single Oversight Framework risk assessment in 2018, with enforcement actions in place aligned to the Trust's financial deficit position and strategy. The enforcement undertakings relating to finance were subsequently removed in 2019/20. During 2020/21 the Trust moved from segment 3 to segment 2 following the removal of enforecement undertakings for strategy, demonstarting an improved overall position. In 2020/21 the Trust reported a £9.38m surplus which was significantly ahead of plan for the year end, as well as, making a significant contribution to the ICP/ICS . The delivery of the continued improved financial position is due in part to the robust Financial Management Performance Framework and Capital Performance Framework, that has operated during 2020/21 which has maintained 'grip and control' over the financial position. The Trust has engaged effectively with NHS Improvement during 2020/21. The Board has timely and effective oversight receiving monthly/quarterly reports via the Corporated Integrated Performance Report which was reviewed and redesigned in 2020 to adopt an integrated approach across Compliance, Quality, Workforce and Finance, reflecting the NHSI Single Oversight Framework, Lord Carter Model Hospital review, contract metrics, and internal reporting requirements, together with key objectives. Due consideration is given to both positive and negative variances and progress against monthly, annual and in year improvement targets. The revised report has been developed in Yellowfin and provides detailed trend analysis, presented in SPC format, with additional commentary provided within the report outlining supporting underlying narrative of the Trust's position. The Board is also provided with sufficient information in respect to the Single Oversight Framework and the Trust position in relation to segmentation and use of resources. The Trust has a robust Risk Management process in place, which is supported through a standardised Board Assurance Framework, with each Corporate risk monitored through the individual Board sub committees and the overall Trust governance structure. The Board and its sub-committees receive timely information in accordance with its scheduled cycle of business and will scrutinise performance. Performance is also reported to the Council of Governors and Governors are provided with an opportunity of holding the Non-Executive directors to account for the performance of the Board. Following a Care Quality Commission (CQC) inspection in November 2017, the Trust received an overall rating of 'Good' across all elements (previously rated as 'Requires Improvement). The Trust is now progressing to an 'Outstanding' rating and there is a strong focus on continuous learning and quality improvement at all levels throughout the organisation. Internally the focus is on 'Excellence as our Standard'. The trust proactively supports a culture of innovation and improvement with a number of initiatives being driven from the frontline staff.
			An independent external Well Led review was undertaken by the Good Governance Institute and reported to the Board in October 2018. The review concluded that the organisation is a well-led Trust, with Executive Directors complemented by a number of experienced Non- Executive Directors who work well as a team. There are effective governance arrangements and a satisfactory system of internal control in place, both of which are fit for purpose and operating effectively. The review observed cohesive leadership from the Chief Executive and Chair, and a professionally run Board with high potential. There was evidence of the Trusts investment in leadership and the strong Board-level visibility and access across the Trust. The review highlighted a positive and patient centred culture, which was well embedded throughout the organisation and at Board level, with clear vision and values. There was strong recognition of the unified, patient focussed, governance and leadership embedded within the organisation. As part of the review ten recommendations based on findings against the key lines of enquiry was identified, with a Board development programme implemented to address these. During 2020/21, a review has been undertaken against well led statements by considering each key line of enquiry (KLOE) in order to provide self-assessment and an overarching trust level response. The collection and collation of qualitative information linked to underpinning evidence will support the identification of further improvements and the development of action plans that will feed into to the trust response for a future external review. The Trust has a robust Business Planning cycle in place, which supports the development and delivery of Directorate Business Plans, and in year service delivery. The Business Planning process has been reviewed by internal audit and received 'Good Assurance'. Operational delivery of business plans is monitored through the Care Group Director's meetings in-year, with appropriate oversight and scrutiny by the Chief Operating Officer and the Director of Planning and Performance. Trust financial performance delivery is monitored though the Executive Team and from an ICP perspective, systeme performance is monitired theough the ICP DoFs / CFOs fortnightly meeting. Governance of compliance with Licence conditions is managed through the Board of Directors and Council of Governors, with assurance provided through the reporting structure outlined above. Evidence to support this statement include: Well led external review Constitutional documents Internal Audit plans, reports and opinion Risk Management Processes Board and Sub-Committee meetings cycle Safer staffing reports Financial performance reports to the Board and Sub-Committees Performance monitoring process and review by the Care Groups Annual Report, Quality Report, Annual Accounts and Annual Governance Statement Leadership Walkarounds
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust has continued to review and focus its attention on the management of strategic risks, which is supported by the Risk Management Strategy and Board Assurance Framework, which drives the Board's agenda. Board sub-committees and other high-level groups who have defined responsibilities and accountabilities for risk management are in place for the escalation of risks from the front line, through governance channels, to the Board of Directors. Overall decisions in relation to prioritisation of corporate risk issues and resource allocation are taken by the Board of Directors, with delegation of decisions relating to specific risks to sub-committees or the Executive Team as appropriate. This features highly in the planning round to deliver the Annual Operating Plan and the Board of Directors ability to self-certify. In 2020/21 the Board of Directors further reviewed the strategic direction in line with the North East and North Cumbria Integrated Care System objectives and the alignment of operational delivery. This included a refresh, reframe and development of the Corporate Strategy to ensure it is fit for the future and incorporates system wide integration and financial delivery, reflecting all external influences accordingly. In April 2019 a new operating model was introduced, with Care Groups replacing the traditional acute services model providing a new and innovative approach to pathway delivery outside the historical specialty level management. This model is now firmly embedded and has provided the opportunity to review how services are delivered through collaborative working both internally and across the community with local authority partners. This is supported by three executive team members taking on the role of 'Locality Director' for the local authority areas served by the Trust, with a focus on delivering the strategic objectives, partnership opportunities and place based planning. The Board of Directors has a range of skills, experience maturity and expertise to deliver the key objectives.Where capacity is a risk an infrastructure of support has been considered and agreed. The Board of Directors has a track record of making intelligent decisions and tackling risks to clinical, operational and financial stability in a proactive and timely manner. The Well Led principles have been reassessed throughout the Trust and key areas of development supported to fit the strategic agenda.

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	A number of changes took place during 2020/21 in the need to support the challenging and changing environment in which the Trust is operating, with consideration given to the senior level structure going forward to ensure the organisation has the necessary capacity and capability to deliver whilst also ensuring continuity and stability of service provision. The Care Group structure and operating model which was introduced in 2019, became fully embedded, reflecting the direction of travel and radical shift away from a traditional acute hospital model in its ambition and responsibilities. Changes implemented included the: • Appointment to the role of Chief Nurse/Director of Patient Safety and Quality with effect 1 November 2020; • Appointment to the 3 Care Group Director roles due to retirement and promotion of incumbent postholders: • Appointment of Chief Executive Advisor on a fixed term basis to support the Chief Executive and senior team in progressing the ambitions of the organisation and the wider system activity and collaborative arrangements; • Chief Information and Technology Officer (CITO) continued for a further 12 months in the role of Chief Digital Officer (CDO) for the Integrated Care System (ICS) for the North East and North Cumbria region, whilst maintaining his CITO role within the Trust. Appointment to a number of posts were through internal organisational change processes, which has meant a broad and strong organisational knowledge, experience and intelligence has been retained and transition has been easier to initiate in practice. The Chief Executive Advisor and Care Group Director: Responsive Care were external appointments, which provides opportunity for new insight and perspective to be brought into practice, whilst recognising and learning from experience and expertise gained from the wider health sector. To ensure capacity, capability and continuity of service provision, the Board of Directors and Executive Team have been supported in 2020/21 by a robust programme of development, which will continue into 2021/22. The Board recognises the benefits of development and taking the time to debate and discuss the impact of governance, legislative matters and future challenges, from both a national, system-wide and local perspective. At Non-Executive level the term of office of a number of postholders came up for review in 2020/21. The tenure of the Chair and four Non-Executive Directors were extended for a further term. In addition, early in 2021, the Chair of the Trust and Chair of South Tees Hospitals NHS Foundation Trust advised they would stand down from their respective roles with agreement reached to appoint a Joint Chair across both organisations to support partnership and provider collaboration. This was endorsed by both Council of Governors with an Interim appointment agreed for 6 months whilst recruitment to the substantive post is undertaken. It is anticipated that the substantive appointment will be made in June 2021.
			The Trust ensures that on appointment and thereafter on an annual basis it undertakes assessment of continued fitness for the role by completion of the fit and proper person test and declaration. This applies to Non-Executive and Executive Directors, as well as other senior staff. In addition, for senior staff that require registration with a professional body, this information is checked on an annual basis to ensure on-going validation. There remains a challenge to the organisation with the recruitment of staff to some specialities, however recruitment plans continue to be developed in order to address any gaps and discussions are continuing are taking place across the Integrated Care System and Integrated Care Partnership in looking at collaboration and network approaches.

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

Signature **Signature**

Name Neil Mundy **Name** Julie Gillon

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

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North Tees and Hartlepool NHS Foundation Trust
Planning submission

2021/22 Priorities and Operational Planning: Narrative Submission Template

29 March 2021 v1.0

1. Introduction and overview

This narrative submission is intended to provide additional information against numerical plans and further detail to support national and regional assurance. Systems should be developing their own local delivery plans to address each area.

ICSs should set out;

- Where appropriate, the actions and assumptions that underpin the trajectories within the activity and workforce numerical submissions;
- other critical actions that systems will take over the next 6 or 12 months to address the priorities set out in 2021/22 priorities and operational planning guidance and in section 3 (elective recovery), section 4 (health inequalities) and section 5 (maternity) of 2021/22 implementation guidance.

Further instructions to support completion are set out within each section of the template.

2. Submission process

Draft and final plans should be submitted at ICS level, using this template to the appropriate regional planning mailbox (see contacts at section 4) by;

- Draft submission: 12noon Thursday 6th May
- Final submission: 12noon Thursday 3rd June

3. Summary of sections

Ref	Section of 2021/22 priorities and operational planning guidance	Response Required Against: Numerical Plan	Response Required Against: Priorities A F
A	Supporting the health and wellbeing of staff and taking action on recruitment and retention	Yes	Yes
B	Continuing to meet the needs of patients with Covid-19	No	Yes
C1	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service	Yes	No
C2	Restore full operation of all cancer services	Yes	No
C3a	*Expand and improve mental health services [incorporated in section A.]*	No	No
C3b	Expand and improve services for people with a learning disability and/or autism	Yes	Yes
C4	Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review	No	Yes
D1	Restoring and increasing access to primary care services	No	Yes
D2	Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities	Yes	Yes
E1	Transforming community services and improve discharge	Yes	Yes
E2	Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	Yes	Yes
F	*Working collaboratively across systems to deliver on these priorities [no requirement for narrative submission]*	No	No
	Other areas outlined within implementation guidance		
	Elective Recovery Framework: Gateway Criteria		
	Health Inequalities: 5 priority areas		

4. Contacts/queries

Any queries relating to this submission and template should be directed to your regional planning leads. Contact details below;

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe2021operplan@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
A1 Looking after our people and helping them to recover	1. Continuing promotion of the carryover and buyback schemes. 2. Encouragement of individuals and line managers to ensure annual leave is used through the financial year, which promotes regular periods of rest for our staff. 3. Promote and evaluate psychological support, with the aim to continuously improve the offer to staff. This includes exploring building on the support provided via TEWV during the pandemic. 4. Continue to work with ICS in relation to system wide offer to staff from a health and wellbeing perspective. 5. Mental Health First Aider Training is now in place for staff, with a plan to roll out plan to all Managers as part of the Health & Well Being offer to our people. 6. Dedicated space for staff to relax away from the workplace in the form or Rainbow Rooms on both hospital sites. 7. Immediate access to mental health support for staff and self-referral 'fast track' process in place for physio / MSK support for staff 8. Pathway for Long COVID developed which is available to staff who would benefit from the assessment and support available. 9. Continue to work with individuals and manager to maximise uptake of the vaccine and ensure active promotion continues on high risk areas. Robust governance in place in relation to reporting on vaccine data.

	10. Work collaboratively across the ICS in exploring potential of enhancing the staff network offer to our staff from a protected characteristic perspective. 11. Collective promise continues to be an integral part of our health and wellbeing of staff agenda, with actions discussed at internal committees. 12. Work collaboratively across the ICS in relation to the overarching psychological support provided to the people employed across the region
A2 Belonging in the NHS and addressing inequalities	1. Further promotion and development of the staff networks for protected characteristic groups. 2. Implementation of cultural ambassadors across the Trust to ensure staff are supported culturally when going through a formal process. 3. Continue to review the recruitment processes and training to ensure fairness, equity, diversity is recognised and encouraged, with no implicit bias 4. Share and learn from local Trusts with regards to equality and diversity best practice, including exploring pooling resource 5. Regular review and challenge of WRES/WDES actions at Board/ Executive level. 6. Health needs assessment to take place with staff (physically and mentally) in order to ensure the health and wellbeing offer is fit for purpose. 7. Review the outcomes from the long Covid staff questionnaire, again to ensure the health and wellbeing offer is accurate and regularly reviewed. 8. Recruitment and selection training to be reviewed in light of the initial learning from cultural ambassador training.
A3 Embed new ways of working and delivering care	1. Healthroster to be rolled out within theatres over the next 6 months.

	2. Plans for Obstetrics, gynaecology and paediatrics to move onto Healthroster from 1st April – providing better control and visibility, especially with short notice movement of clinics. 3. CLWrota used in anaesthetics to schedule consultant sessions, wish to roll out to surgery, orthopaedics etc., to ensure compatibility and efficient scheduling for the MDT 4. There is potential to improve the use of e-job planning for some service areas i.e. MSK based upon current model used with medical workforce 5. E job planning for specialist nursing in progress 6. Continue to work collaboratively across the ICP to encourage neighbouring Trusts to partake in the pilot to maximise benefit 7. Continue to work collaboratively with regards to developing further the clinicians passport to include other staff groups 8. Continue to implement and embed job crafting across the Trust and ICP. 9. Commitment to continue actively engaging in the ICS activity currently ongoing in relation to the 6 work streams. 10. Further development of the Trust support worker approach to ensure our professional workforce is supported and patient care and experience is enhanced 11. Embed and evaluation the impact of the First Contact Practitioner model across the Primary Care Networks building on the Additional Roles Reimbursement Scheme funding 12. Continue to explore any further joint appointments that can be made across the organisations to support the develop Tees Valley Clinical Services Strategy underpinned by the Managed Clinical Network approach
A4 Grow for the future	1. Continue liaison with ICP workforce lead and workforce sub group

	2. In liaison with the workforce lead across the ICS develop a coherent workforce plan and associated education strategy in line with our clinical services strategy and workforce plan 3. Develop competency based approaches to role development to begin to break the traditional workforce approach 4. Maintain the annual workforce planning review as a combined effort with planning and performance team, finance, care groups and corporate teams 5. Development of alternative roles to support care group transformation 6. To continue to push on collaborative health and social (and mental health) generic workers to support multitude of patient requirements. 7. Continue to explore alternative workforce models and roles as part of the workforce planning processes. 8. Continue to work with the newly established Sunderland Medical School to increase the number of Doctors in Training (DiT) 9. Teaching and training has resumed in all specialties with modifications to accommodate social distancing – such as addition of opportunities to join teaching virtually using Microsoft team. Alternative, larger rooms have been identified to allow for social distancing to accommodate teaching and training. 10. Rotations are continuing as normal. ARCP is going as planned with some modifications made to specific requirements set by the UK Foundation programme. .

Please summarise the key assumptions that underpin the numerical workforce plan submissions listed below, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned workforce levels where these are not set out above, including recruitment and retention, use of bank and agency, redesign of teams and roles, deployment across sectors and/or organisations and sickness absence.	
Primary Care	
Assumptions	
Actions	*[Specifically including key actions to address ARRS recruitment and GP recruitment and retention.]*
Risks and issues	
Acute, Community and Ambulance	
Assumptions	• Numbers are based on forecasted demand • Focus on recovery and, as result, sustainability of the workforce to enable this to happen (impact on ability to build in efficiencies) • The trust has assumed recruitment to current vacancies with the maintenance of the below target turnover rate
Actions	• Implementation of alternative workforce models • Continued development of the health and wellbeing offer and support to our workforce • Exploration and commitment to work collaboratively across the ICs/ICP • Implementation of staff employment passport

	• Workforce working additional hours, overtime to address recovery • Risk of a further wave of the pandemic
	[Please outline how systems have considered their Mental Health LTP strategy and commitments to complete this workforce collection, and summarise how the workforce assumptions made as part of the Mental Health Workforce submission link to the system's recovery of delivery of the Mental Health LTP and response to Covid-19.]

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

B. Continuing to meet the needs of patients with Covid-19

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
Preparations for any future potential surge requirements for Covid patients	Although we are working as a provider to restore a level of delivery that will ensure that patients are seen in a timely manner, both from, a backlog and new referral perspective, we cannot underestimate the potential impact any further surge would have upon this recovery. In order to mitigate the impact we will continue to deliver services being mindful of social distancing in all of our waiting areas, supported by virtual consultations where appropriate. The continuation of the green pathways on the Hartlepool site to ensure that we can maintain and increase activity on this site. There will be a continued adherence to all Infection Prevention Control measures currently required and an appropriate response made to any new guidance. The organisations received capital funding to support changes in estates in support of patient flow and provide the ability to manage at pre – covid levels, circa £3m allocation across the ICP. **Hospital@Home** • The service has reverted to carrying out as much of initial assessment over phone as possible prior to face to face review • Continue to assess and treat those patients requiring exacerbation management from base at University Hospital of Hartlepool with touch base in Lawson street, Stockton • Support given to patients to remain at home to reduce hospital admissions. • Palliative care support to patients displaying Covid symptoms to remain at home and not be admitted to hospital where appropriate **Integrated Airways Team** • Work is being undertaken to bring together an integrated, multidisciplinary and multi-skilled respiratory team who are able to deliver a speedy and safe response to meet the needs of the population across Stockton and Hartlepool • **Long term condition management clinics:**

	• Telephone review only when deemed urgent
	• Asthma d/c bundles to continue for admissions of asthma to facilitate d/c: virtual call to ward
	
	• **Pulmonary Rehab**
	  • Where feasible continue virtual pulmonary rehab classes to prevent further deconditioning
	  • Minimal initial assessments: urgent patients only
	  • Home visits where deemed appropriate to minimise bring patients into hospital/clinical setting wherever possible
	
	• **Regional support.**
	Virtual COVID Ward. Potential to collaborate with South Tees around a Tees Valley offer. This was not implemented during wave 2 as number of patients did not warrant service, however, this could potentially be available during any future surge
	
	• **Home oximetry**
	  • H&SH to provide the oximetry @ home service
	
	• **Oxygen clinics**
	  • New patient assessments and urgent appointments only in One Life
	  • Telephone contact with those requiring review where clinically appropriate
	  • Stockton new patients offered assessment at One Life to release staff within acute COPD team
	
	• **Respiratory Support Unit (RSU)**
	
	The introduction of the RSU aims to have a safe and effective Respiratory model that improves escalation and capacity through the development of a Respiratory Support Unit, supported through a Respiratory Patient Pathway. The project focusses on a number of key actions which include;
	  ○ Developed an SOP for escalation and capacity which includes NIV, CPAP and COVID related patients,
	  ○ Developed a high level options paper to review estate options and immediate work requirements i.e. additional oxygen points to prepare for winter pressures,
	  ○ Developed a proposed workforce model which includes a staff to patient ratio specifically for the RSU,

	○ Developed a full skills and education package for Respiratory training, commencing with basic respiratory training and moving up to NIV and CPAP. • **Critical Care** As part of the development work across the Tees Valley Clinical Services Strategy, the Critical Care work stream has focussed on developments for both the short, medium and longer terms options for CC service delivery. This programme of work has reviewed the options for manage a surge in the critical care requirements through a collaborative approach, including capital requirements for the shortfalls across the Tees Valley. The option appraisal will be presented to Clinical Services Strategy Board on 28th April, with a joint business case under development. • **Operating Model** A review is being finalised in terms of outlining the Trust's future clinical delivery model, supported by revised bed model, appropriate patient flow, underpinning pathways, triggers of escalation, Infection prevention control measures etc. in response to the impact of changes implemented as part of the organisational response to Covid.
Provision of timely and equitable access to Post Covid Syndrome ('Long Covid') assessment services.	• Post/ Long COVID pathway developed in collaboration with CCG, Primary Care, TEWV and IAPT. This includes a Multi-Disciplinary Team clinic. One clinic per week currently in place with plans in place to respond to an increase in demand through an additional clinic. The service can move to telephone/virtual consultations if required. • Exploring options to mitigate reduced lung function testing capacity through provision of clinic cabins

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

C1. Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service

Please summarise the key assumptions that underpin the activity plan submission, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.

<table>
<tr><th colspan="2">Elective Spells</th></tr>
<tr><td>Assumptions</td><td>

In line with the Annual Operating Planning Guidance requirements, Elective activity will be recovered as follows, as a minimum;
This is above the required trajectories and subject to the relevant ERF funding allocations being made available to the ICS
As part of the ICS bid to be accepted as one of the ERF accelerator systems, actual delivery may be above these initial trajectories

<table>
<tr><th></th><th>April</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Sept</th></tr>
<tr><td>Inpatient</td><td>75%</td><td>85%</td><td>90%</td><td>95%</td><td>95%</td><td>95%</td></tr>
<tr><td>Day case</td><td>75%</td><td>80%</td><td>90%</td><td>90%</td><td>95%</td><td>95%</td></tr>
</table>

No 52-week waiters by December 2021 subject to Priority 5 & Priority 6 (patient choice to delay pathway) review with system, with the stretched aim to reduce all specialties to a maximum of 40 weeks as soon as possible.
In line with the work being undertaken by the Regional Chief Operating Officers work is focussed on orthopaedics and ophthalmology.

As outlined above, the Trust is aiming to recover at a faster pace, with the aim to support this through the Elective Recovery Fund, linked to meeting the Gateway criteria. The Trust’s position against the Gateway criteria is as follows:

Clinical validation of waiting list and long waiters

Throughout the pandemic, our patients on the waiting list were actively managed based upon clinical priorities through a daily prioritisation clinical meeting
The Trust will continue with the established a clinical prioritisation process to allocate ‘P’ categories to all patients waiting for a procedure

</td></tr>
</table>

- Patients are informed of any decisions relating to WL position, with direct communication to discuss the individual patient pathways

- RTT WL is continually reviewed and tracked to ensure quality is maintained in the accuracy of data

- The Trust is working towards the delivery of the RTT Waiting list MDS for submission to NHSE/I, which will support central oversight of the waiting list position

- The Trust has commenced the clinical validation of the Diagnostic waiting list, with progress already made during the Covid Pandemic.

- Diagnostic surveillance patients have been clinically reviewed and managed, in line with national guidance.

Addressing Health Inequalities

- The Trust recognises that there is a high incidence of deprivation across the population it serves. For example, within the localities 36.2% of Hartlepool population, 20.8% of Stockton on Tees and 18.5% of County Durham population live in the most deprived areas. The Trust has commenced initial analysis of the waiting list by Ethnic Category and deprivation decile to assess the equity of access for patients. As an example, 37% of Hartlepool residents on the Trust's waiting list live in the highest deprivation decile. This information will used to review if adjustments need to be made to the WL recording and management, with a further phase to ensure that other risk factors i.e. social isolation, are monitored to reflect equity of access, with the aim to embed associated support mechanisms to ensure all our patients can appropriately access our services.
- The next step for this development to ensure continued equitable access by using this data to ensure we make every contact count ensuring that we are not only responding to the patients' health needs but promote discussion that takes a holistic view of the person.

- The organisation now has the full PTL broken down into deprivation decile and ethnicity

- The Trust believe that collaboration with primary care to manage prioritisation at the point of referral will, ultimately, be the best way to identify the depth of inequality early in clinical pathways.

	System Led Recovery • Trust Waiting List extract ready to submit to NHSE weekly to enable central oversight of WL position • NHSE/I oversight of IS activity utilisation • Trust continues to work with Nuffield to utilised commissioned lists • Cancer Cell in place to monitor management of cancer waiting list, both diagnosis and treatments • Chief Operating Officer network overseeing key principles for the delivery of system waiting list recovery, which will feed into ICP Annual Operating Plan **People recovery (see section A)** • The Trusts plans include a full programme of health and wellbeing measures to support staff recover, alongside the requirement to return to business as usual post the pandemic pressures. This includes annual leave monitoring and buy back option, mental health support and breakout facilities for staff to use to relax and reframe during break times.
Actions	1. Full review of theatre efficiency and productivity to be undertaken to ensure best use of theatre resource, including provision of weekend lists. 2. Exploring 4 hour versus 5-hour theatre sessions to ensure best utilisation of sessions and potentially increasing the number of sessions over a 12-week period. 3. Exploration of a potential redesign of theatre templates to support level loading throughout the year, which will lead to an increased output within existing resources. 4. Exploration of additional physical theatre estates opportunities. Current estate is inflexible and therefore limits output i.e. recovery areas. 5. Continued review and prioritisation of waiting lists to ensure all capacity is focused and shaped around the current demand linked to, clinical priority, subspecialty and longest waits. 6. Further develop a system approach to tackling significant over 52 week waiters across ICS/ICP

	7. Understand Provider backlog by specialty aligned to a full understanding of system capacity by specialty 8. Complete weekly waiting list submissions 9. Continue to provide offers of support to South Tees as part of Tees Provider Collaborative, linked to the work being carried out by the COO ICS network, offering specific support in regard to Orthopaedics 10. Working as a system to achieve a maximum of 40-week wait across all specialities, patient choice notwithstanding. 11. Clinician discussion between referrer, the provider and with the patients who are unwilling to attend hospital, falling into Priority categories 5 and 6, to ensure all avenues are reviewed to support patient to attend. 12. Preliminary discussions are being held with mental health colleagues to consider how an acute mental illness may affect a patient's willingness or ability to positively engage with care, including elective procedures. This will improve joint working to support people with a learning disability or mental illness to seek and engage in treatment.
Risks and issues	• System backlog • Over recovery by the Trust is absorbed into the ICS position, therefore access to the ERF is at risk. • Workforce • No growth identified in the activity modelling • Equitable access

Outpatients

Assumptions

	April	May	June	July	August	September
Outpatient Trajectories	80%	85%	90%	95%	95%	95%

- Adjustment made for the BOSS bowel screening with the removal of 2,700. Following the NHSE decommissioning of this service it is shown on the waterfall under policy changes
- Profile for advice and guidance based on 2021/22
- Virtual appointments will meet the 25% requirement by March 2022

Actions

Transforming outpatients

- Work is on-going across outpatients to fully embed the innovations initiated during the pandemic including:
- Virtual appointments
- Patient Portal is under development as part of Great North Record to support patient direct access to appointment management
- PIFU being reviewed, initially as part of cancer stratified follow-up

1. Continue with advice and guidance with clear outcomes measures
2. Improve infrastructure to support the continued delivery virtual appointments
3. Education to Primary Care in regards to referrals pathways, options and feedback loops
4. Out-patient Administration Review
5. OPD Performance Dashboard

	6. Electronic Room Booking 7. Work continues to develop the Estates Strategy, including the development of a Community Hub in each of the localities. The hub will provide people with access to IT for video consultation with support in place for people who are unable to utilise technology, with the option to scope out an offer of IT training for the local community aligned to our Education and Training 8. Making Every Contact Count (MECC) is being implemented within the Trust in a phased approach, with Active Hospital being Phase 1 within outpatients, related specifically to physical activity. Learning from Phase 1 will inform roll out to ward areas and wider elective and non-elective pathways.
Risks and issues	Unknown referral backlog in primary care, due to patients not presenting during Covid
Diagnostic Activity	
Assumptions	• Working at 100% of pre-Covid capacity • Return to 99% of diagnostics seen within 6 weeks • Bowel screening – plans in place to meet the age range extension **Endoscopy** • Fit testing pre endoscopy increase • Endoscopy recovery assumes 100% utilisation of Saturday lists

	• Referrals assumed to remain at current levels • Close links with the learning disability team to support any patients attending bowel screening & endoscopy services. This may include walking through the journey pre attendance and the provision of any reasonable adjustments which can ensure the best outcome for the patient • Information leaflets available in various formats e.g. large print, braille, different languages to ensure patients/carers are fully informed of service
Actions	1. Development of the Community Diagnostic Hub as part of the broader ICP work 2. Continued engagement in the development of the rapid diagnostic pathways across the ICP 3. Access to the screening programmes will continue to be actively monitored and targeted health promotion takes place within the low take up localities, which tends to coincide with the high deprivation areas 4. Previous contact made with the local Mosque to collaborate with community leaders to promote bowel-screening services. This was on hold during COVID but will be reinstated as soon as guidance allows 5. Continue to promote attendance to bowel screening services engagement with the local population through twitter, facebook etc. A walk though video of endoscopy services/screening shows the department is COVID minimised, services are continuing and it is safe to attend 6. Refresh of the website to provide additional information to support engaging with the local population 7. Continue to monitor full RTT pathway which is broken down into deprivation decile and ethnicity

Risks and issues	• Workforce to support full diagnostic recovery • Potential impact of future Covid pressures i.e. 4th wave • Patient engagement in health promotion campaigns

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

C2. Restore full operation of all cancer services

Please summarise the key assumptions that underpin the activity plan submission, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels. (Note: this submission is not designed to replace the single comprehensive delivery plan for cancer that Cancer Alliances have been asked to develop on behalf of their respective ICSs. Systems will want to engage with their Cancer Alliance to inform this submission).

Urgent cancer referrals	
Assumptions	• The Trust was successful in gaining Cancer Alliance funding over the next 2 years to support cancer improvement, including resources to support Personalised Stratified follow-up and cancer navigators to enhance pathway management alongside the clinical teams • Continued engagement in the development of the rapid diagnostic pathways across the ICP • The Trust will return treatment numbers to pre Covid levels, taking into account changes in Cancer Waiting Times guidance i.e. TURBT no longer counted as a treatment in Urology • 62 day backlog will reduce to pre-Covid levels • Referrals return to pre-Covid levels
Actions	• Work collaboratively with GP's to support an efficient pathway management for cancer referrals • Continue to work with South Cancer Cell to manage equitable access to diagnostics and treatments • Work with Cancer Alliance to review and develop sustainable cancer pathways across the ICS i.e. Breast Symptomatic services
Risks and issues	• Increase in referrals coming through once patient return to Primary Care

	• Patients presenting at later stage therefore more complex • Sustainability of some Cancer services across the ICP/ICS including Breast and Urology due to workforce gaps
Cancer treatment volumes	
Assumptions	• The Trust has made good progress in restoring its cancer services, including reducing extended waits, fully re-instating screening services, with plans in place to meet extension of the Bowel screening programme, the commencement of colon capsule endoscopy and achievement of the 75% stretch target for faster diagnosis within 28 days. • The cancer treatment volumes have been modelled based on all cancer treatments being fully re-instated, in line with clinical guidelines. • The Trust continues to work collaboratively within the South ICP cancer cell, treating clinically prioritised and long waiters in the first instance. • Cancer surgery continues to be given priority within the theatre schedules, with the Trust planning to fully utilise the allocated IS capacity to support the overall elective programme of work. • Cytosponge – we were not selected to be in the first phase but will possibly do at a later date • Colon Capsule Endoscopy is currently under development with training and equipment purchase supported by the NCA. • • Locality approach to development of Rapid Diagnostic pathways for Upper GI and Vague Symptoms

Actions	• Priority P2 and P3 including diagnostics and treatment • Sustain additional weekend list in endoscopy • Option to offer cervical smears to women who attend for other conditions/reasons. Generically qualified support staff to support • An ongoing discussion with Trust colleagues in the South ICP to develop and implement a digital Patient Tracking List to help support the management of patients on cancer pathways. These discussions have included Edge Health, to develop a bespoke solution that can be used across the organisations in the ICP region to better plan the care delivered through these pathways
Risks and issues	• Increase in referrals coming through once patient return to Primary Care, with potential presentations at a later stage impacting on treatment volumes • Impact of vaccination programme and lack of uptake in certain communities. Working alongside partner organisations to support appropriate advice and communication campaigns
Patients waiting 63 or more days	
Assumptions	• The Trust currently has approximately 71 patients on an urgent 62 day pathway (as at the end of March), indicating a downward trend. • Returning cancer services to pre-covid, with an expectation the number of people waiting for longer than 62 days to the level reported in February 2022 (n=69) and referrals and treatments returning to normal levels by March 2022. • The Trust is fully engaged in the Cancer Alliance programmes of work to recover cancer pathway delivery.

	• As outlined above, the Trust continues to work collaboratively within the South ICP cancer cell, treating clinically prioritised patients and long waiters in the first instance.
Actions	• Return to 62 day pre-covid levels • Daily PTL management of cancer pathways supports the identification of the long waiters, with appropriate escalation as required. • Closer working with system to support patients who need MDT, specialist intervention. • Continue to work with the South ICP cancer cell to ensure equitable access to treatments for the highest clinical priority patients • Internal Cancer recovery groups with each Tumour group to support developments and priorities in rapid diagnostics, personalised care and stratified follow up
Risks and issues	• Increase in referrals coming through once patient return to Primary Care, with potential presentations at a later stage impacting on treatment volumes • Vulnerability of some cancer services across the ICP/ICS, working collaboratively to review vulnerable services (e.g. oncology/haematology) to support new working models including development of Advanced Practitioner roles and use of technology to support interconnectivity and access for improved access, turnaround times and outcomes.

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

C3b Expand and improve services for people with a learning disability and/or autism

Please set out the specific actions that, as a system, you will prioritise over the next 12 months to address the objectives below	
Make progress on the delivery of annual health checks and improve the accuracy of GP Learning Disability Registers	*[Please set out a summary of the key actions you will take in 2021/22 to improve the identification of people with a learning disability in GP practices and to improve uptake of annual health checks]*
Reduce reliance on inpatient care for both adults and children with a learning disability	*[As part of your submission please provide a summary of your investment plan for 2021/22 to increase the capacity of intensive, crisis and forensic community services for children young people and adults at risk of admission to mental health inpatient care* *For local systems confirmed as Keyworker Early Adopters sites, please also set out your plan for ensuring that all children and young people at risk of admission on the dynamic support register or who are in mental health inpatient care settings will have an allocated keyworker by the end of Q2 2021/22]*
Implement 100% of the actions coming out of LeDeR reviews within 6 months of notification	*[Please set out details of your local LeDeR governance system for monitoring the completion of LeDeR reviews and implement actions from learning from LeDeR reviews]*

Please summarise any additional key assumptions that underpin the activity and performance plan submission, highlighting any key risks and issues.	
AHCs delivered by GPs for patients on the Learning Disability Register	
Reliance on Inpatient Care for Adults with a learning disability, autism or both	
Reliance on Inpatient Care for Children with a learning disability, autism or both	

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
Pandemic recovery - recovering the full maternity care pathway	• Full maternity pathway remained in place throughout Covid and will continue to be managed appropriately through any future surges. • During the pandemic some Community Midwifery staff relocated out of buildings that closed due to Covid, however with a long term solution implemented
Confirmation that Local Maternity Systems have a plan in place, agreed with their ICS to deliver the maternity transformation priorities for 2021/22 in line with the timings set out in section 5 of the implementation guidance	The Trust has carried out a full gap analysis against the Ockenden review, with a full supporting action plan in place for any areas that can be further improved. No significant risks identified. • Plan and develop Continuity of care teams to deliver 51% of care by named midwife. Target date March 2022 • Foetal monitoring midwife appointed to post, to collaborate with Consultant lead to develop improvement programme to support recommendations of Ockenden • Support Maternity Voices Partners and professionals to co-produce services and develop partnership • Development of FFT via text system to support gathering of feedback from service users to improve services • Benchmark service mandatory training and validate through the LMS following guidance in relation to further training required • Evidence required to support audit/Risk assessment. This will be supported through a local ICS project to support an Electronic system to support data and audit collection of evidence • Participate with regional plans Northern England Maternal Medicine Network • Develop Trust web site to support patient information in line with Ockenden
How Local Maternity Systems will improve their governance and how ICSs will	• **Enhanced Safety:** All maternity SI reports (and a summary of the key issues) are shared with the Trust Board, alongside the local LMS for scrutiny, oversight and transparency.

strengthen their oversight of Local Maternity Systems	Mandatory 3 monthly return. The local LMS will develop processes for scrutiny, oversight and transparency. • **Listening to Women and Families:** Trusts must create an independent senior advocate role, which reports to both the Trust and the LMS Boards. The LMS Board will develop processes for this. • **Staff Training and Working Together:** Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence is externally validated through the LMS, 3 times a year. LMS will develop a process for this to be done

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

D1 Restoring and increasing access to primary care services

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below	
Getting practice appointment levels to appropriate pre-pandemic levels	*[Please include a summary of the key assumptions that underpin the activity plan submission, highlighting any key risks and issues.]*
Maximising clinically appropriate dental activity	

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below	
Expansion of smoking cessation services	The Stop Smoking Service adapted to a virtual model quickly in response to Covid and resultant closure of community smoking clinic venues. Telephone consultations and reviews were initiated with the purchase of additional telephone headsets and marketing material to promote this method. Following service user evaluation, this has now become the most preferred method of delivery, and will therefore remain a large part of the Stop Smoking offer. To expand the service further and with further investment there are a number of opportunities to support our local population to live healthier lives: • An educational programme for schools would aim to tackle the issues of smoking at an earlier age with a focus on prevention • More promotional events throughout the borough will highlight the benefits of stopping smoking with The backdrop of Covid and associated respiratory issues • Have a bigger presence at food banks and charitable organisations to support deprived areas • A bigger push to offer workplaces a telephone offer to support local workers to quit smoking • Support Change Grow Live (CGL) to offer a stop smoking service outside of the Stockton Borough • Support pharmacies to return to offering a stop smoking service as a high priority. For all of this to be realised more funding/investment will be need within the service.
Improved uptake of the NHS diabetes prevention programme	The Diabetes Prevention Programme is Primary Care based and, as such, our Specialist Diabetes Service is not involved in this. However, during Covid the numbers waiting to attend our structured education programmes such as DESMOND (Type 2 Education) and HATT1E (Type 1 education) have grown and created an increased waiting list, which we are now in a position to deliver again, both virtually and Face to Face. However to expand the delivery of the virtual sessions admin support will be required and a small resource of IT equipment (tablets) that can be loaned to the public to enable access to virtual sessions.

	The diabetic pregnancy service for gestational diabetes has significantly expanded during Covid, which has led to an increase in referrals by around 50%. This has resulted in some capacity issues within the service. For management of gestational diabetes, it is anticipated that this additional input for gestational diabetic patients, who require OGGT and management, will continue. Historically the Obstetrics and Gynaecology nurses managed this; however, since Covid this has now transferred to the diabetes service. During Covid, more capillary glucose monitoring (CGM) are required, initiating increased use of technologies for monitoring. Often there are around 30 patients in each clinic and additional clinics have been put on where possible, however limited by staffing resource. To be sustainable moving forward this will require at least one WTE Diabetes Specialist Nurse. Through the Care Group collaboration, the Trust is actively reviewing pathways of care and service delivery to support health prevention. For example, the multi-disciplinary approach to diabetic foot management across community and secondary care services is reducing the amputation rates across the population and patients as patients presenting late are typically affected by co-morbidities that can affect their daily lives.
Progress on CVD prevention	Prior to COVID the CHD team were part of a regional working group looking at how to develop rehabilitation across Cardiac, respiratory and stroke. One of the focuses of this group was to look at increasing choice and uptake by looking at the possible barriers to uptake and considering different approaches, however resources have been a barrier to progress. COVID provided an opportunity to explore this further as, due to social distancing restrictions, the exercise component of cardiac rehabilitation could not be delivered. Telephone support and virtual classes were started using Attend Anywhere. This was limited to very small groups of three, however allowed the staff to train and become competent in the systems. This is now moving to Microsoft teams to allow larger group sizes. This has proven very successful and ideal for people who struggle with transport or do not like group environments. To support this service going forward, the directorate have converted a pulmonary rehab bay at the Hartlepool site. A 70-inch TV and several pieces of equipment have been purchased to allow this to be the base for the future cardiac pulmonary rehabilitation.
Progress against the LTP high impact actions to support stroke, cardiac and respiratory care	**Enabling more people with heart and lung disease to complete a programme of education and exercise based rehabilitation.**

	The service lead for CHD and Pulmonary Rehab have been working on putting together a pilot of cardiac pulmonary rehabilitation, which was stalled due to COVID, but is now progressing. The new 'rehab suite' will be ready to start hopefully with patients by June. The suite will be used for virtual, face-to-face and functional assessments. Regionally no areas are providing cardiac pulmonary rehab; therefore, we aim to deliver this service first. There is an excellent opportunity to build this into higher intensity, resistant training and functional capacity. **Digital transformation will enable us to make big strides towards forging a lifelong relationship between people and the NHS**. Alongside the face-to-face contacts that remain important to many people and for many conditions, people will be able to use technology to access and interact with health and care services seamlessly. Virtual classes, would also like to use MYHEARTAPP this is a cost of £50 per license it can be used for heart failure patients also which would be an excellent tool for both **Multi-disciplinary teams as part of primary care networks will better support people with heart failure.** Better, personalised planning for patients will reduce in hospital stays and reduce drug spend. The focus on keeping people at home was never more important than during Covid. The CHD service procured funding for training for REACH HF, which is a national rehabilitation programme home, based programme devised for heart failure patients. The Trust have negotiated 8 staff trained and 60 manuals. The manuals cost £30 each; therefore, this will be an on-going revenue implication.
Expansion of NHS digital weight management services	Not applicable
Please summarise the key assumptions that underpin the personalised care activity plan submission (personal health budgets, personalised care and support planning, social prescribing unique patient referrals), highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.	
Assumptions	

Actions	
Risks and issues	

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

E1 Transforming community services and improve discharge

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objective below	
Deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days	1. Commitment to a programme of rotation for in hospital wards with staff to spend some time with Out of Hospital Care services to improve understanding of what support can be provided in the community. 2. Enhanced Care project is underway to improve utilisation of this resource inclusive of the transition from hospital to community. Engagement with system partners has commenced. This will realise a system benefit if successful but should also reduce LOS in hospital. 3. Frailty co-ordinators in place to manage pathways across front of house, base wards and discharge. 4. Criteria to reside audits utilised to focus on the long stay patients 5. Hospital@home 6. A phased approach is being adopted to establishing PCN social prescribers within pathways. Phase 1 has been agreed with partners and will take place within the integrated MSK service and community respiratory service providing a platform to upscale to include other pathways 7. There is a programme of work underway across adult and children & young people services, learning from the Trust's Active Hospital Pilot regarding data collection and taking a Population Health Management approach to the planning and delivery of services.

Please summarise the key assumptions that underpin the 2 hour crisis community health 12 month activity plan submission highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.	
Assumptions	Vision established to deliver on the 2-hour crisis community response. This includes: • Expanding Clinical Triage from 8-8, 7/7 to 24/7 offer. This has been piloted as part of winter/ COVID response, however the 2000-0800 element continues unfunded at this time. This will be reviewed through the 2021/22 budget allocation process. • Bed bureau process now includes Clinical triage to support potential to manage people via alternative pathways to admission. • Holdforth Hub workforce reconfiguration from a bed based model to also support patients on the Discharge to Assess (D2A) / Home First pathway. This includes step down from hospital, step across from ED and step up from community crisis. Ability to support three people in any given 24- hour period.
Actions	1. Clinical triage out of hours is now collocated with urgent Care on the Hartlepool site as we aim to develop an MDT approach to out of hours provision with an ability to escalate / include primary care & / or Advanced Nurse Practitioner / Nurse Practitioner in decision making. The out of hour's infrastructure referenced links to Out Of Hospital District Nurses, Home First/D2A, telecare, etc. 2. **Requirement to secure funding for Discharge to assess** delivery for up to 10 people in any 24-hour period. This is an area that will continue to develop as awareness and confidence in the pathway increases across the system. Resource is required to deliver on the activity aligned to system funding stream. Longer-term expectation is a swap out of beds and associated costs with a shift of resource to community infrastructure; however, this requires full feasibility assessment.

	3. At present, additional therapy resources have been allocated into the iSPA to ensure MDT representation across an extended period each day, 7/7 to aid assessment and decision making to improve pathways for patients. This has stretched resource from the CIAT / patient facing roles, therefore presents a challenge in terms of maintaining appropriate responsiveness to people accessing community services with varying levels of need. Long term resource requirements will be reviewed to support this additional resource. 4. Requirement to secure funding for 7/7 Community matron model.
Risks and issues	• Continued funding for the continuation of the D2A to support 10 patient in a 24 hour period

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation
E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	
Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objective below	

Continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes	• Patients who 'walk in' to the service are reminded for the future that by contacting NHS111 they will be given an allocated time to attend if they require urgent care • Over 50% of patients who attend the Trust's Urgent Care units come in via 111 into a booked slot. The Trust has a well-established 'Talk before you walk' communication across the urgent and emergency care services, in alignment with NEAS. • Three slots available each hour via EDDI (Emergency Department Digital Integration), need to be involved in an audit with NHS111 in the future re the number of patients who were expected via EDDI into ED and were safely streamed to Urgent Care. • Monitor impact of DOS going live on capacity / demand. • Evaluate impact of pushing the call through iSPA/ Clinical triage as gatekeeper to services feeding into iSPA rather than having multiple services published on the DOS. • Same Day Emergency Care (SDEC) – Pre Covid, the Trust treated circa 30% of emergency patients within a zero length of stay, with well-established ambulatory care pathways in place, delivered through dedicated emergency assessment units across medicine and surgery. • Capital investment to the front of house has enabled patient flow to be managed at a pre pandemic level
Roll out of the Emergency Care Data Set (ECDS) to all services	*[Please include commentary on the readiness and ability to capture 'Ready to Proceed' and the ability to monitor time to initial assessment and 12 hours from time of arrival.]* • The Trust was one of fourteen A&E pilot sites for the revised emergency care standards, including the delivery of the ECDS, therefore is already delivering on this objective. • The Trust is in a position to report against the above standards, with the exception of the 'Clinically Ready to Proceed' within the Type 1 A&E department. This requires an amendment to the Trakcare system to support the recording of the data items; however, work is in progress to address the issue. However, this measure can be delivered for the urgent care activity recorded on SystmOne.

	• Urgent care activity equates to a significant proportion of the activity seen within the organisation, circa 70%.
Please summarise the key assumptions that underpin the UEC activity plan submission highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.	
A&E attendances excluding planned follow ups	
Assumptions	• Assumes that it flexes back to 19/20 (without growth). • Baseline taken and increase to 19/20 levels 5% increments
Actions	Further work on the 111 utilisation of booked slots Ensure the Clinically Ready to Proceed standard can be recorded and reported within the Type 1 facility.
Risks and issues	
NHS 111 referrals to SDEC	
Assumptions	
Actions	• Evaluate impact of pushing the call through iSPA/ Clinical triage as gatekeeper to services feeding into iSPA rather than having multiple services published on the DOS.
Risks and issues	

System name:	North East & Yorkshire – North Tees & Hartlepool NHS Foundation

Elective Recovery Framework: Gateway Criteria

To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports the requirements in sections C1 and C2 of the planning guidance and the five objectives listed in the accompanying implementation guidance. Please set out the specific actions that, as a system, you will take to meet the gateway criteria below:

Addressing health inequalities	*Plans should take due regard of the need to reduce pre-pandemic and pandemic related health inequalities using related waiting list data that is embedded within system performance frameworks to measure access, outcome and experience for BAME populations (and those in the bottom 20% of IMD scores)* Population health needs are at the forefront of the Trusts clinical service strategy and operating model. Local health needs assessments are identified within the Health & Wellbeing Strategies across the Tees Valley and County Durham; The Trust has identified executive leads for each of the localities who ensure good communication links and a cohesive approach to different locality health needs. This includes membership of the Health & Well Being Boards (HWBB) for each locality and developing relationships with PCNs and primary care. The Trust employs a public health consultant and is expanding the PH team to support collaborative work with primary care and DPHs and inform the targeting of services to those at greatest risk. Further work is required to ensure that the PHE health equity assessment tool (HEAT) and HEAT e-learning is promoted and informs the development of local approaches. The Trust continues to work proactively with partners (commissioners, LA, voluntary sectors, hospital user group) to incorporate key standards that reflect local needs. This is any area the Trust will build upon going forward. Work has commenced to develop a Health Inequalities Group within the Trust, which will oversee the work to support addressing health inequalities, ensuring that all strands are brought together. This group will ensure links with the National and regional work, ensuring that the organisation can learn from work undertaken in other areas and access any funding available to support this development. The access to the high level dataset from National, Regional and local level and work alongside the Regional Team in the National development of a Dashboard.

	• Further work has commenced to understand the wider composition of the waiting list, mapping individual patients to deprivation and ethnicity. This analysis will be assessed to ensure equitable access to services is being managed appropriately. • Once finalised, the information will used to review if adjustments need to be made to the WL recording and management • The Trust is working with ICP and ICS planning leads to develop system wide plans to address reducing overall waiting times, based a set of key principles, with a focus on the high priority areas of Orthopaedics and Ophthalmology. • System wide waiting list- at COO level, COOs leading this work, linked to recovery, more about prioritising patients within the system rather than an actual shared PTL •

Transforming outpatient services	*Plans should embed outpatient transformation, taking all possible steps to avoid outpatient attendances of low clinical value and re-deploy capacity where needed. Specifically, plans should; demonstrate that Patient-Initiated Follow-up (PIFU) is being implemented and scaled up across at least three outpatient specialities; show that uptake of Advice and Guidance or similar models is being increased; ensure that telephone or video consultations are typically being used for at least 25% of outpatient attendances; and provide evidence that concrete progress is being made to be able to capture and report full quantitative data on the above within the first half of 2021/22.*
	
	• Work is on-going across outpatients to fully embed the innovations initiated during the pandemic including:
	  ○ Virtual appointments
	  ○ Advice and Guidance
	• Patient Portal is under development as part of Great North Record to support patient direct access to appointment management

	• PIFU is under review, with some specialties already utilising a PIFU type model i.e. Gynaecology Oncology and MSK services. PIFU will be further rolled out across appropriate specialties, initially as part of cancer stratified follow-up. • Advice and Guidance is well embedded within the organisation with circa 550 referrals per month dealt with through A&G. The Trust continues to promote the A&G service with primary care stakeholders. • Outpatients Healthcall project in place across a number of specialties. • Development of enhanced proactive health promotion across OPD, using MECC as a vehicle for health promoting conversations. This will help provide opportunity to our population to access additional support and supports a system approach to addressing health inequalities. • Establishing a Video Consultation steering group to improve ensure that anyone who wants a video consultation and is clinically appropriate is able to have one. • Taking a place based approach to digital inclusion, with key partners • Work completed last year during COVID integrate MSK, pain and rheumatology services to meet NHSE vision of better MSK health, ensuring that only patients are seen in the right place at the right time for their MSK condition
System led recovery	*Plans should ensure that Patient Tracking List (PTL) management is undertaken at a system level and that all capacity (including IS) is being used to the benefit of the whole-system population.* • Trust Waiting List extract ready to submit to NHSE weekly to enable central oversight of WL position • NHSE/I oversight of IS activity utilisation

	• Trust continues to work with Nuffield to utilised commissioned lists • Cancer Cell in place to monitor management of cancer waiting list, both diagnosis and treatments • Chief Operating Officer network overseeing key principles for the delivery of system waiting list recovery. • Commenced the work with NHSE/I with weekly data submission • IS activity and used to date with 6 list per week in line • Validated waiting list all patients clinically categorised by 'P' codes • Refresh of Trakcare training to input and waiting list management is supported
Clinical validation, waiting list data quality and reducing long waits	*Plans should ensure ongoing clinical validation and shared decision making between patients and clinicians as well as maintain a continuous focus on waiting list data quality* • The Trust has established a clinical prioritisation process to allocate 'P' categories to all patients waiting for a procedure • Patients are informed of any decisions relating to WL position • RTT WL is continually reviewed and tracked to ensure quality is maintained in the accuracy of data • There are also plans to pilot a health coach/health improvement practitioner within outpatients to support patients and upscale this depending upon its success.

People recovery	*Plans should demonstrate how the health and wellbeing of staff will be monitored, including through an appropriate set of measures, and that the rate of service restoration takes account of the need for individuals and teams to recover from what they have been through and consider the wider workforce capacity available.* **People recovery (see section A)** • The Trusts plans include a full programme of health and wellbeing measures to support staff recover, alongside the requirement to return to business as usual post the pandemic pressures. This includes annual leave monitoring and buy back option, mental health support and break-out facilities for staff to use to relax and reframe during break times.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	NHS Resolution Maternity Incentive Scheme – Year 3										
Date:	27 May 2021										
Prepared by:	Elaine Gouk, Consultant Obstetrician & Gynaecologist Stephanie El Malak, Head of Midwifery										
Executive Sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality										
Purpose of the report	This report provides an update to the Board of Directors in relation to the recent self-assessment of the Trust's maternity services in respect of the ten maternity safety actions specified in NHS Resolution's Maternity Incentive Scheme - Year 3.										
Action required:	Approve	x	Assurance		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		Well Led		

Executive Summary and the key issues for consideration/ decision:

- NHS Resolution (previously the National Health Service Litigation Authority) now employ a Maternity Incentive Scheme, which has the specific aim of raising safety standards within maternity services.

- The scheme requires the payment of circa an additional 10% premium on the Trust's Clinical Negligence Scheme for Trusts (CNST) payment. Acute Trusts that subsequently demonstrate that they are compliant with all ten of the maternity safety actions specified in NHS Resolution's Maternity Incentive Scheme are eligible to recover the additional contribution, and to receive a share of any unallocated funds. There is no partial repayment for the achievement of less than all ten of the actions.

- Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Compliance against the ten safety actions has been assessed by the senior Obstetric a Gynaecology clinical team and the collective opinion is that **the Trust are compliant with seven the ten maternity safety actions**. Whilst work is ongoing in the 3 non-compliant safety actions, th is no acknowledgment for partial compliance.

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

This report outlines work undertaken by the Obstetric and Gynaecology team to enable compliance with seven of the ten maternity safety actions. The safety actions are deemed by NHS Resolution to promote safer care. It follows therefore that the work undertaken to achieve compliance with seven of the ten safety actions is in line with the Trust's drive to reduce clinical

risk and incidents. There are improvement plans to work to achieve the standards where full compliance has not been achieved in three of the ten safety actions	
Committees/groups where this item has been discussed	Internal meetings within Healthy Lives Care Group.
Recommendation	The Board of Directors are requested to approve the Chief Executive signing the Board Declaration Form, confirming they are satisfied that the Trust's maternity services are compliant with seven of the ten maternity safety actions cited in NHS Resolution's Maternity Incentive Scheme – Year 3. If approved, share the content of the Board Declaration with commissioners and submit the Board declaration form to NHS Resolution by noon on 15th July 2021.

North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

27 May 2021

Trust progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

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

Strategic Objective*:* Putting Our Population First, Valuing People, and Transforming our Services.

1. Introduction

1.1 NHS Resolution (NHSR) is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), to continue to support the delivery of safer maternity care. The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNST MIS contributions were not taken in April 2020 as would otherwise have occurred.

1.2 With the delay in the funding element of the Maternity Incentive Scheme in 2020/21, contributions into the incentive fund and distributions from it will be carried out in 2021/22 as per the usual timeframes.

1.3 As in year two, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds.

1.4 Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

1.5 The Maternity Incentive Scheme requires the Trust's maternity services to provide a Report to the Trust Board in which there is evidence of the position against each of the 10 safety actions. It also requires that the Board give permission to the Chief Executive to sign the declaration form, after the contents of the declaration have been discussed with the Commissioners, confirming that the Board are satisfied that the evidence provided demonstrates compliance with the required standards. The signed Board declaration form is required to be submitted to NHS Resolution Maternity Incentive Scheme by 12 noon on 15th July 2021.

1.6 This paper provides an update to the Board in relation to the compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions.

2. Background

2.1 NHSR has published the Maternity Incentive Scheme for the third year running. This scheme for 2020/21 builds on previous years to evidence both sustainability and ongoing quality improvements. The safety actions described if implemented are considered a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025.

2.2 The maternity service has assessed itself against the current Maternity Incentive Scheme safety standards.

3. Current Position

3.1 The reporting period for Year-3 of the CNST Maternity Incentive Scheme was deferred by NHSR due to Covid-19.

3.2 Therefore, this report shows the status, which includes the ongoing impact of Covid-19 in relation to achieving the actions.

3.3 Overall, the Trust has achieved full compliance in seven out of the 10 Safety Actions. There is partial but not complete compliance in three of the 10 Safety Actions.

The list of supporting evidence documents for each of the safety actions is included in Appendix 2.

4. The CNST Incentive Scheme Maternity Safety Actions

<u>Safety Action 1</u> Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

A multidisciplinary review team in 100% cases has completed a review, using the Perinatal Mortality Review Tool (PMRT), within four months of death. In all cases, the parents were informed that a review would take place and they were invited to submit questions from their perspective or raise any concerns, to be considered in the review.

Although the trust are compliant with the review of cases, which meet the criteria for a PMRT review, a report has not previously been submitted to the Trust Board of Directors on a quarterly basis. A report, standard template, has now been developed and this will be submitted to the Trust Board Maternity Safety Champion.

Safety Action 1 - Partially Met.

<u>Safety Action 2</u> Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The organisation can demonstrate data submission to the MSDS to the required standard**.**
NHS Digital has confirmed that the MSDS data quality achieved the required mandatory criteria.

Safety Action 2 - Met.

<u>Safety Action 3</u> Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal Units (ATAIN) Programme?

Transitional care is delivered on the postnatal ward and the activity is captured and coded. There is an agreed pathway, which has been developed with support from maternity and paediatric departments. There are improvement plans in place for further development of the service model for the transitional care services to support the ATAIN Programme and these have been shared with the Local Maternity System Board, the Maternity and Neonatal Champions and the Neonatal Operational Delivery Network (ODN).

Throughout the Covid-19 pandemic, the Trust's Special Care Baby Unit (SCBU) participated in regular (weekly/fortnightly/monthly/bi-monthly) virtual meetings with representatives of all units within the neonatal network and network leads to discuss any occupancy and staffing issues and discussed plans for escalation if required. The meetings were also used to identify and share learning from other ODNs. We were aware of an increase in neonatal complications resulting from Covid-19 from other ODNs. This is not reflected in the admissions seen throughout our unit or the Northern Neonatal Network. There was no noted increase in neonatal admissions, because of Covid-19 in our Unit.

On an ongoing basis, any unexpected term admissions to the SBCU are reviewed at the local risk management meetings, to determine any common themes and learning points. The minutes are shared within staff members across the department so that lessons are disseminated.

Safety Action 3 - Met.

<u>Safety Action 4</u> Can you demonstrate an effective system of clinical workforce planning to the required standard?

The organisation has achieved the Anaesthetic Clinical Services Standards (ACSA) listed in the Maternity Incentive Scheme and the Neonatal medical workforce standards for a Special Care Unit.

The nursing staffing on the Special Care Unit Staffing is based on the British Association of Perinatal Standards (BAPM) at an 80% occupancy level, which is one nurse to four babies within the unit. To be fully compliant there is a requirement for a supernumerary team lead to be incorporated into the current establishment and an action plan has been developed (Appendix1).

Safety Action 4 - Met.

<u>Safety Action 5</u> Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The service has a BirthRate+ staffing report for the midwifery establishment and clear guidance on monitoring staffing and escalation plans. A delivery suite acuity tool enables the organisation to identify when escalation to increase Midwives is required to support the shift leader to be supernumerary. There is an active plan for recruitment.

Supernumerary Coordinator and fully established to BirthRate+ board paper has been presented by the Deputy Chief Nurse July 2020 and March 2021. Staffing levels remained safe and non-clinical staff and NHSP were used to staff shortfall due to Covid 19

Safety Action 5 - Met.

<u>Safety Action 6</u> Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?

The Saving Babies' Lives care bundle is designed to tackle stillbirth and early neonatal death. It brings together five elements of care that are recognised to reduce risk: reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; effective fetal monitoring during labour; reducing pre-term birth. The Trust participates in the Perinatal Institute's Growth Assessment Protocol using customised fundal charts.

Element 1:
Carbon monoxide monitoring remains suspended due to the Covid-19 pandemic, however, this is due to resume shortly. Audits are undertaken to assess the patients smoking status at booking and 36 weeks' gestation. The audits identify 100% of patients have a smoking assessment undertaken and recorded in the health care records.

Element 2:
A risk assessment to identify pregnancies at increased risk of developing fetal growth restriction (FGR) is undertaken at the time of booking. This is recorded in the handheld records. Development of the electronic handheld records and the rolling out of BadgerNet, will allow future electronic recording and auditing of those women identified with risk factors for FGR. Audits of babies low birth weight babies are undertaken. All women with a body mass index >35kg/m^2 are offered serial scans for growth from 32 weeks of gestation.

It is recommended that a uterine Doppler is undertaken at 24 weeks of gestation if the pregnancy is identified at risk of FGR. The training plan to upskill staff, paused due to Covid-19 has been reinstated.

Element 3:
Women are provided with an information leaflet at booking about reporting reduced fetal movements and audits are undertaken to assess women's awareness. Women presenting with reduced fetal movements have a cardiotocograph (CTG) to assess fetal wellbeing. On the maternity day unit, computerised CTG assessments are undertaken.

Element 4:
All maternity midwifery and medical staff receive training on fetal monitoring as part of the departmental multidisciplinary mandatory training. The maternity department has also acquired the fetal monitoring modules of the K2 Perinatal Training Programme for further training in intrapartum fetal surveillance. A Fetal Wellbeing Lead Midwife has been appointed and will take up post in May 2021 and will specialise in the CTG training for staff.

Element 5:
A risk assessment is undertaken at booking to identify women at increased risk of preterm birth. There is a dedicated preterm prevention antenatal clinic on each site and access to cervical length scan assessment. There is monitoring of the compliance with steroids, magnesium sulfate and birth in the appropriate setting reported through the Neonatal ODN.

Safety Action 6 Partially Met.

<u>Safety Action 7</u> Can you demonstrate that you have a mechanism for gathering service users feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services?

There is an established process for involving patients and feeding back to patients involved in serious incidents or who complain. There is a Maternity Voices Partnership (MVP) with actions and feedback and involvement at the Maternity Engagement Group. During the Covid-19 pandemic, a regional group and a local group was developed through the LMS. Following the local Maternity Survey 2019 an action plan has been completed and during the Covid-19 pandemic, although the National maternity survey was suspended, a local survey was conducted, with the results being compiled recently. The MVP have posted information for women of Black, Asian and Minority Ethnic (BAME) backgrounds via social media channels and information is available on the Trust website.

Safety Action 7 Met.

<u>Safety Action 8</u> Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

There is a programme for multiprofessional training in the management of obstetric emergencies as part of the mandatory training. The programme has been modified due to Covid-19 and has continued. There is a mandatory training package available to staff with the department. This includes an E-learning package, which was developed during the Covid-19 pandemic. Resuscitation and Neonatal Life Support training is also offered to staff, and as the Covid-19 pandemic is ongoing, staff are offered to attend Covid-19 in situ training. There is an ongoing training action plan in place to continue to achieve compliance.

The Trust Board is committed to facilitating delivery of local, in-person multidisciplinary training.

Safety Action 8 Met.

<u>Safety Action 9</u> Can you demonstrate that the Trust safety champions (obstetric, midwife and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

There is an established schedule for the Trust's Maternity and Neonatal Safety Champions to meet bi-monthly with the Board level champion to discuss local issues, local quality improvement projects and national or regional initiatives or reports. In addition, the Trust's Board level safety champion has regular meetings with the Head of Midwifery.

There is a Maternity and Neonatal Safety Champions Pathway outlining how staff can share safety intelligence from floor to Board and through the Local Maternity System and maternity safety networks.

The implementation of Continuity of Carer and the action plan has been discussed with the Board level champion.

The organisation has supported engagement in the Maternity & Neonatal Safety Improvement Programme (MatNeoSIP) and the work was presented at the annual National MatNeoSIP Learning Event in March 2020 and Regional meeting in March 2021.

A Non-Executive Director Maternity Champion has been appointed. In addition to the bi-monthly champions' meetings, a schedule for the Board level champion monthly walk-around in the clinical areas is in place to enable direct communication with staff and service users. A safety dashboard to include the actions taken following issues raised by staff or service users is being developed.

Safety Action 9 Partially Met.

<u>Safety Action 10</u> Have you reported 100% of qualifying cases to HSIB (for 2019/20 births only) and reported under NHS Resolution's Early Notification (EN) scheme?

The Trust can demonstrate that 100% of qualifying 2019/20 incidents under NHS Resolutions Early Notification Scheme were reported.

The Trust has a clear process for managing any case that qualifies for the NHS resolution Early Notification Scheme, which includes compliance with the duty of candour regulations. Two cases qualified for the NHS Early Notification Scheme and HSIB in the 2019/2020. One patient engaged with HSIB, however, the other case declined any involvement.

Between the timeframe of October 2020 and March 2021, there have been no reported cases. There is an established process for incident review and reporting within the Trust with a summary of serious incidents being presented at the Patient Safety and Quality Standards Committee along with quarterly reports of all incidents, including claims and complaints.

Safety Action 10 - Met.

5. Recommendation

The Board of Directors are asked to give delegated authority to the Chief Executive to sign the Board declaration form confirming they are satisfied that the evidence provided to demonstrate compliance with seven of the maternity safety actions, meets the standards of the Maternity Incentive Scheme.

Elaine Gouk
Clinical Director Obstetrics & Gynaecology
On behalf of

Lindsey Robertson
Chief Nurse/Director Patient Safety and Quality

Appendix 1: Special Care Unit Nursing Workforce Action Plan

Plan: DH toolkit Service(s): Healthy Lives Ward/Department: Paediatrics Developed by: V Whitfield/J Atkinson

Date (including revisions): January, June 2020, May 2021

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue: *These actions should be agreed within SMART principles.*	Date action initiated:	Responsibility: *Individual names of identified staff who have agreed to complete the action.*	Date to be evaluated:	Evaluation Status / Progress Update. ***Where monitoring shows no improvement/change in practice, additional actions should be added with timescales for completion and further evaluation.***
1	Boards must ensure there is a strategic multi professional staffing review at least annually (or more frequently if service changes are planned or quality or workforce concerns are identified), which is aligned to the operational planning process. In addition a mid-year review should provide assurance that neonatal services are safe and sustainable. This should assess whether current staffing levels meet the recommended levels and are likely to do so in future.	• Strategic annual multi professional staffing review • Neonatal care is delivered primarily by suitably qualified and trained nurses and medical staff, supplemented by allied health professionals (AHPs), working as a team to offer the highest possible standards of care. • Staff need to be available in sufficient numbers and with sufficient knowledge, experience and training to offer safe, effective care to babies and their families as part of a cohesive MDT where and when required.	Jan 2020	SCM	Annually	**Date-Jan 2020** discussed with SEM, JA and SP. Action plan created to meet safe staffing. Currently utilising ANNP's, HCA competency programme and trainee ANNP's. Permanent ward matron appointed **On-going .** **22/6/20** yearly workforce review completed. 5.3 WTE needed to provide correct work force. Finance to be obtained and KS will raise this at board level **On-going** **14/4/21** Next workforce review due July 2021. BAPM compliance continues to vary depending on acuity and occupancy. To meet with the head of workforce to review the last 12 months data.

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue: *These actions should be agreed within SMART principles.*	Date action initiated:	Responsibility: *Individual names of identified staff who have agreed to complete the action.*	Date to be evaluated:	Evaluation Status / Progress Update. ***Where monitoring shows no improvement/change in practice, additional actions should be added with timescales for completion and further evaluation.***
2	All neonatal units should work collaboratively within an operational delivery network (ODN), sharing their workforce plans and strategies for recruitment and retention across the ODN.	• Part of the Northern Neonatal network • Receive quarterly reports detailing staffing, recommended levels and highlighting shortfalls	Jan 2020	SCM	Jan 2020	**Date-Jan 2020** part of ODN. Fully integrated and represented at all meetings by the SCM and Matron **Completed**
3	Skill mix should be regularly reviewed to ensure that the most suitable staff are in undertaking the correct roles and are available in sufficient numbers.	• The NICE quality standard (2010) in support of the *Toolkit for high quality neonatal services* (DH 2009) includes a standard for safe staffing in neonatal care. This recommends an adequate and appropriate workforce, with the leadership and skill mix competencies to provide excellent care at the point of delivery for babies receiving medical and surgical interventions. • The minimum standards for nurse staffing levels for each category of neonatal care are (DH 2009, NICE 2010, BAPM 2010): □ neonatal intensive care: 1:1 nursing for all babies □ neonatal high dependency care:	Jan 2020	SCM	June 2020	**Date-Jan 2020** discussed with SEM, JA and SP. Action plan created to meet safe staffing. Currently utilising ANNP's, HCA competency programme and trainee ANNP's, ward layout. Permanent ward matron appointed. Discussion regarding band 6 supernumery nurse within workforce reviews. To be discussed at exec level **On-going .** **Date June 2020.** Re-discussed at workforce review. KS to raise with JL. Further established for HCA 0.25 to increase HCA coverage long days 7 days a week. Discussed with matron HCA workforce not needed overnight. Shortfall in ward clerk coverage. Not covered all day or 7 days a week. SCM raised at STM. Continue to have Trainee and ANNP's in post. Identified training, supervisors and NNU identified to support training Shift leader responsible for Safe staffing of the unit during that shift Effective deployment of staff Capacity management Safe transfers in and out of the unit Entry of nurse staffing into badgerNet Effective liaison with the medical team **On-going** **14/4/21** Next workforce review due July 2021. BAPM

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue: *These actions should be agreed within SMART principles.*	Date action initiated:	Responsibility: *Individual names of identified staff who have agreed to complete the action.*	Date to be evaluated:	Evaluation Status / Progress Update. ***Where monitoring shows no improvement/change in practice, additional actions should be added with timescales for completion and further evaluation.***
		2:1 nursing for all babies □ neonatal special care: 4:1 nursing for all babies. • NHSE specifications for neonatal care (2015a) • Utilisations of the dinning tool • Workforce needs to be adequate to cover peaks and troughs • Minimum of two qualified nurses should always be on duty (one of whom QIS) • There should be a supernumerary team leader on each shift • Non registered nurses should support clinical care • ANNP's provide a flexible solution • **Minimum percentage of nurse for SCBU 70%**				compliance continues to vary depending on acuity and occupancy. To meet with the head of workforce to review the last 12 months data.
4	Professional judgement should be used together with appropriate workforce and acuity tools.	• Health roster KPI • Safecare live data • Can be subjective and should be used together with appropriate workforce tools • Senior decision maker to oversee	Jan 2020	SCM	June 2020	**Date-Jan 2020** safecare live integrated within the unit. Training re professional judgement delivered **On-going** **Date June 2020** compliance varies-number of errors within system identified and resolved. Cot capacity captured also on Badger. On-going **Date 14/5/21** Monthly workforce and KPI reviews. Safecare continues to be submitted as per local Trust requirements. Monthly audits in place to look at

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue: *These actions should be agreed within SMART principles.*	Date action initiated:	Responsibility: *Individual names of identified staff who have agreed to complete the action.*	Date to be evaluated:	Evaluation Status / Progress Update. ***Where monitoring shows no improvement/change in practice, additional actions should be added with timescales for completion and further evaluation.***
						accuracy and compliance
5	Data collected using BadgetNet and the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity. This should be shared with the neonatal ODN.	• Dinning tools-calculated on an average occupancy of 80% • BadgerNet utilised to determine workload based on activity • Uplift added to establishment (21%) to support annual leave, study leave and additional roles that require allocated time • Benchmarking and peer review ad part of the ODN	Jan 2020	SCM	June 2020	**Date-Jan 2020** Dinning calculated. **Completed** **Date-June 2020**- re done for June and integration of HCA. **Completed**
6	Training and development must be linked to annual individual appraisals and development plans, and must be provided within the resources available to the team.	• TNA report • Rag report • Monthly SCM report • 70% of the nursing establishment mist be qualified in speciality (QIS) • Established formal learning opportunities including e-learning, seminars, simulation, rotation and shadowing	Jan 2020	SCM	June 2020	**Date- Jan 2020**-great compliance evidenced within RAG report. QIS compliance 93% **Completed** **Date June 2020**-training continues to be excellent and monitored monthly by matron and SCM 1 staff member accessing pre QIS in view to complete QIS in full. **Completed**
7	Organisations should recognise the increasing need for flexible working patterns to meet the fluctuating needs in neonatal services.	• Daily staffing briefings • Escalations plans • Huddles • Established recruitment and retention programme • Staff turnover • Career development opportunities • Job satisfaction • Fair rostering policy • Flexible working • Minimising agency staffing	Jan 2020	SCM	June 2020	**Date-Jan 2020** daily staffing huddles and OPEL meetings in place. Jointly attended with maternity matrons. **Completed** **Date June 2020** Staffing meetings continue 2-3 times per day depending on activity. No current vacancy rates. Sickness monitored monthly low % of long and short sickness levels. **Completed**

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue: *These actions should be agreed within SMART principles.*	Date action initiated:	Responsibility: *Individual names of identified staff who have agreed to complete the action.*	Date to be evaluated:	Evaluation Status / Progress Update. ***Where monitoring shows no improvement/change in practice, additional actions should be added with timescales for completion and further evaluation.***
8	All neonatal units should adhere to the pathways agreed with the ODN and specialised commissioning teams to ensure efficient working across the network.	• Re-commissioned level 1 unit • 11 cots • Neonatal network •	Jan 2020	SCM	June 2020	**Date Jan 2020** fully integrated level 1 unit following reconfiguration **Complete** **June 2020**-specialist commissioning and uncertainly re community neonates commissioning-raised with contracting manager **On-going**
9	All neonatal units should input data into BadgerNet to enable national benchmarking.	• Badger data and network compliance	Jan 2020	SCM	June 2020	**Date-Jan 2020** fully evidenced through quarterly reports **Complete** **June 2020**-Quartlerly reporting on-going **Complete**
10	Areas of concern highlighted by parents/families or staff using workforce planning and analysis methods must be carefully scrutinised and appropriate actions taken to address them.	• Measurement of patient outcomes-ATAIN, • Improved outcomes • Number of incidents • Quality dashboards • Number of SI's • Number of reported shifts with insufficient staffing • Numbers of medication errors • NNAP reports • Staff and patient satisfaction surveys • FFT • Network feedback • ODN reports • Feedback from regulators-CQC, MBRACE,< NHSI/E	Jan 2020	SCM	June 2020	**Date-Jan 2020** measured continually and evidenced within a variety of literature Gold accreditation from the Trust re safety and quality standards. Aiming for platinum next 12 months **On-going** Date-**June** journey to platinum continues. **On-going** **14/5/21** Accreditation for platinum in July. Deep dives of the unit completed. Local parental feedback survey completed and excellent feedback obtained. Weekly matron drop in for parents/Guardians re-established.

Appendix 2: Supporting Evidence Documents

Improvement Plan

Safety Action 1
Perinatal Mortality Review Tool Report - April 2020 to April 2021
HSIB North Tees & Hartlepool NHSFT Quarterly Review Meeting July 2020
Maternity Safety Board Quarterly Report Template

Safety Action 2
Confirmation Notification from NHS Digital on MSDSv2 to Head of Information Management

Safety Action 3
ATAIN Improvement Plan
Guideline for Identification and Management of Neonatal Hypoglycaemia in Term Infants
Skin-to-Skin Audit Presentation – June 2020
Term Admissions to SCBU/Neonatal Unit Datix Report
Transitional Care Improvement Plan
Northern Neonatal Network OAS Paper
LMS Quarterly Activity Report - December 2020
Maternity Safety Champions Meeting Minutes - August 2020
Special Care Unit Nursing Workforce Action Plan

Safety Action 4
Joint Obstetric and Anaesthetic Clinical Governance Learning Event Register December 2020
Joint Obstetric and Anaesthetic Clinical Governance Learning Event Agenda December 2020
GOA Meeting Agenda - April 2021
OG13 OPEL Escalation Process
Joint Anaesthetic & Obstetric Ward Round Agreement
Anaesthetic/Obstetric Rotas
Special Care Unit Staffing Action Plan

Safety Action 5
Acuity Q1 April May and June 2020
Escalation Unit Closure Datix Report
Midwifery Workforce Assessment BirthRate+
OG13 OPEL Escalation Process
Delivering Midwifery Intrapartum Care During Covid-19 Escalation

OBS12 Process for Daily Women and Children's Staffing, Safety and Activity Huddles
Professional Workforce Report for the Board of Directors July 2020

Safety Action 6

Preventing Pre Term Births Guidance
Pre Term Birth Flowchart – High-Risk Pathway
Community Local Audit – Hartlepool
Community Local Audit – Peterlee
Community Local Audit – Stockton
Presentation for Antenatal Women CO Levels Performed on Ward 22
Driver Diagram – Increasing Smoke Free Pregnancies
Data for CO Monitoring on Antenatal Ward – 2019
Clinical Governance Learning Event Minutes – May 2019
Advice Regarding Stop Smoking Medications
Smoking at Delivery Report – 2019 to 2020
Audit of Babies Born on the Third Centile – 2019
SGA FGR Referral and Detection Rates – 2020 to 2021
GROW Update Presentation
GROW Training – 2019 to 2020
Midwifery Led Ultrasound Scan Audit Presentation – February 2021
NTH MatNeoSIP Preterm Prevention QI Presentation – March 2021
Reduced Fetal Movements Audit Presentation – February 2021
Electronic Fetal Monitoring and Fresh Pair of Eyes Audit Presentation – March 2021
SARS-CoV-2 (Covid-19) in Pregnancy/Postpartum Presentation
MDAU Rolling Action Plan for Audits
Analysis of Provider Responses of the SBLCBv2 Survey 4
Education and Training Improvement Plan
Saving Babies Lives North East Clinical Network Report
CTG/Fetal Monitoring Mandatory Training Compliance

Safety Action 7

CQC National Maternity Survey 2019 Improvement Plan
Maternity Voices Partnership Meeting – Minutes December 2020
Maternity Voices Partnership Terms of Reference
Maternity Voices Partnership Update – March 2021
Maternity Voices Partnership Presentation
Maternity Voices Partnership Budget – 2020 to 2021
Maternity Voices Partnership Work Plan – April 2021 to April 2022

Maternity Voices Partnership Co-Chair Information
Poster Presentation from Maternity Voices Partnership Survey April 2021

Safety Action 8
Education and Training Improvement Plan
Annual Mandatory Training Requirements for Obstetrics/Maternity Staff
Staff Training Statistics – April 2020 to March 2021
Mandatory Training GAP Analysis for Rowan Team
Mandatory Training Plan
Programme for Maternity Training
Paediatric Training Update
E-Learning Training Screenshot
In-Situ Training and Covid-19 SIM Training Information

Safety Action 9
Continuity of Carer Improvement Plan
Maternity and Neonatal Safety Champions Pathway
Maternity Safety Dashboard
NENC MatNeoSIP Presentation
Maternity and Neonatal Safety Champions Meeting Minutes
Network Meeting papers
Trust presentations at National MatNeoSIP Event March 2020
Trust MatNeoSIP Newsletter
NENC MatNeoSIP Presentation at Regional Event March 2021

Safety Action 10
HSIB QRM North Tees Hartlepool - January 2021

Overall rating for North Tees and Hartlepool NHS Foundation Trust GOOD

North Tees and Hartlepool NHS Foundation Trust

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

Annual Report

April 2020 - March 2021

of the

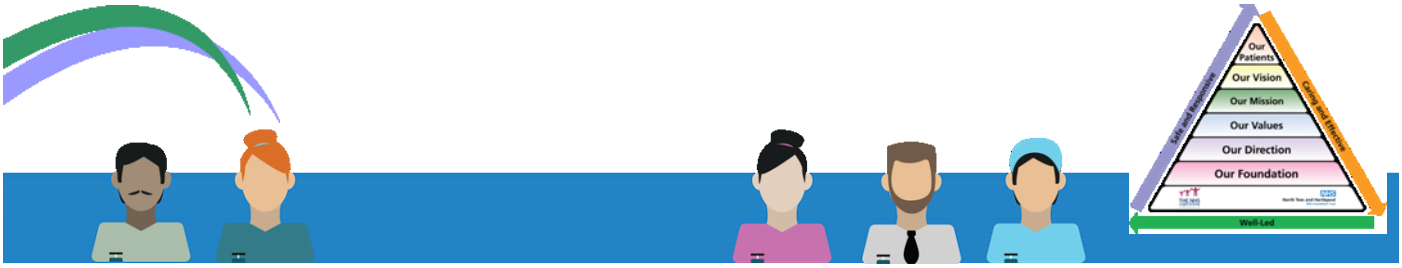
Vulnerability Unit

Safeguarding Adults,

Children and Young People

Report of the Chief Nurse, Director of

Patient Safety and Quality



Safeguarding Adults

Children & Young People

Introduction

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

Please insert photo of

Lindsey Robertson

Lindsey Robertson

CHIEF NURSE,

DIRECTOR OF PATIENT SAFETY AND QUALITY

Lorraine Mulvey

NAMED NURSE

Stuart Harper-Reynolds

NAMED NURSE

Care Quality Commission — Overall rating for North Tees and Hartlepool NHS Foundation Trust: GOOD

NHS
North Tees and Hartlepool
NHS Foundation Trust

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

Adult Safeguarding 'protecting our adults in need'

ADULT SAFEGUARDING

Section 1.	Introduction	pg. 5
Section 2.	External and Internal Governance	pg. 5
Section 3.	Adult Safeguarding Performance	pg. 6
Section 4.	Adult Safeguarding Training	pg. 7
4.6 - 4.7	Children's Safeguarding Training	pg. 8
Section 5.	Domestic Violence and Abuse (DVA)	pg. 9
Section 6.	Deprivation of Liberty Safeguards	pg. 10
Section 7.	Safe Recruitment	pg. 11
Section 8.	Mental Health including Learning Disabilities	pg. 12
8.4 - 8.5	Recognition of good practice to MDT LeDer mortality reviews.	
Section 9.	PREVENT strategy and Channel	pg. 13
Section 10.	Adult Safeguarding - Key Achievements 2020—2021	pg. 14
	Adult Safeguarding - Key Priorities 2021 - 2022	

Stephen Nicholson

SAFEGUARDING ADVISOR AND DEMENTIA SPECIALIST

Carly Ogden

SAFEGUARDING ADVISOR AND LEARNING DISABILITIES SPECIALIST

Jenny Duthie

SENIOR NURSE ADULT SAFEGUARDING

Liam Gates

ADULT SAFEGUARDING ADMINISTRATOR

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

CHILDREN'S SAFEGUARDING WORK PROGRAMMES

Section 11.1	Children's Safeguarding work programme	
11.2 – 11.8	Children's Safeguarding Reviews / Learning Lessons Reviews	pg. 15
Section 12	Development Work and Audit (sections 11 - 25)	pg. 16
12.1 - 12.2	Child Not Brought to Appointments Policy	pg. 16
13 - 13.2	Safeguarding Supervision compliance	pg. 16
14	SAFER referrals	pg. 17
15 - 15.2	Domestic Abuse	pg. 18
16 - 16.4	Child Sexual / Criminal Exploitation	pg. 18
17 - 17.1	Partnerships with local authority LADO	pg. 19
18 - 18.1	Joint working with Adult Safeguarding	pg. 19
19 - 19.1	Voice of the Child	pg. 19
20 - 20.1	Child Protection Information System (CP-IS)	pg. 20
21 - 21.2	New Partnership Arrangement	pg. 20
22 - 22.1	Audit programme	pg. 20
23	Named Doctor for Children's Safeguarding	pg. 21
Section 24	Children's Safeguarding - Key Achievements 2020 - 2021	pg. 22
Section 25	Children's Safeguarding - Key Priorities 2021– 2022	pg. 23

Laura Holroyd
SENIOR NURSE

Terri Wells
SENIOR NURSE

Denise Hopkins
SENIOR NURSE

Catherine Flanagan
SENIOR NURSE

Wendy Murdoch
SAFEGUARDING

Section 26	*LOOKED AFTER CHILDREN (LAC)*	
Section 27	Children's Health in Care Arrangements and Provisions (IHA's)	pg. 24
Section 28	Children's Health in Care (Review Health Assessments)	pg. 25
Section 29	Looked After Key Achievements 2020 - 2021	pg. 26
Section 30	Looked After Key Priorities 2021—2022	pg. 27

1 Introduction

1.1 Safeguarding is a fundamental component of all care provided. The purpose of this Annual Report is to provide an overview of the work of the Vulnerability Team in relation to Safeguarding and Children's Health in Care (CHiC) - formerly Looked After Children activity across the Trust in the last 12 months ***(April 2020 – March 2021).***

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

2 Governance

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

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

2.3 The Trust has maintained membership and has made active contributions at senior level on the 2 Safeguarding Partnerships and 1 Adult Safeguarding Board:

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

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

Steering Group (is held bi-monthly)

Responsibilities

- Performance Monitoring.
- Children's Safeguarding Work Programme including

Members (Commissioners and Providers)

- Tees Valley CCG
- Designated Doctor
- Designated Nurse Safeguarding and Looked After Children

3

Adult Safeguarding Performance

3.1

447

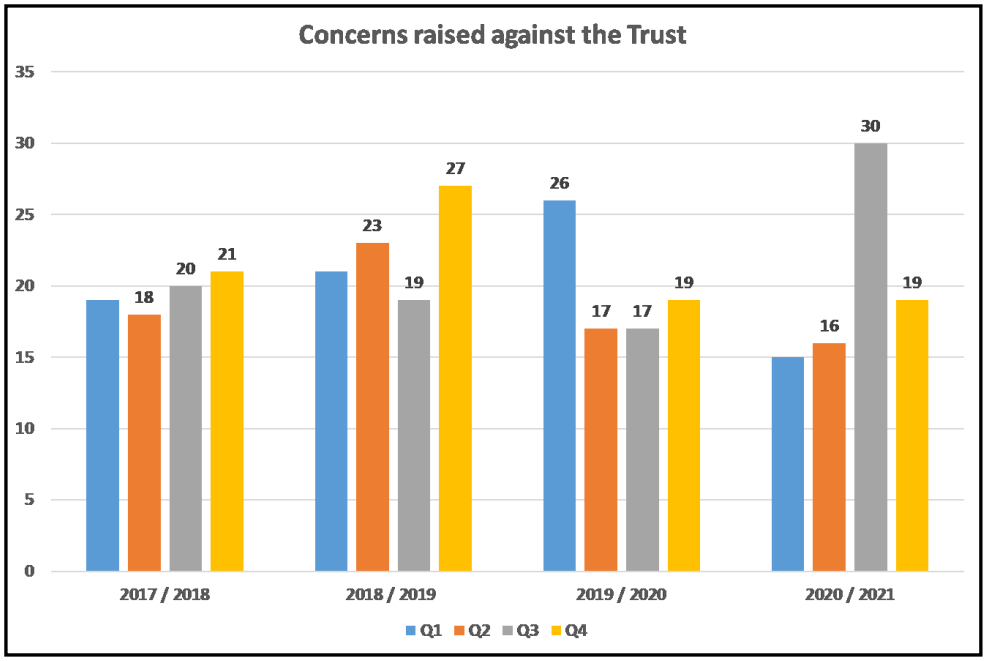
Safeguarding Concerns

Previous year

536

Trust involvement with Safeguarding Concerns

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



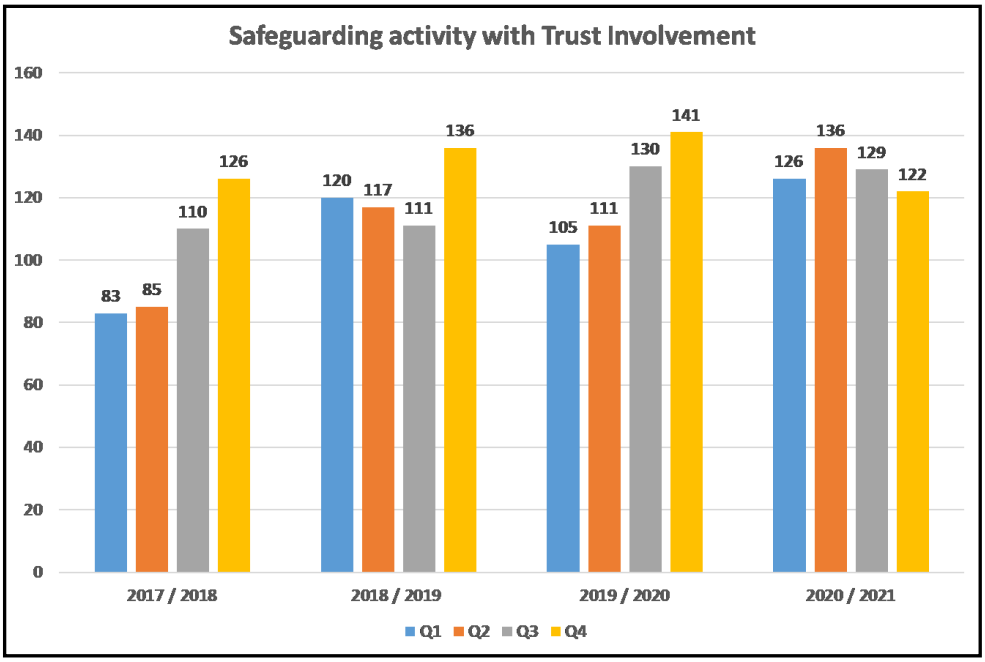
3.2 Increase in concerns against the Trust is consistent with the increase in numbers across Stockton and Hartlepool local authorities. The table below demonstrates the comparator data across 2017—2021

79

Concerns raised against the trust previous year

80

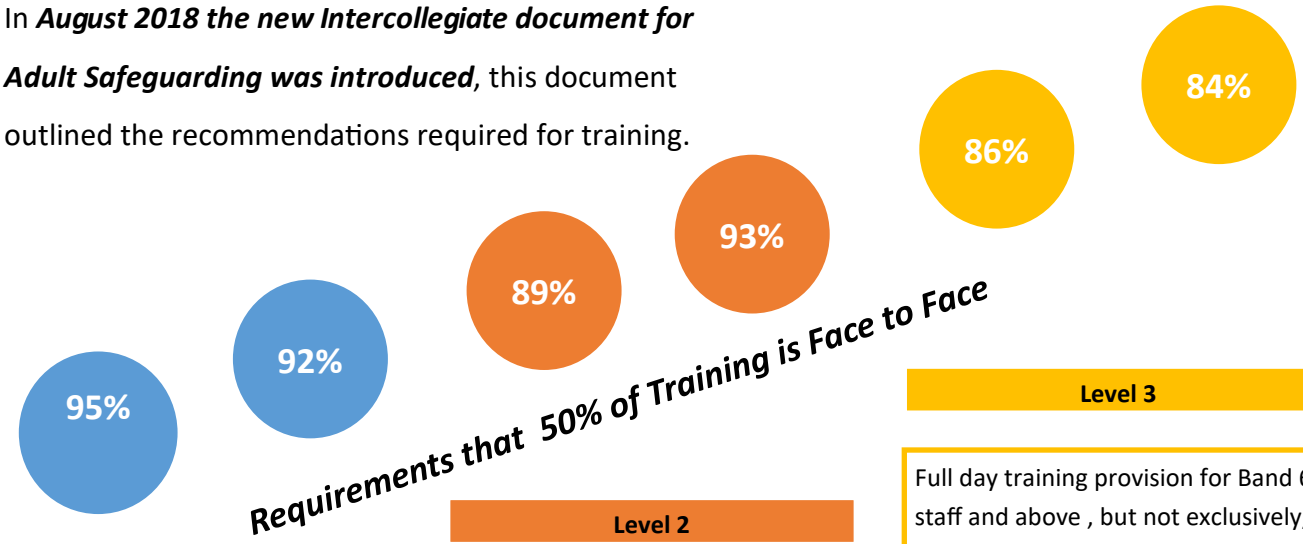
Concerns raised against the Trust this year investigated through safeguarding process.



4 Adult Safeguarding Training

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

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



4.3

Level 1

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

Level 2

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

Level 3

Full day training provision for Band 6 staff and above , but not exclusively, open to any staff that requires more detailed knowledge of adult safeguarding is promoted as identified through;

4.4 **Face to Face Training delivered to**

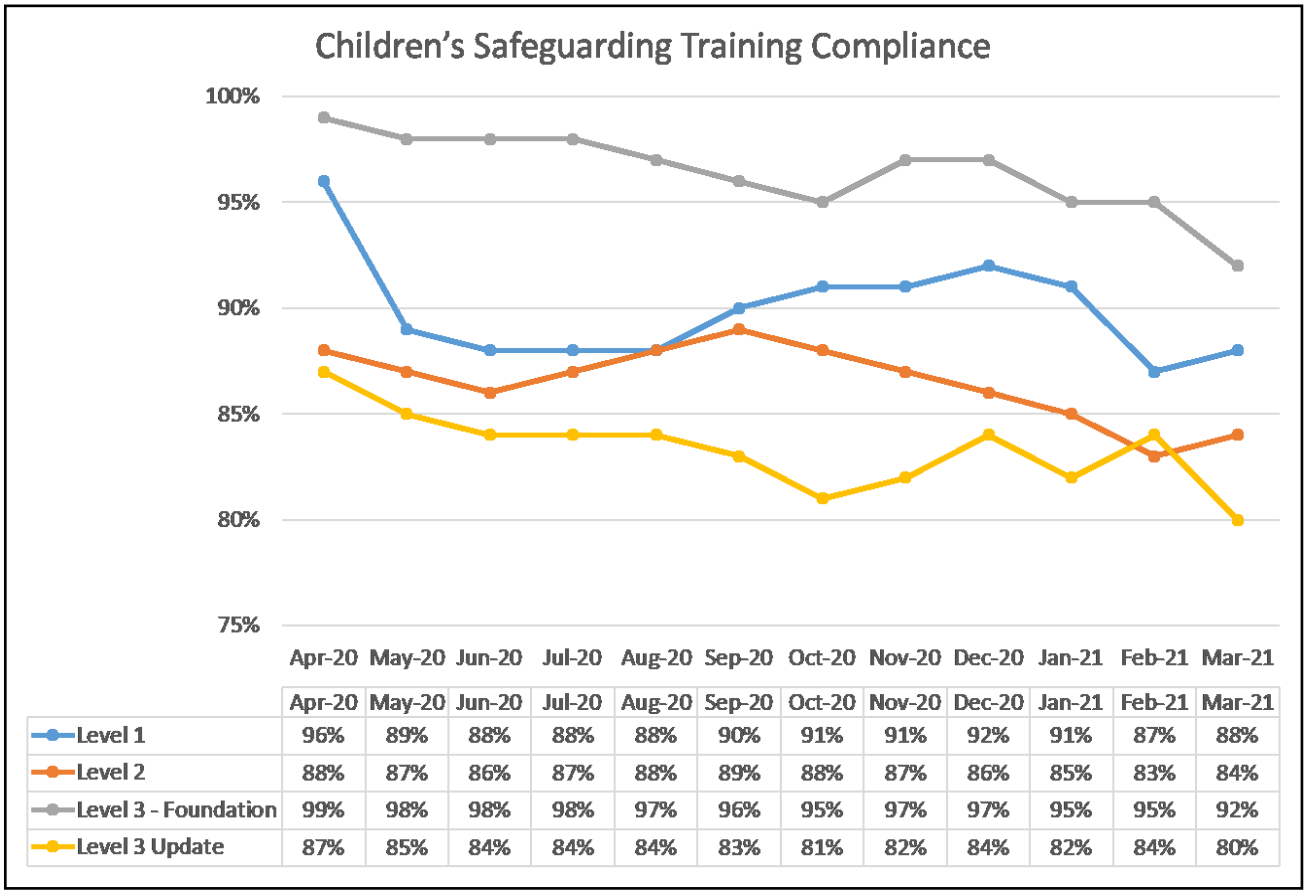
- Emergency Care
- Overseas Nurses
- Newly quality Staff
- Volunteers
- Mandatory Training Programme in a

4.5 Focused work is being undertaken to improve compliance with mandatory training and an improvement trajectory is in place. The slight drop in the training figures is due to increasing training from once only to three yearly and also increasing the number of staff that require level 2 and level 3 training.

Children's Safeguarding Training

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

4.7 The table below demonstrates the training compliance monitored by the Safeguarding Steering Group and an action plan has been developed by each Care Group Lead to address areas of reduced compliance. In addressing the challenges faced by staff and the Trust in response to the pandemic our Children's Safeguarding Trainers, although continuing to offer face to face training throughout have been creative in developing e-learning packages for both the Level 3 Children's Safeguarding Foundation Training and Update. This has been a temporary measure to offer alternative methods of accessing training in light of additional stressors placed on staff.

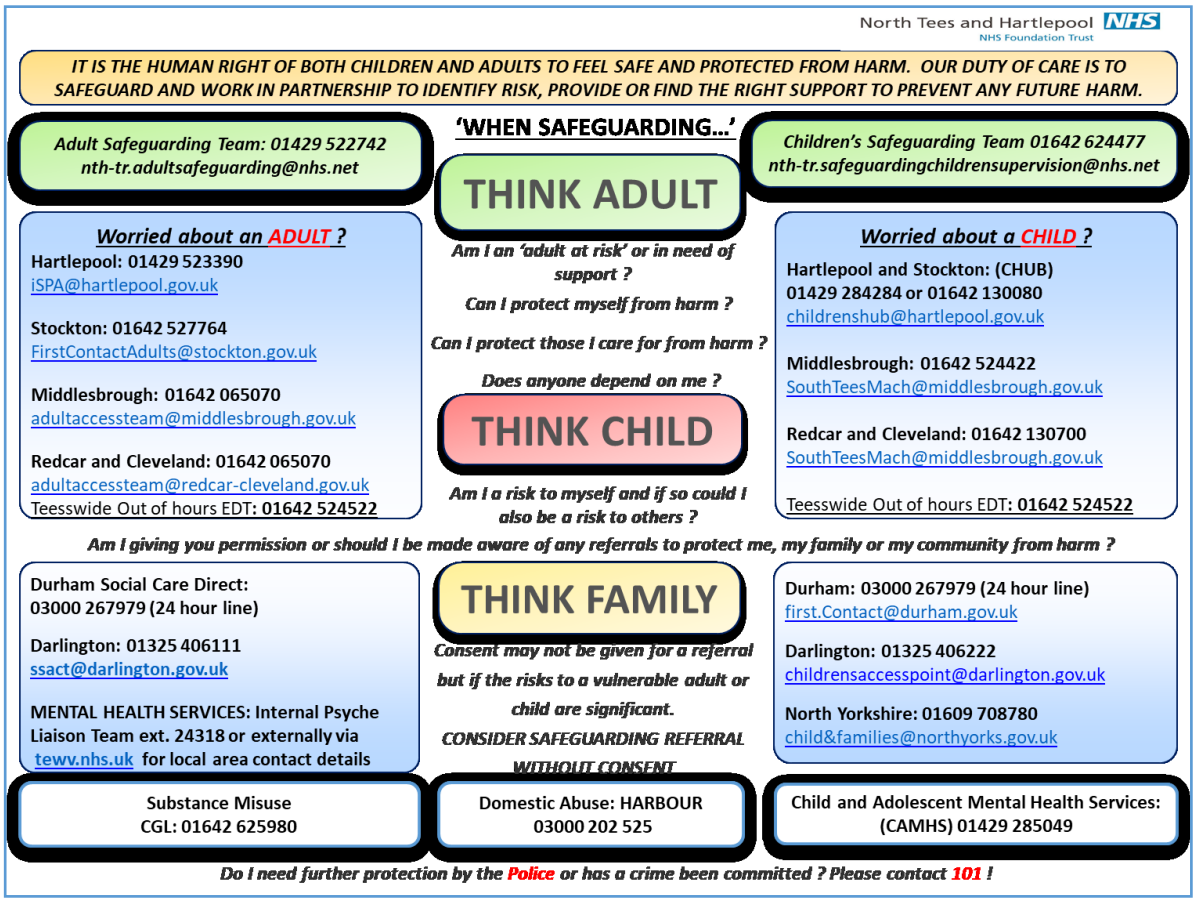


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Level 1	96%	89%	88%	88%	88%	90%	91%	91%	92%	91%	87%	88%
Level 2	88%	87%	86%	87%	88%	89%	88%	87%	86%	85%	83%	84%
Level 3 - Foundation	99%	98%	98%	98%	97%	96%	95%	97%	97%	95%	95%	92%
Level 3 Update	87%	85%	84%	84%	84%	83%	81%	82%	84%	82%	84%	80%

5 Domestic Abuse

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

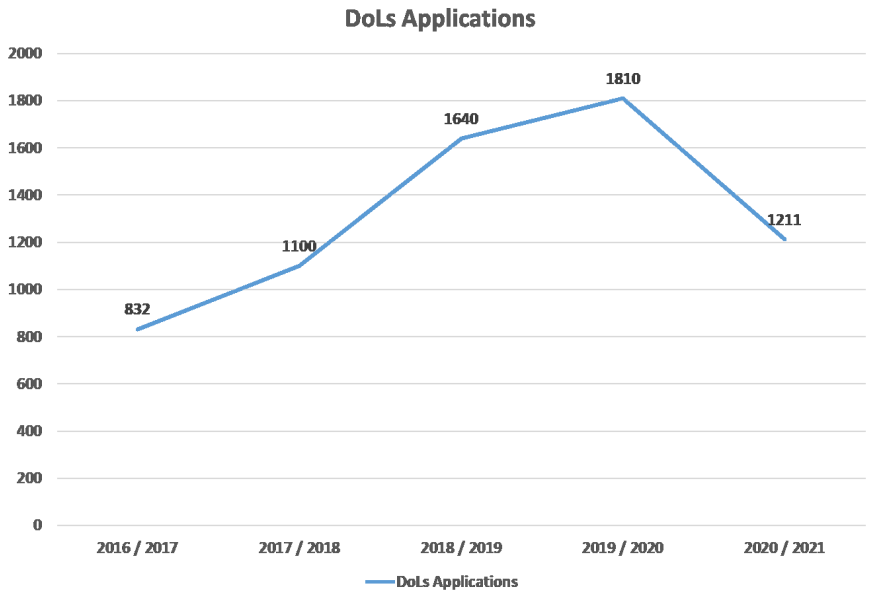
5.2 The adult safeguarding data base has been redesigned to include domestic abuse as a category. The Trust has contributed to one Domestic Homicide Review for the period of this report. Trust actions included raising awareness through teaching on Adult Risky Behaviours and 'The Think Family Approach' which prompted the development of the poster below which was distributed through clinical areas and the 'Ward Boards.' The trust has contributed to Serious Safeguarding Adult Reviews (SARS) within other organisations to support external review process.



6 Deprivation of Liberty Safeguards (DoLS)

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

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



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

6.3 The DoLS policy has been updated to reflect Cheshire West and the changes in the DoLS process making it more user friendly. Prompt cards have been developed to help assist security staff when responding to incidents where patients are under a DoLS. The law commission reviewed the legislation underpinning DoLS and published its final report and draft bill on the 13 March 2017. It plans to replace the current process with Liberty Protection Safeguards (LPS), the code of practice has not been agreed due to government pressures, once this in place the Trust will look at moving

7 Safe Recruitment

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

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

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

8 Mental Health including Learning Disabilities

North Tees and Hartlepool NHS Foundation Trust

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

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

Carly Ogden

SAFEGUARDING ADVISOR AND LEARNING

8.3 During the last financial year, the Trust has worked with Stockton and Hartlepool Borough Council, who has provided relevant information to enable the Trust to flag people, accessing services, who have a learning disability. This has enabled the Trust identify 3851 patients with a learning disability. This has had an impact on the amount of referrals via the virtual ward system.

8.4

Learning Disabilities Mortality Review Programme (LeDeR)

LeDer is a national initiative to ensure lessons are learned from deaths where people with learning disabilities have received care and is undertaken as part of a multi-agency approach, which the Trust are actively involved in. 16 reviews were carried out in 19/20, in 20/21 this has increased to 27. In most cases the care has been co-ordinated with other care services or persons involved and has identified evidence of reasonable adjustments when planning and delivering care. The Trusts process of co-orienting the LeDeR reviews has received national recognition.

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

- Mental Health Act advice
- Training

for lead professionals on behalf of the Trust. During 20/21, 387 new patients were identified, the overall cohort is now 4482. In comparison to last year figures of 1316 this

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

9 Prevent Strategy and Channel

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

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

9.2 During 20/21, staff have been trained as Health WRAP 3 trainers (Workshop for raising awareness on Prevent), through monthly planned WRAP sessions. The Trust has developed an e-learning package on Prevent for staff.

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

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

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

Number of Channel referrals from Trust 2020—2021

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

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

10 Adult Safeguarding - Key Achievements 2020 / 2021

- Development of the dementia strategy.
- Developed closer working relationships with enhanced care, discharge and frailty team to support patients with vulnerabilities during admission and supporting complex discharges.
- Introduced daily safeguarding huddles to improve communication and teamwork.
- Very positive feed back received from Teeswide Safeguarding Adults Board regarding the Quality Assessment Framework — All areas green.
- In response to the pandemic, virtual safeguarding meetings have been carried out for safeguarding and best interest's to ensure family engagement is maintained.
- Introduced a new section on datix to manage safeguarding concerns, this is linked to yellowfin, so reports on trends and audit's can be seen Trustwide.

10.1 Adult Safeguarding - Key Priorities 2021 / 2022

- Embed the Liberty Protection Safeguards and provide training within the Trust once the code of practice has been released.
- Continue to embed and share learning from LeDeR (Learning Disability Mortality Review).
- Implement recommendations from the Domestic Abuse Bill.
- Continue to disseminate lessons learned from Safeguarding Incidents.
- Continue to provide clinical supervision for staff with regards to Safeguarding, also to provide supervision for clinical leads following safeguarding concerns raised against that area.
- Continue to audit and monitor performance and improve the quality of referrals.
- Contribute to the Treat as One work to achieve parity between physical and mental health needs.
- Introduce a new flagging system for autism and reasonable adjustments, to support clinical staff, this will also include attaching '***all about me'*** and '***hospital passport'*** to active clinical notes to increase personalised care.

11 Children's Safeguarding Work Programme

11.1 The Children's Safeguarding Work Programme monitors action plans from Children's Safeguarding Practice Reviews (CSPR); learning lesson reviews, Domestic Homicide Reviews and internal incidents. Informing the Trusts safeguarding children professionals' development work, the safeguarding children annual audit and assurance programme and reviews the impact of any key national drivers on Trust practices.

Children's Safeguarding Practice Reviews

11.2 The Trust has supported HSSCP and DCSP with 8 Rapid Reviews since going live in April 2019. 4 reviews progressed to Local Children's Safeguarding Practice Reviews (LSCPR) of which there were actions required by the Trust which were completed through the Children's Safeguarding Work Program.

11.3 3 LSCPR's have been published early 2021 and the Trust remains involved with the partnerships in disseminating wider learning from final recommendations made.

11.4 The National Children's Safeguarding Practice Review Panel have conducted their yearly deep dive audit around the quality of the reports and learning. Suggesting '*resilience, creativity and adaptability of partners in taking forward the new partnership arrangements during the unprecedented challenges of COVID.' However 'yearly reports require a sharper focus on impact, evidence, assurance and learning.'* Their 2nd Annual Report is due to be published in May 2021 which will provide further guidance for the Trust and their Partnerships.

Learning Lesson's Reviews

11.5 1 LSCPR and 3 Rapid Reviews were conducted as a result of significant Neglect. Emerging key learning identified throughout all cases related to professionals over optimism, lack of robust information sharing including among health colleagues, minimal consideration to parental history and cumulative vulnerability.

11.6 The LSCPR conducted in response to attempted murder of 4 year old young boy (T) has been published now criminal proceedings have been concluded. With emphasis on where extensive mental health history identifying the need for, up to date mental health assessments prior to making step down decisions.

11.7 Learning informs our Children's Safeguarding training strategy for staff within the Trust and the focus of the Safeguarding Work Program operationally within our Strategic Steering Group.

No new Safeguarding Practice Reviews from Durham have involved the Trust in the last financial year.

12 Development Work

12.1 Management of Children referred for child protection medicals

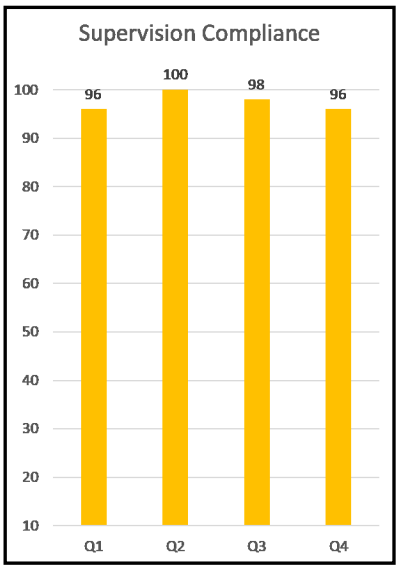
The Good Practice service delivery standards for the management of children referred for Child Protection Medical Assessments was published by Royal College of Paediatrics and Child Health (RCPCH) in October 2020. Collaborative Gap Analysis has been carried out with our Neighbouring Trust Named and CCG Designated Professionals to inform changes to practice, professional guidance, audit and training to promote best practice when working together that acknowledges the stresses on both the child and the family.

Fabricated and Induced Illness and Perplexing Presentation.

12.2 In March 2020 the RCPCH published new guidance for practitioners in managing cases where Fabricated or Induced Illness is suspected superseding previous guidance from 2009 . Perplexing Presentation is a term which has been adopted by practitioners over the years which is defined by the guide along with new considerations impacting practice. In response staff training is to be updated to incorporate new practice guidelines and definitions and actions within the Work Program for Trust policies and partnership procedures reflect this.

13 Safeguarding Children's Supervision

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



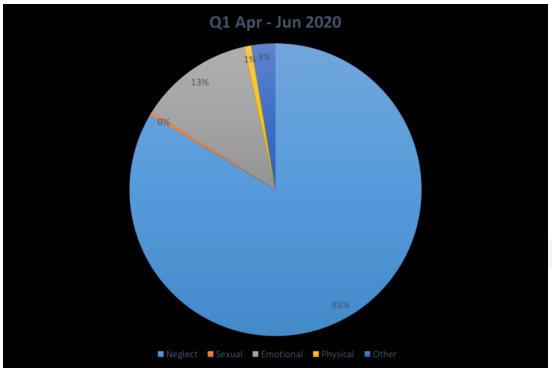
13.2 Compliance to safeguarding supervision continues to be monitored as a local quality and performance indicator, and consistent high compliance level is maintained through the year as demonstrated in the following graph, reported via the quarterly dashboard.

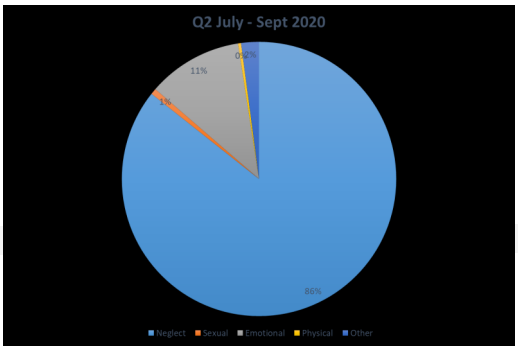
Supervisee sickness is *not included* in compliance figures.

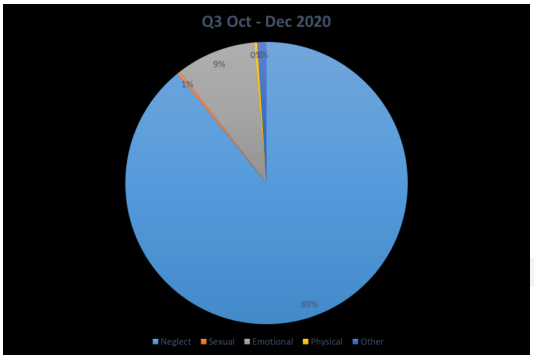
14

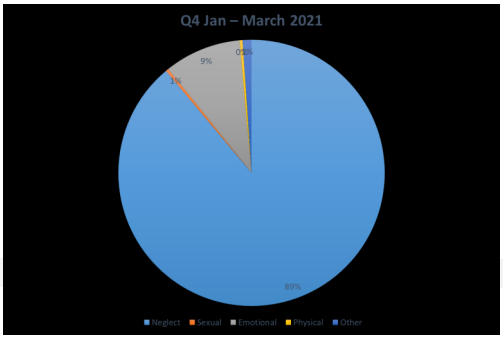
SAFER REFERRALS

The Charts represent referrals based on categories of abuse as per quarter.









Other (Teenage Pregnancy / Sudden Death / FII / VEMT

The table below identifies referrals completed by each department as per quarter.

	Qtr 1 (Apr - Jun 2020)	Qtr 2 (Jul - Sept 2020)	Qtr 3 (Oct - Dec 2020)	Qtr 4 (Jan - Mar 2021)
A&E	163	205	211	195
Urgent Care	17	17	18	17
Children's Day Unit / Children's Ward / Consultant Paeds / Physio Paeds / PDU Nurses	8	4	3	4
Midwifery	54	55	60	54
Delivery / Neonates / Wards (i.e. Ward 4 / Ward 24 / Ward 33 / Ward 36 / Ward 41 etc…)	9	4	5	7
Community (SALT / MSK / Dietician / Dental / Orthoptist)	6	0	0	2
Clinical Psychology / Education Psychotherapist	2	1	0	0
Others (Safeguarding Adults & Children / Nursing Education / NHS Direct etc...)	2	0	0	0
Total figures as per quarter	261	286	297	279

15 Domestic Violence and Abuse

15.1 The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton by a safeguarding children's senior nurse, where high risk victims of domestic abuse are identified and safety plans put in place with further contribution to the Multi Agency Tasking and Coordination (MATAC).

15.2 A Domestic Abuse Policy is in place across the Trust and is promoted throughout the trust.

16 Child Exploitation (CSE / CCE)

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

16.2 The Serious and Organised Crime Local Partnership Group is attended to understand the changing landscape and challenges for children, the impact and how children may present to the Trust. Update training incorporates support staff to understand the wider implications of risk to whole peer groups and safeguarding not only from the perspective of risks to the individual child but also to the public interest.

16.3 Through collaborative work with HSSCP a Contextual Safeguarding Hub is presently under development. This is to acknowledge the very different approach required to respond to this form of harm. This new structure has the potential of affecting how the function of the local VEMT (Vulnerable, Exploited, Missing Trafficked) practitioners group which the Trust continues to provide representative to. VEMT identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk and the Trust is represented on both the Strategic and within Operational groups around VEMT.

16.4 A CSE risk assessment is completed on all LAC children over the age of 11 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk. This risk assessment has also been rolled out to Paediatric wards.

17 Local Authority Designated Officer (LADO)

17.1 Regular meetings have been established between the Named Nurse and staff within the Human Resources (HR) department to improve communication and referrals to the LADO. Additional safeguarding training has been delivered to Trust senior managers to increase their awareness of adult risky behaviors that may require safeguarding intervention when supporting staff are on sickness/absence or there are capability issues.

18 Joint working with Adult Safeguarding

18.1 A Senior Nurse in the Vulnerability Unit continues to provide both adult and children's safeguarding training across the Trust including Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery. The Named Nurses for Adult and Children's safeguarding both equally contribute to the Safeguarding Children's Steering Group and The Adult Vulnerability Committee

19 Voice of the Child

19.1 Following recommendations from the CQC report 'Not Seen, Not Heard' the Trust took forward a number of actions to further improve how we listen to children and gain their wishes and feeling around the care they receive.

19.2 The CHiC (Children's Health in Care) team have devised new health assessment forms that enable the practitioner to capture the wishes and feelings of children in care receiving health assessments. Electronic health care records for children receiving care within the Trust now incorporate prompts for practitioners to gain the voice of the child during contacts/assessments.

20 Child Protection Information System (CP IS) and Unscheduled Care Settings

20.1 The Trust has worked closely with NHS England to ensure that the CP-IS project is implemented across all unscheduled care settings within the Trust. This is presently being audited to ensure that information is shared with the local authority for all children who are Looked After or on Child Protection plans who attend the Trust unscheduled care settings.

21 New Partnership Arrangements

21.1 The Trust has made active contributions at senior level to the Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) and the Durham Safeguarding Children Partnership (DSCP).

21.2 The Trust continues to maintain representation on a number of Safeguarding Partnership subgroups such as to name but a few;

- Tees procedures policy group
- Tees Engine room
- County Durham MASH Board

22 Audit

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

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

Named Doctor—Striving to Achieve Excellence !

The Children's Named Nurse and Named Doctor alongside the Children's Safeguarding Team work collaboratively within the Trust in providing governance, leadership, education and support to all staff. The following areas have been addressed to ensure the child protection service we offer is robust, enabling a high quality service to our community, keeping our children and families safe.

Patient Experience

Patient information leaflets (PIL's): To empower children and young people, we have introduced a few new Patient information leaflets (PIL's).

Child Protection Clinics: To see children & young people in a friendly, supportive and timely manner, we started formal Child protection medical clinics with two slots every day (Monday-Friday).

Dedicated Child Protection Suite: Under review - having a dedicated area (suite) to do Child Protection medicals more discreetly.

Networking

A National Fabricated or induced illness special interest group (FII-SIG) set up by the Named Doctor and includes over sixty-five Named & Designated Doctors from the United Kingdom to discuss complex cases and share learning.

E-conferences led by the paediatric department has provided low-cost, high-quality education to Doctors. These conferences are free for Nurses and partner agencies.

Single point of contact: To minimise interruptions to the colleagues in Children's Social care & Police in accessing Child Protection service and subsequent communication, we have established a single point of contact.

Quality of Service: Following the new RCPCH Child Protection service standards (October 2020), we undertook a gap analysis with identified areas for improvement.

Supporting staff: Child Protection work is highly stressful and in response amongst other Health and Wellbeing initiatives - a dedicated child protection Schwartz round was organised on 5th May 2021 to support staff.

I feel extremely proud in saying that our Trust has pioneered and set an example of excellent working in many areas of Child protection, acknowledging that there are always improvements to be made, locally and nationally driven

Dr Shashwat Saran
NAMED DOCTOR
CHILD PROTECTION

Children's Safeguarding Key Achievements 2020 / 2021

- Key priorities of the Trust continue to be aligned with those of HSSCP and DSCP through ongoing representation at Operational and Strategic Partnership Meetings / Subgroups and Task and Finish Groups.
- Compliance with all local safeguarding children quality requirements has been achieved as per targets and continues to be monitored closely.
- Despite the challenges faced by the Pandemic the Safeguarding children training program has continued to be delivered face to face by the trust with appropriate safety mechanisms in place. The team as led by children's trainers have been creative in producing e-learning as an additional tool to encourage and support staff in maintaining their safeguarding awareness.
- Through audit and liaison by our Senior Nurses and Safeguarding Champions risk assessment screening tools to identify children who are vulnerable, exploited, missing or trafficked continue to be promoted.
- The Trusts Named Doctor has been supported in the development of new policies / audits and pathways in response to new standard.
- A Multiagency National Child Protection e-conference was organised by Named Doctor in collaboration with the Trust Business Support Team in February 2021 which was extremely successful attended by 400 participants. This received excellent feedback from attendees.
- Ongoing development and monitoring of action plans following recommendations from the Joint Targeted Area Inspections and Local Safeguarding Children Practice Reviews.
- Level 3 Foundation and Level 3 Update Training included training for staff surrounding contextual safeguarding to understand the changing landscape and challenges for children/young people and the impact of being exposed to extra-familial harm.
- Children's safeguarding supervision offer has been extended to allied services from the Trust who provide an intensive, continuous level of health care delivery, to support complex case discussion and reinforce their role and responsibilities in assessing safeguarding needs.

Children's Safeguarding Key Priorities 2021 / 2022

- Whole service review to be carried out to establish workforce priorities.
- To work together with Partner agencies responding to changes in practice required to protect children exposed to extra-familial harm, peer on peer abuse, criminal and sexual exploitation and potential impact on present VEMT (Vulnerable, Missing and Trafficked) practices. Learning to inform future Level 3 Update training and Safeguarding Procedures accordingly.
- Increased visibility and targeted briefings to be delivered with adult clinical areas who receive admissions for young adults to increase awareness of key indicators of extra-familial harm and how to respond, 'Think Family' and adults who present with 'risk taking behaviours.'
- Continue to develop and monitor action plans following recommendations from both Local and National Children's Safeguarding Practice Reviews and Joint Targeted Area inspections to inform children's safeguarding training updates and facilitate dissemination of any targeted learning.
- As the impact of the pandemic on children's psychological, social and physical wellbeing is not fully understood children's safeguarding team to deliver targeted work with the Trust's front of house staff to ensure robust use of screening tools that supports identification of risk and harm to respond to any unmet need that may be in response to reduced visibility of children during lockdown. Senior Nurses to continue to audit this and target areas requiring more support.
- Safeguarding activity data to be captured effortlessly through recording system's which can then be analysed to inform targeted response to quality improvements.
- In response to Royal College of Paediatrics and Child Health (RCPCH) publishing new standards for Child Protection Medicals new child protection medical assessment guidelines, proforma's and new audit processes are presently being strengthened. This has also resulted in the development of a Chaperone training module and review of service level agreements with neighbouring Trust's.
- New Terms of references for Peer Review meetings has been developed. Peer reviews acknowledging the emotional challenges of child protection work by inviting Schwarzt Round. Further individual and group supervision processes for Doctors are being explored.
- New Fabricated and Induced Illness and Perplexing presentation guidance published by the RCPCH in March 2021 has prompted a working group comprising Named Doctor and Nurse and two senior social workers to explore the impact of guidance aligning these with Trust policies and Teeswide Procedures.

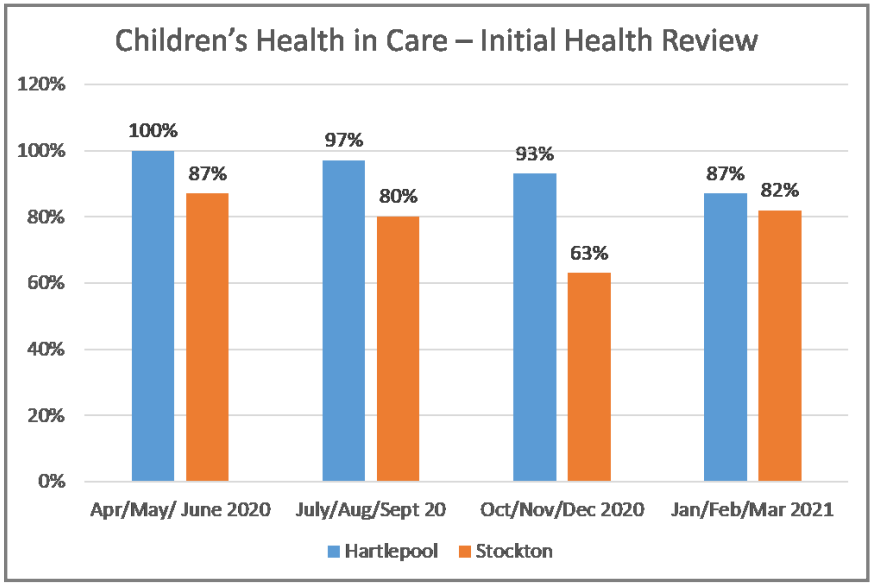
26 Children in Our Care (CIOC) formerly (LAC)

26.1 The services and responsibilities for CIOC are underpinned by legislation, statutory and good practice guidance including: "Statutory Guidance on Promoting the Health and Well-being of Looked After Children" (DH, 2015) and "Promoting the Quality of Life of Looked After Children and Young People" (NICE, 2010). The importance of the health of children and young people in care cannot be overstated as many children in care are likely to have had their health needs neglected prior to coming into care. The health of looked after children is everyone's responsibility, so partnership working is essential to ensure optimum health for each individual child and young person.

- CIOC health provision is an integral part of the Trust Safeguarding and CIOC Steering Group work programme which reports to the Trusts Children's Safeguarding Steering Group and Patient Safety Committee.
- The Children's Health In Care Team (CHiC) continues to be involved with the Lets Take Action group (CICC, Stockton) and Children in Care Council (Hartlepool)

27 Children's Health in Care Arrangements and Provision—IHA's

27.1 Initial Health Assessments (IHA) are a statutory requirement. All children who come into care must be offered an Initial Health Assessment (IHA) within 20 days by a suitably qualified medical practitioner, which should result in a Health Care Plan by the time of the child's first Looked after Review (LAR).



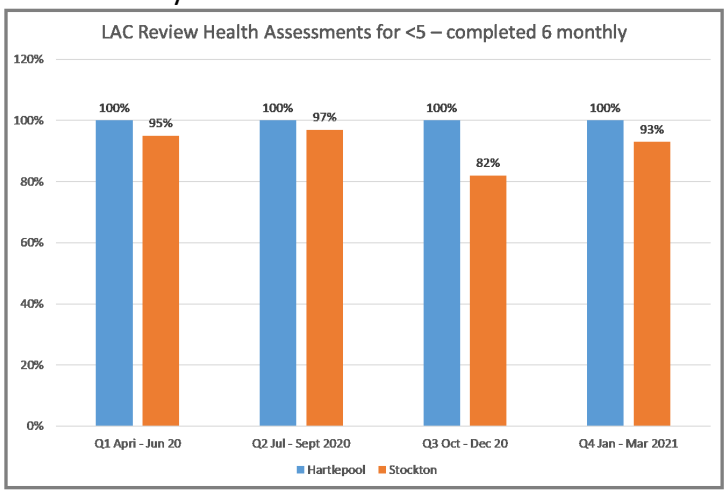
The table demonstrates compliance when children are notified to the service that they are in care.

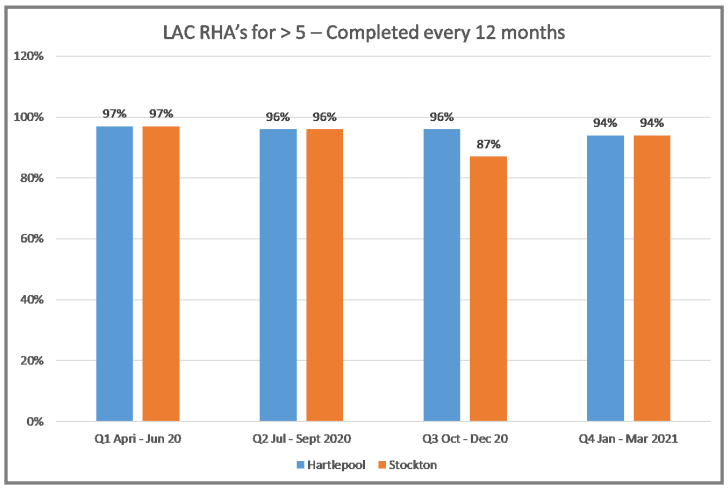
27.2 Any reduction in compliance is addressed weekly by the Senior Nurse following an agreed escalation process. Service demand is monitored so that resilience plans can be implemented to ensure there is sufficient capacity to respond. Points to note in relation to reduced compliance include:

- Not receiving timely admission notifications or consents for IHA's.
- Appointments being rearranged or cancelled by carers/parents.

28 Review Health Assessments

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





The tables demonstrate compliance of RHA's

28.2 Reviews are designed to identify and monitor health needs of Children in Our Care (CIOC) and are a statutory obligation. In Stockton the service model includes Health Visitors and School Nurses who undertake the RHA for those children in our care accessing Universal services. Health Visiting and School Nursing are a Public Health commissioned service.

28.3 In 2018 the Trust was commissioned to provide the RHA's for all LAC children in Hartlepool. These assessments were previously completed by the 0-19 service provided by Hartlepool Borough Council Public Health. The CHiC team are committed to improving LAC services and are able to evidence a sustained improvement in compliance with dedicated resource to

28.4 The data identifies issues where compliance has not been maintained and include:

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

28.5 In response to the issues identified the Standard Operational Procedure for out of area RHA was reviewed and updated and more recently an escalation pathway was sent out with every out of area request so that all agencies are aware of expected timescales and actions our CHiC team will take if

29 Children's Health in Care - Key Achievements 2020 -2021

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

30 Children's Health in Care - Key Priorities 2021 - 2022

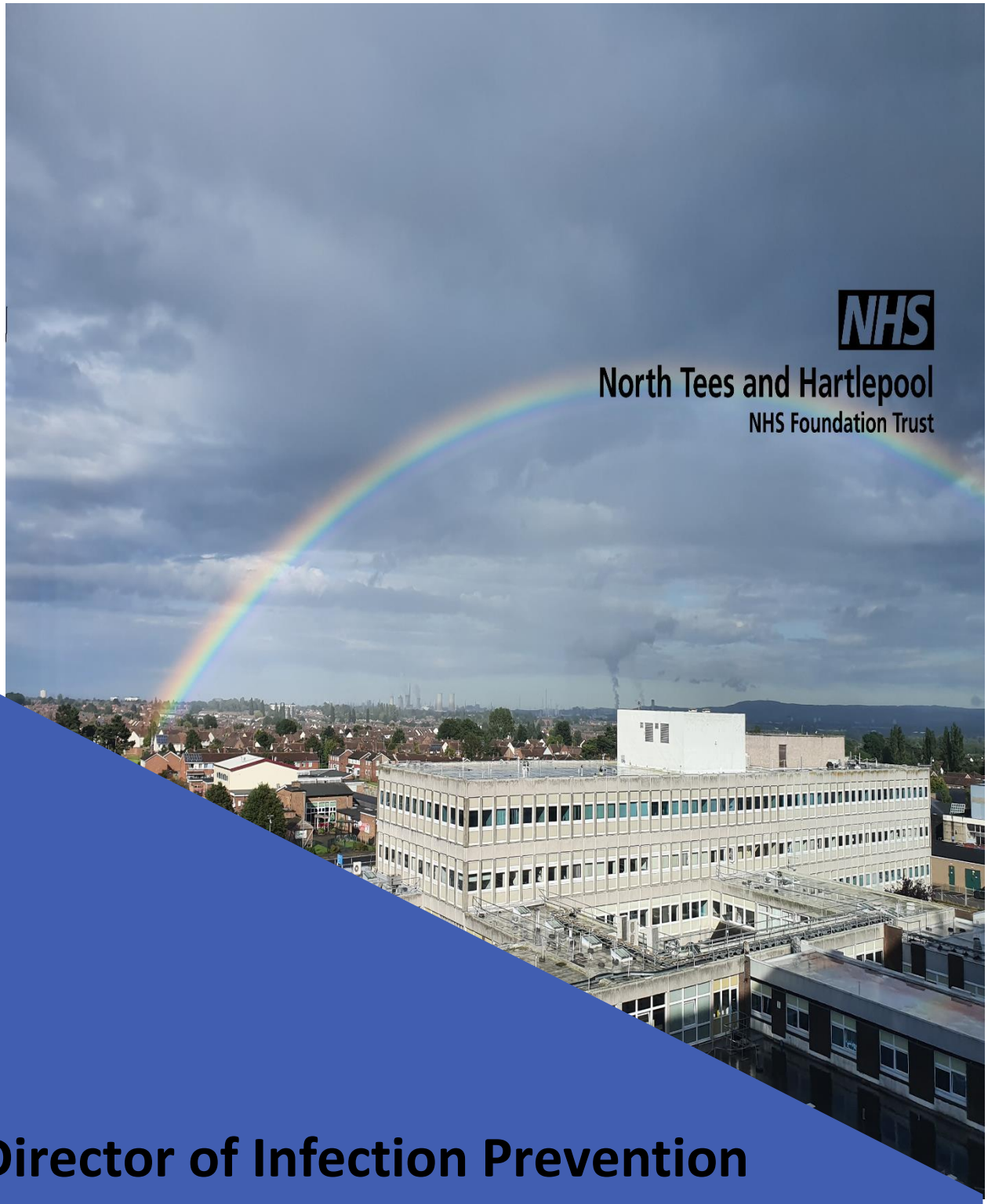
- Any changes to CHiC services in response to commissioning decisions are supported to ensure completion of children's health assessments is not affected and a smooth transition is enabled that informs partner agencies.
- To continue to achieve compliance of local quality requirements as agreed with Care Quality Commission on the delivery of Initial and Review Health assessments for children in our care.
- To ensure that families and carers are engaged and involved as appropriate to promote optimum health and development of all looked after children.
- To ensure that the young person's views, as appropriate are included in the health care plan.
- To work in conjunction with local authority and other partners to promote the health and well-being of looked after children.
- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population.
- To identify and address barriers to accessing health services and make them accessible to Children and Young People in Care.
- To provide training for foster carers and residential workers in agreement, or jointly, with social work and health colleagues.
- To provide expert health advice and training for partner agencies and carers in the needs of this specific client group.

Vulnerability Team Summary

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

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

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



Director of Infection Prevention and Control Report 2020-21

Executive Summary

The last 12 months have been a time of unprecedented challenge and uncertainty for hospitals across the UK. Much of our usual work has had to be paused or scaled back because of the global pandemic and its impact on hospitalisation figures. We have had to adapt the way we work and to keep our patients and staff safe in the most difficult circumstances. There has not been a time in recent history when infection prevention and control practice was as essential as it is now. The profile has been raised, and while that has presented some challenges, it has also contributed to success. We have seen the majority of cases of infections in the mandatory surveillance programme either remain at a low level or improve from the previous year. This may be due to heightened awareness of hand hygiene, environmental cleanliness and correct use of personal protective equipment. Our staff have worked collaboratively and imaginatively to overcome difficulties and adapt to new guidance. They have a lot to be proud of

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

Contents

Infection Prevention and Control Arrangements Page 4

Healthcare Associated Infection Surveillance & Performance Page 6

a. Mandatory Reporting
b. Clostridioides difficile infection
c. MRSA bloodstream infections
d. MSSA bloodstream infections
e. E coli bloodstream infections
f. Klebsiella species bloodstream infections
g. Pseudomonas bloodstream infections
h. Glycopeptide resistant Enterococcus
i. Surgical Site Surveillance
j. Influenza
k. Hand Hygiene
l. Outbreaks

COVID-19 Page 13

Policies Page 15

Audit Programme Page 16

Training Page 16

Antimicrobial Stewardship Page 17

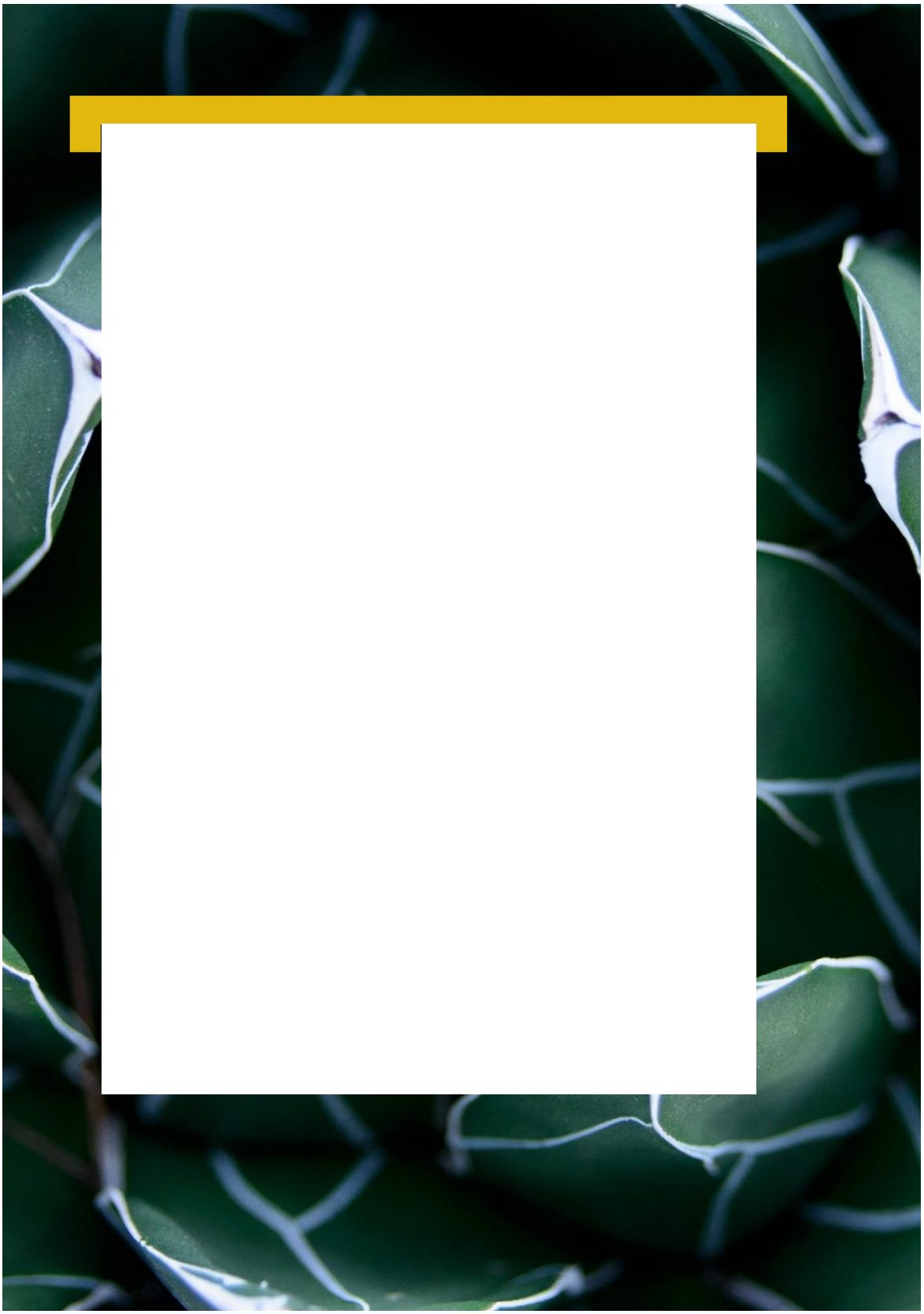
Decontamination of the Environment and Equipment Page 18

Conclusion Page 19

Infection prevention and control arrangements

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

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



Healthcare associated infection surveillance and performance

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

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

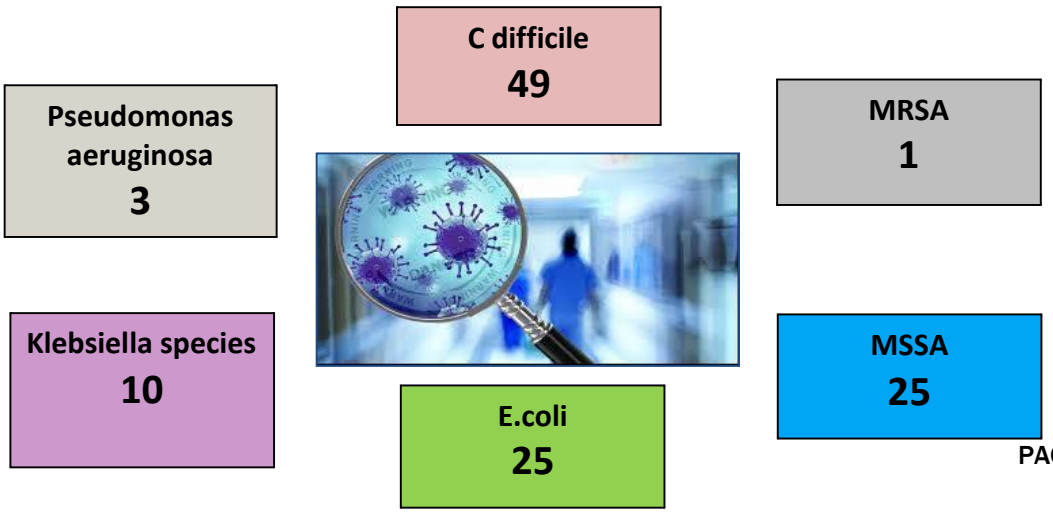
National criteria are applied to establish whether cases of the infections above are attributable to the Trust (hospital onset or healthcare associated).

For bacteraemia cases when the sample is taken on the day of admission or the following day it is considered to be community onset, and samples taken after that time are considered to be hospital onset.

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

In previous years national reduction objectives have been set for CDI, MRSA and gram negative blood stream infections (E coli, Klebsiella and Pseudomonas), however no objectives were given for 2020-21. The Trust aim for this year was to report no more than 53 CDI cases, zero preventable MRSA bacteraemia and 10% reduction on the other infections.

Fig 1. Total number of healthcare associated infections during 2020-21



Clostridioides difficile infection (CDI)

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

During 2020-21 we reported 49 healthcare associated cases of CDI which was a 9% reduction on the previous year. Although we would have preferred to achieve a greater reduction this is perhaps a reflection of the number of patients admitted with Covid, requiring significant antibiotic treatment, thus increasing the risk of this infection.

Fig 2. C difficile cases 2018-21

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

Actions to reduce CDI form part of the Trust HCAI Improvement plan and are discussed at regular meetings. These include a continued focus on hand hygiene and environmental cleanliness and promotion of good antibiotic stewardship. Each healthcare associated case is subject to an investigation to identify any trends or learning that can be included in the improvement plan.

MRSA bacteraemia

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

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

In 2020-21 we reported one healthcare associated MRSA blood stream infection. This is very disappointing as we had a period of 34 months with no such cases. Two community onset cases were also reported.

Fig 3. MRSA bacteraemia cases 202015-21

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

Healthcare associated MRSA bacteraemia cases are subject to root cause analysis to identify where things could be done differently. From the case this year we identified that admission screening had not been carried out as required by Trust policy. Therefore we do not know if the patient was already positive on admission, in which case we could have given decolonisation treatment to reduce the risk of infection. The source of infection was thought to be an infected intravenous cannula and learning around care and documentation for these devices was identified. Monthly audits of screening compliance are underway and are showing improvements.

MSSA bacteraemia

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

In 2020-21 we reported 25 healthcare associated cases of MSSA bacteraemia, just a small reduction on the previous year when 26 cases were reported. In many cases the source of infection has been a chest or skin infection which would have been difficult to prevent and in some cases the source infection has been present on admission. However we recognize the need to make further improvements and projects to facilitate this are part of the annual programme for 2021-22.

Fig 4. MSSA bacteraemia cases 2015-21

Year	*Healthcare associated cases*	*Community onset cases*
2015-16	24	64
2016-17	21	57
2017-18	25	71
2018-19	21	93
2019-20	26	75
2020-21	**25**	**63**

E coli bacteraemia

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

In 2020-21 we reported 25 healthcare associated cases which is a significant improvement on the previous year. This may be due in part to reduced occupancy in the middle of 2020 due to COVID-19, or to the use of personal protective equipment, increased cleaning and better hand hygiene across the year because of the pandemic. The most common source of infection remains the urinary tract, with some cases being related to urinary catheters. Trial work on new cleaning solutions was paused during the surge of cases but has now recommenced with the aim of making a recommendation for rollout.

Fig 5. E coli bacteraemia cases 2015-21

Year	*Healthcare associated cases*	*Community onset cases*
2015-16	44	224
2016-17	50	267
2017-18	43	304
2018-19	39	317
2019-20	52	279
2020-21	**25**	**205**

Klebsiella species bacteraemia

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

We reported 10 healthcare associated cases of Klebsiella bacteraemia in 2020-21. This is the same as the previous year. It is difficult to identify trends with a small number of cases but we continue to look for opportunities to reduce this infection by improving IPC practices across all settings.

Fig 6. Klebsiella bacteraemia cases 2016-21

Year	*Healthcare associated cases*	*Community onset cases*
2016-17	22	49
2017-18	29	42
2018-19	20	40
2019-20	10	49
2020-21	**10**	**39**

Pseudomonas bacteraemia

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

In 2020-21 we reported three healthcare associated cases which is the same as the previous year. The number of cases is too small to identify trends in terms of place or practice.

Fig 7. Pseudomonas bacteraemia cases 2016-21

Year	*Healthcare associated cases*	*Community onset cases*
2016-17	9	9
2017-18	5	19
2018-19	9	20
2019-20	3	17
2020-21	**3**	**13**

Glycopeptide resistant Enterococcus (GRE)

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

The number of blood stream infections caused by GRE is low and sporadic in the Trust. In 2020-21 we reported 3 cases, only one of which was healthcare associated. This case is subject to an investigation and genetic typing is being carried out. More commonly we see GRE from screening swabs which is more likely to be colonisation than infection.

Surgical Site Infection (SSI)

All trusts are required to submit surgical site infection data for a minimum of one quarter per financial year. Since 2019 we have been reporting data continuously across the year and are expanding the number of surgical procedures included in the surveillance. In 2020-21 the number of procedures carried out was greatly reduced by the halting of elective surgery due to Covid for parts of the year. Only one surgical site infection has been identified. The national report has not been published for 2020-21 at the time of writing therefore we have been unable to benchmark our results.

Year	Primary total hip replacement No of procedures and infections	Primary total knee replacement No of procedures and infections	Reduction of long bone fracture No of procedures and infections	Repair of neck of femur No of procedures and infections
2019-20	322/0	399/0	39/0**	79/0**
2020-21	146/0	146/0	186/0	288/1

** data submitted for one quarter only

Influenza

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

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

Hand hygiene

This year we introduced monthly self-audit of hand hygiene for our clinical teams, with quarterly assurance audits by the IPC team. However the pressures on the teams due to COVID-19 have meant not all areas were able to complete the monthly audits. Overall the target of 95% compliance has been achieved each month. The pandemic may have had a positive effect on hand hygiene so the reintroduction of the assurance audits will be a good measure of consistent improvement.

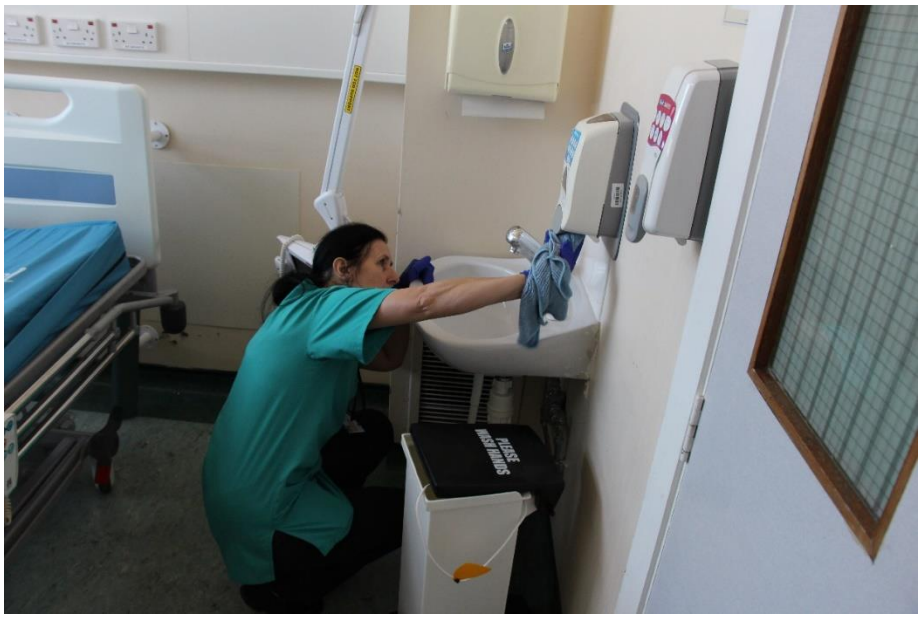
Fig 9. Hand hygiene compliance May 2020 to March 2021

May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
99.03%	98.43%	96.34%	98.91%	99.49%	96.24%	95.92%	98.70%	98.46%	97.79%	98.67%

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

Outbreaks

We reported only three outbreaks of diarrhea and vomiting in 2020-21, two of which had a viral cause. Unusually all of these outbreaks occurred in summer months, affecting 33 patients and 6 staff. The IPC team has worked with domestic and clinical staff to improve management of such outbreaks by early recognition, prompt action and enhanced cleaning, to reduce the impact on patient flow and outcomes. Cleaning is always increased in an outbreak situation and the ward is 'deep cleaned' prior to reopening once the outbreak has been closed.



COVID-19

The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases were reported in the UK in January 2020. COVID-19 surveillance has been ongoing since January 2020, which due to the high number of cases has provided all Infection Prevention and Control (IPC) teams with challenges and impacted their work significantly.

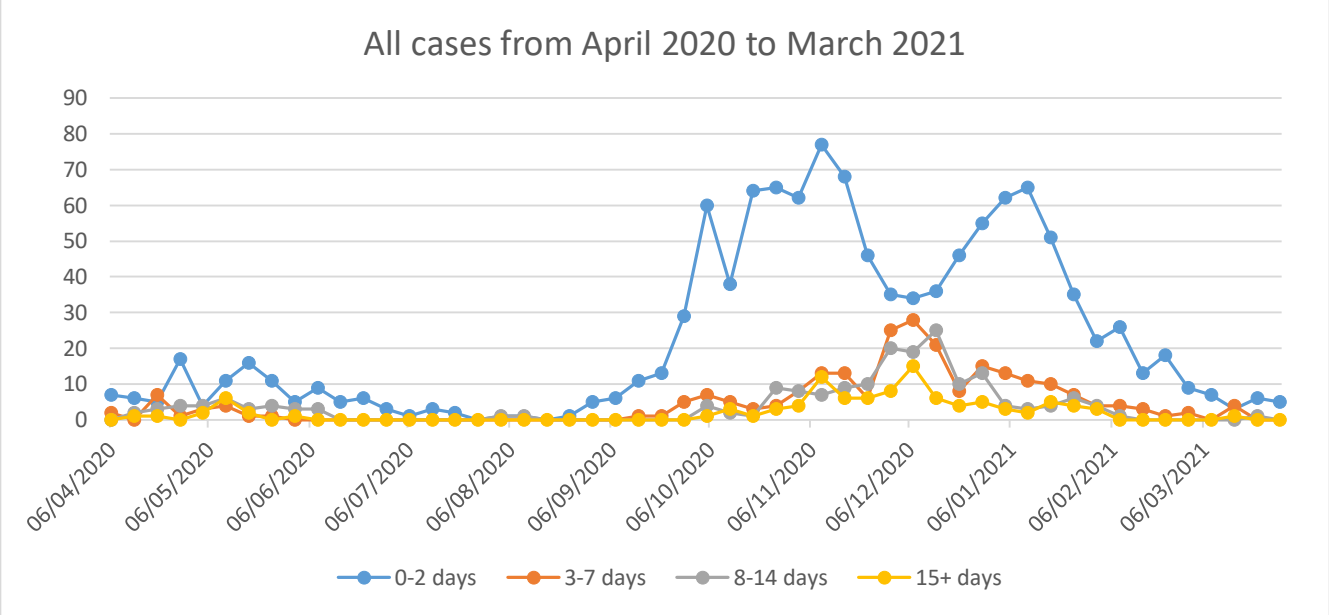
Relevant working groups were developed, both within the trust and with local authorities, to ensure that clinical decision in relation to new and evolving guidance was discussed and implemented as appropriate and as timely as possible. The Trust followed national guidelines and recommendations in ceasing elective work, reconfiguring acute services with increased intensive care capacity and redeployment of the workforce.

The trust implemented a comprehensive screening service for staff, which demonstrated collaborative working between the IPC team and occupational health teams. The IPC team supported staff across the organisation and training was delivered in donning and doffing of Personal Protective Equipment (PPE) to both clinical and non-clinical staff. From April 2020, PPE Safety Officers were introduced trust wide, additional training was provided to over 200 staff to ensure that new guidance, and recommendations were embedded quickly. The IPC team worked closely with procurement and supplies to ensure that relevant PPE was provided in line with national guidance. The IPC team

provided a seven day service for 7 months during this year in order to support staff across the full week.

From April 2020 to March 2021 the trust cared for 1730 patients positive for COVID-19. 1188 patients were admitted and had a positive Covid-19 result within 0-2days of admission. A further 244 patients tested positive within 3-7 days of admission. Both of these categories are attributable to the community. There were 193 cases identified within 8-14 days of admission and are possibly hospital acquired. 105 patients tested positive after 15 days or more of admission and are categorised as definite hospital acquired cases.

Fig 10. COVID-19 in patients 2020-21



During the second wave of the COVID-19 pandemic the trust saw a significant increase in the amount of nosocomial COVID-19 infections. These are cases where the patient has been in hospital for 8 days or more. Despite the rising community prevalence of the virus the trust fought hard to review our measures and implement additional ones to help maintain the safety of our patients and staff. Reduction in patient movement, increased routine testing, increased visor usage and tougher compliance with all standard infection control precautions (SICPs) including hand washing and safe distancing all contributed to a successful decrease in hospital onset cases of COVID-19. The trust continues to report low numbers of hospital onset cases.

Outbreak management of the COVID-19 virus also provided a challenge to the IPC team. By collaborating with the regional IPC teams we were able to share learning providing vital insight into outbreak management, and since early April there have been no COVID-19 outbreaks.

NHS England and NHS Improvement provided a COVID-19 Assurance Framework to help organisations provide assurance to their board that all measures required were in place or mitigating actions were identified. This document has been revised several times and has been presented to Trust Board and the ICC since July 2020. Any gaps in assurance form part of the improvement plan for 2021-22.

The Trust has provided IPC support to adult care homes in Stockton and Hartlepool since 2008 but worked closely with care group colleagues to increase the support during the pandemic, including establishing a PPE Champion role, providing advice and training to mental health homes and domiciliary care providers and assisting with outbreak management in special schools.

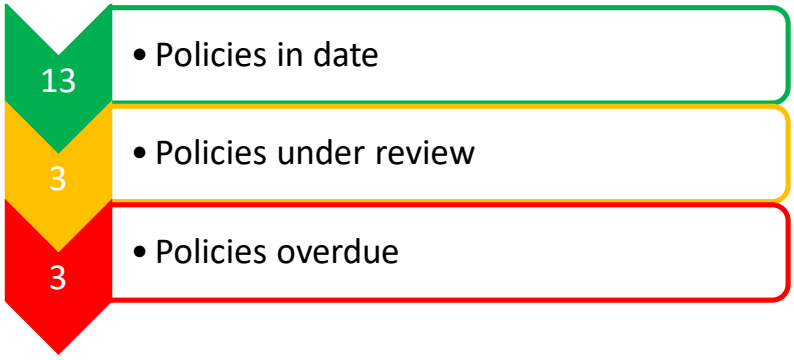
Our vaccination Programme began in December 2020, with redeployed staff supported by volunteers and temporary vaccinators, based in our vaccination hub. Between December 2020 and March 2021

85% of our staff and volunteers had received at least one dose of vaccine and 42% had received both doses.

Policies

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

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



Audit Programme

Usually a programme of audits are planned for each year as part of the IPC annual programme. This allows us to monitor adherence to policy and identify areas for focused work. However, as 2020-20 was not a normal year, most of our audit programme was paused to allow the IPC team to focus on training and support staff caring for patients in a situation where the guidance changed frequently.

Only two audits were completed during the year. In October 2020 the MRSA screening audit was performed and from July 2020 a new PPE compliance audit was introduced across all clinical areas. This audit is completed by ward matrons, senior nurses and the IPC team and so frequency varies but each area has been audited a minimum of 3 times. 200 audits were completed between January and March 2020. The results of these audits can be seen below. Feedback is given to individual teams at the time of the audit, and actions identified are added into the IPC action tracker which is discussed at each HCAI Operational Group and ICC meeting.

MRSA screening policy	
Overall Trust compliance 2019-20	Overall Trust compliance 20-21
New combined audit so comparison not possible	57%

PPE compliance audit	
Overall Trust compliance July – Dec 2020	Overall Trust compliance Jan to March 2021
86%	87%

Training

We apply a blended approach to IPC training with a mixture of face to face and online learning or workbooks to facilitate different learning preferences. As all training is in line with a regionally agreed programme and is recorded on the electronic staff record (ESR) it is portable between organisations

which is beneficial for staff in rotational posts. Level 1 training is for non-clinical staff and is required every 3 years. Level 2 for clinical staff is required annually.

In response to the pandemic the team has also provided a significant number of face to face training sessions for donning/doffing PPE and also runs sessions for PPE safety officers to allow them to support colleagues in the workplace to choose and wear the appropriate PPE safely.

Antimicrobial Stewardship

Collaborative work with South Tees Hospitals NHS Foundation Trust around shared empirical antibiotic guidelines is underway with the aim of having guidelines that have a regional approach to stewardship and are easier for clinicians moving between organisations to use. Once the guidelines are approved they are uploaded to the Trust intranet site and the plan for the future is shared use of the MicroGuide® app. The development of these guidelines has been RAG rated and presented to the ICC. It is essential these updated guidelines are approved and published to support good stewardship

Discussions have taken place around the role and membership of the Trust Antibiotic Stewardship Committee (TASC) and a refresh is underway. The new group will meet following the approval of the first group of empirical guidelines as described above.

We have a multidisciplinary approach to improving and expanding our outpatient antibiotic therapy (OPAT) service allows us to treat more patients with antibiotics at home, reducing admissions, facilitates patient flow, reduces the use of broad-spectrum antibiotics and leads to cost efficiency and greater patient satisfaction.

Antibiotic ward rounds take place daily in Critical care and we hope with the arrival of new microbiologists to extend these rounds to further clinical areas. A weekly C difficile patient review round also takes place.

Our antibiotic consumption data shows that North Tees and Hartlepool NHS Foundation Trust is among the highest users of carbapenems, piperacillin/tazobactam and co-amoxiclav in the North east although other trusts have seen an increase in these antibiotics due to COVID-19 and winter. Our antibiotic strategy will be reviewed and shared with the new TASC to ensure we have measures in place to reduce this consumption.

Decontamination of the Environment and Equipment

Decontamination is a process which removes or destroys infectious agents from furniture or medical equipment. Cleaning is always the first step in this process, which can then be followed by disinfection or sterilization depending on the circumstances in which the equipment is used.

The Sterile Services Department is responsible for reprocessing reusable medical devices. All processes are fully validated and compliant to national standards HTM 01-01 and ISO 13485:2016, an internally and externally audited process. Disposable items are used whenever this is possible and efficient

Decontamination audits are completed annually in departments where local decontamination takes place and the audit team includes the IPC nurses. Results are reported to the Decontamination Group which reports into the ICC.

The endoscope decontamination facilities on both sites are validated and compliant with national requirements. An Authorizing Engineer (Decontamination) has validated the annual reports.

The provision of cleaning services in our hospitals and other premises is provided by a combination of NTH Solutions LLP and external contractors who cover some community premises. Performance monitoring is undertaken by quality monitors and the results fed into the Decontamination Group and ICC via a quarterly report presented by the Assistant Director Decontamination Services (NTH Solutions). Enhanced cleaning is provided by a response team and hygienist team. All decontamination staff have been a vital part of the work to reduce infections and particularly in the measures taken to reduce COVID-19. They have worked flexibly, often in unfamiliar settings and wearing PPE. We are grateful for their continued support as part of our wider team.

During 2020-21 we have been exploring the use of an alternative cleaning product, to achieve the levels of cleanliness and assurance around effect on microorganisms but with fewer impacts on the

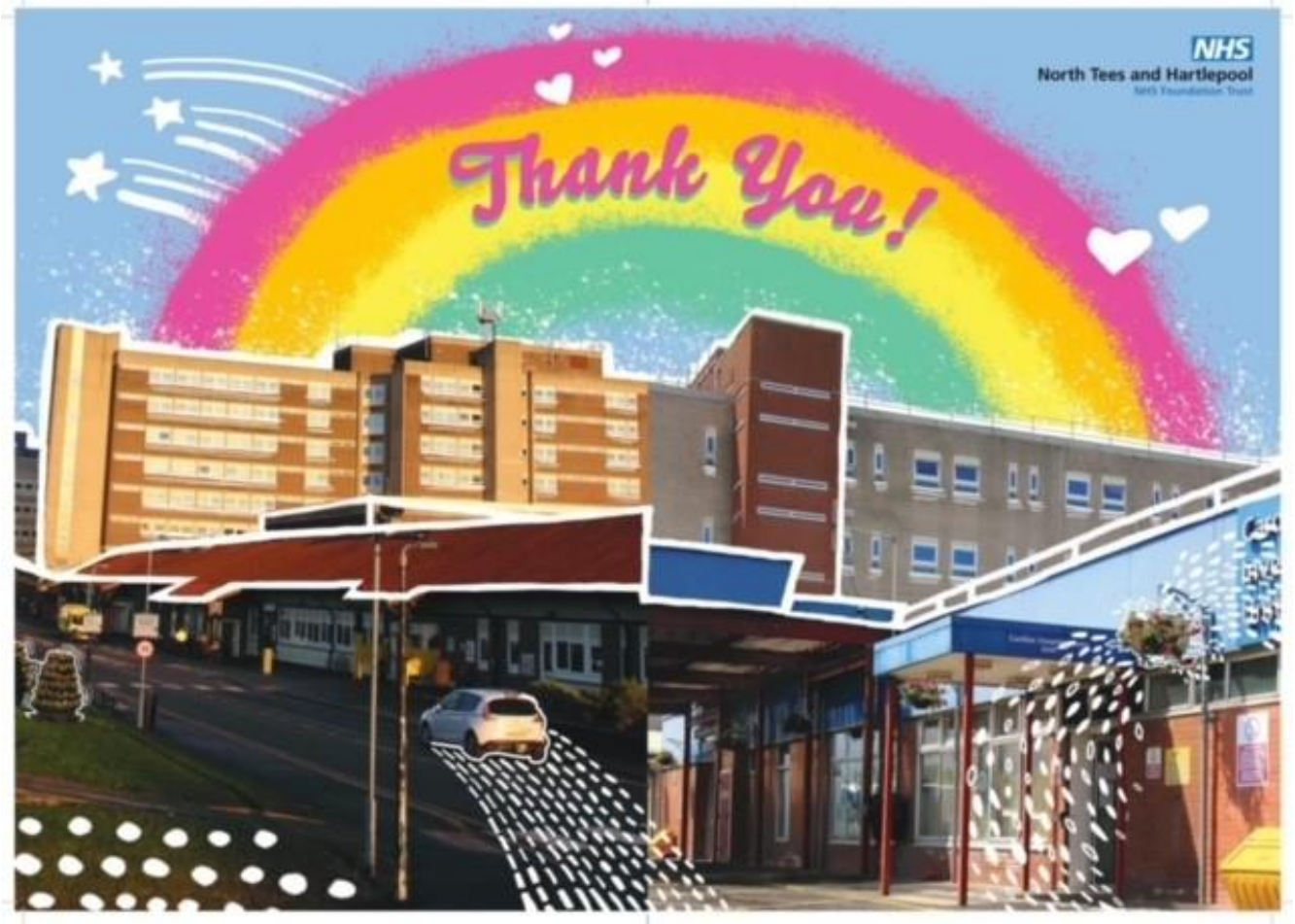
environment and staff wellbeing. A trial is underway in collaboration with NTH Solutions and Teesside University following which a recommendation will be made to the Trust Executive Team for further roll out if the product is successful.

Conclusion

2020-21 has been a year like no other for our trust and the NHS as a whole. It has brought significant challenge in terms of the ability to respond quickly to rapidly changing national guidance, anxiety in staff and patients, changing community transmission rates of COVID-19 which impacted on our patient pathways and staffing challenges due to sickness and shielding. Our staff have risen to that challenge in a way that makes us very proud. There have been some difficult decisions and tough times but patient safety has remained at the forefront.

The IPC team has continued to deliver valuable knowledge and skills to the staff within the trust, providing advice and guidance during a global pandemic to ensure the safety of the patients, visitors and staff is maintained at every opportunity.

Reducing the risk of infection has been our priority and remains so in the coming year. Antimicrobial stewardship and the availability of single rooms are two priorities for improvement in 2021-22 and we will continue to build on the collaborative relationships with our colleagues across the North East and North Cumbria to make those improvements.



Thank you to the following for their contributions to the report:

Graeme Kelly, Assistant Director Decontamination Services, NTH Solutions LLP
Richard Cowan, Antimicrobial Pharmacist
Rebecca Denton Smith, Lead Nurse IPC