North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 9 November 2023
at 1.00pm

Boardroom
University Hospital of North Tees

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
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3 November 2023

Dear Colleague

A meeting of the **Board of Directors** will be held in public, on **Thursday, 9 November 2023 at 1.00pm** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(1.00pm)	Apologies for Absence	Chair
2.	(1.00pm)	Declaration of Interest	Chair
3.	(1.00pm)	Network Story	L Robertson
4.	(1.15pm)	Minutes of the meeting held on, 5 October 2023 **(enclosed)**	Chair
5.	(1.20pm)	Matters Arising and Action Log **(enclosed)**	Chair
Items for Information			
6.	(1.25pm)	Report of the Joint Chair **(enclosed)**	Chair
7.	(1.35pm)	Joint Partnership Board Update **(enclosed)**	Vice Chair
8.	(1.45pm)	Report of the Managing Director **(enclosed)**	N Atkinson
9.	(1.55pm)	Retrospective Approval of Documents Executed Under Seal **(enclosed)**	N Atkinson
Performance Management			
10.	(2.00pm)	Board Assurance Framework Quarter 2: 2023/24 **(enclosed)**	S Irvine
11.	(2.10pm)	Integrated Performance Report **(enclosed)**	R Dean, L Robertson, K Hudson-Halliday, S Cook
Governance			
12.	(2.25pm)	Fit and Proper Person Framework Requirements **(enclosed)**	S Cook/S Irvine

13. (2.35pm)	Provider Collaborative Responsibility Agreement **(enclosed)**	N Atkinson

Quality

14. (2.45pm)	Maternity Board Report Quarter 2: 2023/24 **(enclosed)**	L Robertson

Operational Issues

15. (2.55pm)	Winter Resilience Plan **(enclosed)**	R Dean
16. (3.05pm)	NHS Core Standards for EPRR 2023/24 **(enclosed)**	R Dean

Items to Receive

17. (3.15pm)	Assurance Report of Quality Committee **(enclosed)** (30 September 2023)	F Scullion/A Baxter
18. (3.20pm)	Assurance Report of Resources Committee **(enclosed)** (30 September 2023)	C Macklin
19. (3.25pm)	Assurance Risk Management Group Report **(enclosed)**	L Robertson
20. (3.30pm)	Data Protection SIRO Report - DSPT Year End 2022/23 **(enclosed)**	N Dobinson
21. (3.35pm)	Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation Report **(enclosed)**	L Robertson
22. (3.40pm)	Any Other Business	

Date of next meeting
(**Thursday, 1 February 2024, Boardroom, University Hospital of North Tees**)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing Our People

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

Transforming Our Services

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

Health and Wellbeing

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

Agenda Item 4

North Tees and Hartlepool NHS Foundation Trust

DRAFT Minutes of a meeting of the Board of Directors held on Thursday, 5 October 2023 at 9.00am at the University Hospital of Hartlepool / Via Video Link

Present:

Ann Baxter, Vice Chair/Non-Executive Director* (Chair)	AB
Fay Scullion, Non-Executive Director* via video link	FS
Alison Fellows, Non-Executive Director*	AF
Professor Liz Barnes, Non-Executive Director*	LB
Neil Atkinson, Managing Director*	MD
Kate Hudson-Halliday, Acting Director of Finance*	ADoF
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Susy Cook, Chief People Officer/Director of Corporate Affairs*	CPO/DoCA
Stuart Irvine, Director of Strategy, Assurance & Compliance	DoSA&C
Dr Narayanan Suresh, Deputy Chief Medical Officer	DCMO
Lindsey Wallace, Care Group Director, Collaborative Care	CGDCC
Ruth Dalton, Deputy Director of Communications, Engagement & Marketing	DDoCE&M

In Attendance:

Heidi Holliday, Secretary to the Trust Board [note taker]
Stephanie Worn, Associate Director of Midwifery (Item 12 only)
Deepak Dwarakanath, Chief Medical Officer
Gareth Lightfoot, Local Democracy Reporter

BoD/5138 Apologies for Absence / Welcome

The Vice Chair welcomed members and members of the public to the meeting.

Apologies for absence were noted from Professor Derek Bell, Joint Chair, Chris Macklin, Non-Executive Director and Dr Elaine Gouk, Acting Chief Medical Officer.

BoD/5139 Declaration of Interests

Declarations of interest were noted from the ADoF for her role as a member of the LLP Management Board and the DoSA&C for his role as Chair of Hartlepool College of Further Education.

BoD/5140 Patient Story

The CN/DoPS&Q welcomed Hayley Robertshaw, Director of Care and Development, St Martins Care to the meeting who shared information regarding the work of the organisation and the collaborative work that was being undertaken across Local Authorities, the Integrated Care Board (ICB) and out-with NHS Trust boundaries.

St Martins Care had six Care Homes, two Nursing Homes and a mix of residential and support living services with 422 registered beds and c.400 staff. Admission avoidance was a key focus of the organisation and a raft of solutions were being discussed with commissioners and regulators at present.

A falls strategy was also being developed, to best support and treat those patients. It was noted that a large number of calls to the North East Ambulance Service was due to falls as there were currently no hoisting services in the community and the impact of a long lie could be critical. An option for a lifting cushion had been explored, which assisted patients up to a seating position safely reducing the risk of injuries and Aging Well had provided funding of £20k for this. The lifting cushion had been piloted in three Care Homes and had prevented 31 long lies and 31 admissions to hospital. It was

* voting member

hoped that following evaluation of the data following these falls the ICB would provide funding for the development of an app similar to the ISTUMBLE app, which helped perform health assessments around when to lift a fallen resident and when to call an ambulance. A business plan would be presented to the ICB by the end of the year.

Other areas of work included the development of a head injury pathway, nurse prescribing and advance practitioner roles, working with Northumbria University regarding a Nurse Associate pathway and an information pack 'Concerned About Your Resident', which provided support to care home staff and raised awareness of additional community services that could be contacted when there was a concern about a resident, which included the 2 Hour Urgent Community Response Team.

The Board of Directors thanked Hayley for sharing the information on the important work that was ongoing. The ADoF agreed to share this information with her colleagues on the Critical Care Board to help raise further awareness.

Following discussion it was agreed that the Patient Story be widened to Network Stories.

Resolved: (i) that, the story be noted; and
(ii) that, the ADoF share information with colleagues at the Critical Care Board to raise further awareness of the work being undertaken; and
(iii) that, future stories be named Network Stories.

BoD/5141 Minutes of the meeting held on, Thursday, 27 July 2023

Resolved: that, the minutes of the meeting held on, Thursday, 27 July 2023 be confirmed as an accurate record.

BoD/5142 Matters Arising and Action Log

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

a. BoD/5009 BAF Quarter 4 Report: 2023/24

A full review of the Business Assurance Framework (BAF) was undertaken to identify whether it continued to be fit for purpose and how it linked to the strategic aims. A Board Seminar was held on Thursday, 27 July 2023 where the BAF review was discussed in detail. It was agreed that BoD/5009, BoD/5048 and BoD/5089 be condensed into one action.

b. BoD/5092 NHS Workforce Disability Equality Standard (WDES) 2023

Work continued to review the ESR system and the issues raised regarding barriers staff were experiencing. Work was ongoing with the Care Groups to help provide support where needed, to encourage teams to update their status, especially those with access to ESR.

c. BoD/5093 Utilisation of the University Hospital Elective Hub

Early discussions had taken place with the Get It Right First Time (GIRFT) Team and a lot of work was being undertaken to prepare for the next visit scheduled to take place on Friday, 24 November 2023.

d. BoD/5096 Freedom to Speak Up Annual Report

The Annual Report was ready to be shared with Governors however, had not yet been circulated.

Resolved: (i) that, actions BoD/5009, BoD/5048 and BoD/5089 be condensed into one action; and
(ii) that, Freedom to Speak Up Annual Report to be shared with Governors.

BoD/5143 Report of the Joint Chair

A summary of the Joint Chair's report was provided by the Vice Chair with key points highlighted.

- Group and Joint Working – positive meetings continued including the joint meeting of the Council of Governors held on 19 September 2023 where an update on key topics and progress of joint working was provided and the Joint Partnership Board (JPB) meeting held on 20 September 2023 where the draft Partnership Agreement was shared and agreed in principle.
- The appointment of the Group Chief Executive was well underway with formal interviews scheduled to take place on 13 October 2023.
- An NHS Confederation Briefing Event took place in August 2023 regarding the Major Conditions Strategy, which was a national framework focusing on six major groups of conditions and how to take that forward as part of levelling up.
- A national Quality and Safety Event was held on 6 September 2023 where discussions were held around current monitoring arrangements such as Freedom to Speak Up, Fit and Proper Person to highlight any gaps that needed to be addressed. In light of the recent Lucy Letby case quality and safety remained a top priority.

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

BoD/5144 Joint Partnership Board Update

The Vice Chair presented the Joint Partnership Board (JPB) Update Report and highlighted the key issues.

- An excellent staff story was shared from Janice Atkinson, Neonatal Ward Manager regarding the changes to neonatal services across both trusts and the lessons that had been learnt.
- The draft Partnership Agreement was agreed and would be shared with internal and external stakeholders with the final draft being presented to the JPB in November for agreement prior to approval by both unitary Boards.
- The development of the Clinical Services Strategy continued to progress with a workshop for clinical colleagues scheduled to take place on 9 October 2023.
- The Communications and Engagement Strategy to support the Partnership Agreement had been shared and the joint financial statement regarding the Group had been ratified, setting out the Groups commitment to use joint resources to improve the financial situation.
- It was agreed that the Associate Director of Group Development would produce a proposal for Group performance reporting, which would be presented at the next meeting in October.

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

BoD/5145 Report of the Managing Director

The MD presented the Report of the Managing Director and highlighted key points.

- Julie Gillon, former Chief Executive retired on 30 September 2023 following 40 years NHS service, of which 21 years were at the Trust. The MD placed on record his thanks for her leadership, inspiration and dedication.
- Dr Deepak Dwarakanath had chosen to step away from his role as Chief Medical Officer for a temporary period of time however, would continue with his clinical duties. Dr Elaine Gouk was the Acting Chief Medical Officer, whilst expressions of interest were sought from senior consultants to undertake the role for a period of around six months.
  Dr Hamish McLure had been commissioned to provide external support to the new post holder as part of succession planning.
- The Staff Survey had been launched on 19 September 2023 and it was hoped that this would build on the very positive position from the last survey.
- Operational challenges were noted which included elective recovery and industrial action. The MD acknowledged the contributions of all staff groups in keeping patients safe. Industrial action had impacted on levels of RTT activity and in particular the increase in over 52 week waits. The

Trust remained in a good position regionally however, focused work was ongoing to reduce the numbers. It was noted that two patients had been waiting over 65 weeks and no patients were waiting over 78 or 104 weeks.

- Trust bed occupancy had seen a slight increase in August 2023 with an average occupancy of 92.28%, against a threshold of 92% largely driven by the increase in covid patients. The Trust was one of the best performers in relation to discharges and the national discharge team had visited the Trust in August to gain insight into how the Trust was achieving the lowest number of stranded patients in the country.
- During August there were 89 patients waiting beyond the 12 hours in Accident and Emergency, with almost 80% of the waits being due to patients waiting to be admitted to either the Emergency Assessment Unit, Surgical Decision Unit or a Mental Health facility. Focus continued on this to ensure there was no harm as a result of any long waits.
- At month five the Trust had a planned year to date surplus of £2.992m and had delivered a £1.074m surplus, which was £1.9m behind plan, attributable to the cost of the national pay award and industrial action.
- Following the outcome of the trial of Lucy Letby, the NHS welcomed an independent inquiry, which was to be led by Lady Justice Thirlwell into the events at the Countess of Chester Hospital and the wider implications for the NHS.
- NHS England had published a Fit and Proper Person Test Framework with revised requirements to strengthen current arrangements, which came into effect from 30 September 2023 for executive and Non-Executive directors of ICBs, NHS Trusts and Foundations Trusts, NHS England and the Care Quality Commission (CQC).
- The New Hospital Outline Business Case (OBC) continued to be developed with support from a dedicated project team to ensure the Trust would be "ready to bid" following any future funding announcements that may arise. The Trust expected to complete the OBC by its target date of 28 February 2024.
- The Department of Education published new guidance around the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) in the school estate, which generated heightened public interest within the NHS estate. Following an assessment, it was noted that the Trust did not have any RAAC present in any patient facing areas. An overview of work undertaken to address its presence in the non-patient facing areas was provided along with the plan for ongoing reviews.
- Following appointment of the Kier Group as principal contractor, construction of the new build Community Diagnostic Centre (CDC) commenced on 3 September 2023. The "first spade" ceremony was held on 15 September 2023, which proved a popular event. The operating model had been agreed and the scheme was expected to be completed by summer 2024, which was six months ahead of the original plan.
- Positive progress had been made with regards to the development of the Health and Social Care Academy. A competitive tender process was underway to assist in the appointment of the main contractor. In addition to the capital funding, a submission had been made to the Local Skills Improvement Fund (LSIF) to support with costs associated with additional equipment.
- The Trust had been shortlisted for a Health Service Journal (HSJ) patient safety award for its CareScan+ project and the Trust was very proud of the work the team had achieved in developing this.

Following a query regarding recompense following the industrial action, the MD reported that early discussions were being held to identify funding for this. A proposal had also been made to reduce the target for elective recovery to a reasonable level in recognition of the industrial action and some of those costs would be put towards this. The impact on patients from delayed treatment due to the industrial action was noted.

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

BoD/5146 Integrated Performance Report

The CN/DoPS&Q, CPO/DoCA, ADoF and the CGDCC presented the Integrated Performance Report (IPR) for 2023/24 and highlighted the key points.
Safe:

- During August, the Trust reported one serious incident and the case was under review, however there had not been any Never Events during August.
- There were no falls resulting in severe harm and there were two in-patient falls reported in August resulting in moderate harm, both of which had been reviewed and closed.
- The Trust continued to be a positive outlier across the system in relation to Clostridium difficile (C.diff) and were providing support to other organisations as part of a peer review. There were no healthcare associated MRSA bacteraemia cases reported in August.
- There had been a cluster of infections in relation to Breast and several MDTs had been held to identify the root cause, which was being kept under surveillance.
- There had been a small increase in the number of Covid cases resulting in some bed and ward closures however, the Trust managed well within the bed base available.
- Excellent work had been undertaken on the CQC 'must do' and 'should do' actions and all had been signed off by the External Team and were presented to the Quality Committee.

Caring:

- The Trust had exceeded the 75% Very Good/Good standard for all six Friends and Family Test (FFT) and the significant increase in response to the FFT was noted.
- Complaint themes continued to be monitored and the Trust continued to strive for local and face to face resolution of concerns.
- Of the 125 complaints received in August, 89% were resolved locally, 5% were resolved with a face to face meeting and 6% opted for a written response.
- 440 compliments had been received in August, a slight decreased from July with the feedback being shared with the services in question.

Responsive:

- The Trust continued to exceed the overall 4-hour national target and achieved 85.20% in August. A Steering Group had been established to identify lessons that could be learnt and improvements that could be made and the Trust was on track to deliver against its internal improvement plan trajectory set. As part of the focussed work following the relaunch of the 4-hour standard a 'More Before 4' group had been established to review themes from long waits in the Emergency Department.
- The Trust was working in collaboration with the ICB on admission avoidance and discharge processes, building on the Trust's successful use of OPTICA, the multi-agency Integrated Single Point of Access and 2-hour community response.
- RTT remained above the regional and national standards with zero patients waiting over 78 or
- The Cancer Two Week Rule was reporting a fairly static position with patient choice remaining a key factor. Cancer navigators had been appointed and were contacting patients prior to appointments to ensure attendance and a patient engagement portal had recently been piloted, working with patients to enable them to engage and attend their appointments.
- Pressures were being seen within the 62 Day standard across the majority of tumour specific pathways, which were key areas of focus within the Trust's Cancer Improvement Plan. From 1 October 2023, cancer standards would be combined into 3 standards, 28 day, 31 day and 62 day treatment and the impact of that should see an improved position in terms of performance.

Well Led (People & Finance):

- Since the previous report, sickness absence had increased from 4.94% in June to 5.39% in July. Long term sickness accounted for 3.32% of the overall sickness absence with short term being 2.08%, which aligned with the industrial action and pressures in terms of workload. People Clinics continued to be undertaken at Care Group level to ensure the robust management of absence and trigger points and appropriate support was provided to staff. Action plans and formal processes had been developed to manage long-term sickness, which had shown positive results.
- The position for appraisal compliance for August stood at 87.24%, which was an increase of 0.68% on the previous month. Following on from the improvement workshop, revised appraisal documentation had been trialled and was now being rolled out across the Trust.
- Mandatory training compliance for August was 90.18%, which was a decrease on the previous month of 0.64%. Following a comprehensive review of mandatory training, agreement was reached to move to 'core 10' topics and a single reporting system via ESR, which was due to

commence at the end of October 2023.

- Turnover was 9.30% for August 2023, which was 0.12% lower than July 2023. Partnership working with South Tees Hospitals NHS Foundation Trust was progressing to undertake joint job evaluation processes across the two organisations.
- At month 5, the Trust was reporting an in-month deficit of £0.472m against a planned deficit of £0.195m, which was £0.277m behind plan.

The MD left the meeting.

Maternity:

- VTE compliance had improved in July from the previous month however, still remained at 79% against the Trust standard of 95%. The Maternity Team had undertaken a deep dive to identify the reasons for underperformance. Following the identification of an administration issue, additional support had been put in place and it was hoped that an improved position would be seen in the next report.
- Smoking at Booking was at 16%, which was higher than the NENC 11% average.
- Compliance was being monitored with regards to the Maternity safety actions.

Following a members query it was reported that a Workforce Plan was being developed and would be taken to a People Committee meeting, linking all areas together.

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

BoD/5147 Learning from Deaths Report

The DMD presented the Learning from Deaths Report and highlighted the key issues.

- There had been 329 inpatient deaths from April to June inclusive.
- The latest SHMI value was 97.5 from February 2022 to January 2023 and continued to remain inside the 'as expected' range. HSMR was no longer in use by the Trust as at the end of March 2023. The depth of coding within the Trust remained consistent and within range.
- Assurance was provided that all deaths were scrutinised by a Medical Examiner and a breakdown of the cases reviewed in Quarter 1 was provided. A thematic analysis of the data for Quarter 1 was being undertaken and information would be included in the next update report. It was noted that an action plan was in place to complete the outstanding Structure Judgement Reviews (SJRs).
- There had not been any identified preventable deaths or deaths related to problems in care and no deaths of patients with Learning Disabilities, no maternal deaths and no coroner regulations for this report.
- Two National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports had been identified and full details were provided in the report.
- Recruitment continued for the Learning from Deaths Co-ordinator role and SJR reviewers.
- Terms of Reference for the Learning from Deaths Steering Group had been drafted and a schedule of meetings was to be produced. The Steering Group would be overseen by the Quality Committee.

Following a query regarding the impact of smoking on stillbirths it was noted that these were reviewed as part of the perinatal mortality report and that there was a safety action focussing specifically on that.

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

BoD/5148 Guardian of Safe Working Hours Annual Report, August 2022 to July 2023

The DMD presented the Guardian of Safe Working Hours Annual Report and highlighted the key issues.

- The current Guardian of Safe Working was appointed in September 2022 and since then the exception reporting process continued to improve with a total of 214 exceptions submitted by 42 doctors in training, 5 of which were marked as an immediate safety concern.
- Six fines had been levied by the Guardian equating to a total of £358.95 however, it was noted that the Guardian's reserve was increasing to £493.03.
- A number of changes implemented had helped, including the reduction of shifts from 13 hours to 12.5 hours.
- Concerns had previously been raised regarding out of hours catering facilities for all staff who work in the evening and throughout the night. Following the 8 week pilot of the Tees restaurant overnight opening hours the Trust took the decision to cease the service due to poor uptake. Vending machines that provided hot meals was an option currently being explored as an alternative option.
- A QR code had been introduced to access the exception reporting system quickly and easily.

The MD returned to the meeting reporting that a number of Health Care Assistants had arrived to submit a joint grievance regarding the agenda for change national profiles for Clinical Support Workers. It was noted that the Trust had committed to provide back pay to 2021, which was greater than other organisations however, a request was being made to provide back pay for 4 years. It was noted that as the Trust was part of a system and group any decisions that were made needed to take that into account.

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

BoD/5149 Maternity Board Report – PQSM and Training Syllabus

Stephanie Worn, Associate Director of Midwifery joined the meeting and presented the Maternity Board Report and highlighted the key issues.

Quality and Safety:
There were two reportable cases for PMRT with no immediate learning identified. The maternity service did not receive any completed reports for PMRT and HSIB and it was acknowledged the service was meeting the required process standards. The monthly KPIs were presented with actions to increase VTE compliance. An improved position for obstetric haemorrhage >1.5l and ATAIN rates was presented along with an ATAIN action plan.

Culture and Leadership:
The Trust's quadrumvirate were actively involved in the national perinatal culture and leadership programme, supported by the Board Safety Champion through the bi-monthly meetings. Organisational planning was underway for the SCORE (Safety Culture, Operational risk, Reliability/burnout and Engagement) staff survey scheduled to go live in October 2023. The Board Safety Champions undertook monthly walkabouts across the perinatal services and fed back themes for action, which were visible in all areas**.**

Workforce:
The maternity service was compliant with the recommended funded establishment by BirthRate+. Staffing levels continued to be challenging however, plans for mitigations and escalation were discussed. The forecasted trajectory demonstrated an improved position for November. Safe services were monitored through the BR+ acuity tool and in July two red flags were submitted on a shift basis for loss of labour ward coordinator (LWC) supernumerary status. Following a review at the Maternity Quality Assurance Council, LWC supernumerary status was maintained as internal escalation had been activated and the LWC did not provide 1:1 care during this short interval. Obstetric delivery suite cover was achieved in month. A SOP for obstetric compensatory rest had been developed and approved by the Board of Directors. The external community review undertaken by the regional Midwifery Team was progressing with a report of recommendations expected by October 2023.

Maternity Training:
The obstetric emergency training, in line with the core compete framework v2 (CCFv2) and the requirements for the maternity incentive scheme, was on trajectory to meet compliance, following

discussion at the Maternity Quality Assurance Council. The maternity service had supported the revised NENC Maternity Mandatory Training Needs Analysis, Syllabus and Assessment Framework for 2023/24 and the Board of Directors approved this. The service was to commence planning on the training syllabus for 2024/25, along with a training needs analysis.

Maternity Incentive Scheme:
A review of the Maternity Incentive Scheme (MIS) year 5 and the technical guidance had taken place and collated evidence had been discussed at the Maternity Quality Assurance Council meeting held in September, with the Maternity Improvement Advisor in attendance. There was an agreement of the guidance for safety actions 5 and 8, with in-month compliance however, robust monitoring was to be maintained. A progress update for saving babies lives care bundle version 3 was received by the Board. The national implementation tool had been launched however, the service had discovered potential issues which had been escalated to both the national team and LMNS. It was reported July's clinical quality improvement metric had been submitted to NHS digital, the initial data validation demonstrated compliance and official confirmation was expected to be published on 25 October 2023.

It was noted that a review of community services was being undertaken, which was a real positive and supportive piece of work. Work was ongoing with Maternity Voices and the Safety Champions to drive this forward.

It was agreed that there had been a real positive development around leadership and moral within the maternity services department and staff returning to the Trust was a real quantitative measure of that. The Board of Directors thanked Stephanie Worn and the team for all their hard work.

The Board of Directors approved the Maternity Training Syllabus.

Stephanie Worn left the meeting.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Maternity Training Syllabus was approved.

BoD/5150 Annual Quality Account

The CN/DoPS&Q presented the Annual Quality Account and highlighted the key issues.

The Annual Quality Account had been published on the Trust's website and it was important to note that work was ongoing to identify how the data could be used to help focus on priorities as the Trust moved through the next year.

During 2022/23, the Trust met all standards required for successful and unconditional registration with the CQC for services across all of the community and hospital services. The focussed CQC inspection held in May 2022 concentrated on Maternity and Well Led and the report identified 13 'must do and 18 'should do' actions. Assurance was provided that the Trust had now met these actions and the next step was to engage with CQC colleagues.

As well as producing a new Dementia Strategy the Trust launched its first Mental Health Strategy, which demonstrated commitment that those with physical needs had mental health needs dealt with at the same time. The most vulnerable patients continued to be a priority and this year the team had developed level 2 training to give key staff intensive training and understanding of Adult Safeguarding resulting in a 12% increase in concerns raised by the Trust.

Priorities remained the same as 2022/23, with one addition of Maternity in the priority area of Safety.

There were no new high risks identified.

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

BoD/5151 Safeguarding Annual Report 2022/23

The Vice Chair presented the Safeguarding Annual Report 2022/23 and highlighted the key issues.

There were no specific items to be escalated to the Board in relation to the information within the report however, there was ongoing close monitoring of the compliance with the mandatory safeguarding training levels.

There was no substantive Designated Nurse or Designated Doctor safeguarding children in post at the North East North Cumbria Integrated Care Board (NENC ICB). This remained on the Trust risk register and had been escalated.

The Liberty Protection Safeguards implementation had been delayed beyond the life of this Parliament and had therefore been removed from the Trust risk register. Ongoing concerns regarding mental health support had been highlighted and work continued with Tees, Esk and Wear Valleys NHS Foundation Trust.

Training compliance was not at the Trust's contractual target of 100% and local quality requirements were currently being agreed. Following a member's query information relating to the Level 4 training programme was provided and it was agreed that the data be shown in future reports to confirm whether this was on track.

Resolved: (i) that, the content of the report be noted; and
(ii) that, level 4 training data be included in future report highlighting whether this was on track.

BoD/5152 Report of Quality Assurance Committee

The Vice Chair and FS presented the Report of the Quality Assurance Committee and highlighted the key issues.

The Committee commended the organisation around the CQC must do and should do actions and the tremendous amount of work that had been undertaken.

The CN/DoPS&Q reported that work was being undertaken with Tees, Esk and Wear Valleys NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust regarding mental health provision to improve the position.

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

BoD/5153 Report of People Committee

The Vice Chair presented the Report of the People Committee and highlighted the key issues.

A wide range of issues had been discussed at the last meeting which included the review of the BAF, the ongoing people metric, organisational development and the Guardian of Safe Working. Full details were noted within the report.

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

BoD/5154 Report of Resources Committee

KHH presented the Report of the Resources Committee and highlighted the key issues.

A wide range of issues had been discussed at the first Resource Committee meeting which included the terms of reference for the Committee, BAF and Risk updates, month 5 financial position and the financial management performance framework.

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

BoD/5155 Risk Management Group Report

The MD presented the Risk Management Group Report and highlighted the key issues.

Due to a number of Trust commitments, the meeting held on 29 September was conducted virtually, rather than standing the meeting down.

There was one new operational high risk that had been identified in August 2023 relating to neonatal and Children and Young People's acute service delivery due to potential consultant vacancies. The risk was being managed operationally within the Care Group and was referenced in the BAF. This was in addition to the existing two red risks relating to the Trust's ageing estate and delivery of savings.

The National Risk Profile advised by Pricewaterhouse Coopers (PwC) was to be reviewed at a future meeting. The DoSA&C advised that the analysis of the top ten national risks would be included in the next BAF report.

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

BoD/5156 Any Other Business

Staff were encouraged to have their Covid and flu vaccinations. AF reported on her positive experience, which was to be fed back to the team. It was noted that any members of staff receiving their vaccinations elsewhere needed to advise the Occupational Health department or Deputy Chief People Officer.

The Trust was holding its Annual General Meeting on Wednesday, 11 October 2023, 4.00pm at Stockton Baptist Church.

BoD/5157 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 2 November 2023 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 11.20am.

Signed:  Date: 9 November 2023

Agenda Item 5

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
27 April 2023	BoD/5047	***Report of the Managing Director*** Board Development Session to be held at a later date regarding the Health and Care Academy and the wider picture.	SC/SI	31st March 2024	Ongoing	A review of board meetings, development sessions and board seminars has been undertaken and five sessions were agreed to be delivered by Aqua. Two sessions have been delivered and this is currently being evaluated, with additional topics to be considered and an evaluation meeting to be held with Aqua in Nofemebr 2023.
27 April 2023	BoD/5053	***Data Protection and Cyber Assurance Interim Position Report 2022/23*** Full report to be brought to a future meeting.	ND	23 November 2023	Ongoing	The Data Protection SIRO Report 2022/23 is on the agenda for 9 November 2023. The CITO commenced post on 31 October 2023 and the Digital BAF domain is in the process of being updated, with update reports to follow.
27 July 2023	BoD5151	***Safeguarding Annual Report 2022/23*** Data relating to Level 4 training be included in future reports to confirm whether on track.	LR	December 2023		
Completed items:						
23 March 2023	BoD/5009	***BAF Quarter 4 Report: 2023/24*** Board Seminar meeting to focus on the Ageing Estate Risk	NA	28 September 2023	Completed	Following the Board Seminar on 16 March, a detailed update would be provided in 6 months. An update was provided in relation to the Trust's estates risk at the Public Board at 27 July 2023. A Board seminar event was held on 27 July 2023 to review the BAF, including the Trust's ageing estate. A new BAF domain for the Trust's ageing estate will be established to allow the multi-faceted impact of this risk (e.g. finance, quality, safety, people etc.) to be appropriately reflected, reported and monitored going forward.
27 April 2023	BoD/5047	***Report of the Managing Director*** Update to be provided at the next meeting on the replacement of the Interim Chief Information and Technology Officer.	NA	27 July 2023	Completed	Following a detailed interview process, focus groups and presentations a successful appointment had been made. Final aspects of the recruitment stage were ongoing. The successful candidate was required to serve a 3 month notice period at their current post however discussions were ongoing to confirm if this could be reduced. It was agreed that Neil Dobinson would deputise until the candidate was in post.
27 April 2023	BoD/5048	***Board Assurance Framework Report Quarter 4: 2022/23*** An update on the new hospital programme and alternative solutions be provided as and when necessary.	NA	26 October 2023	Completed	This would form part of the detailed update at a Board Seminar in six months time. This links to action BoD/5009.

27 April 2023	BoD/5056	***Learning from Deaths Report, Quarter 4 2022/23*** Further information to be provided in the next report regarding compulsory case reviews and training.	DD	27 July 2023	Completed	Work was ongoing with regards to review meetings with Mortality Leads to agree a plan. Further update to be provided in the next report. This report was presented to the Board meeting on 5th October 2023.
25 May 2023	BoD/5088	***Report of the Managing Director*** An update on the NE&NC Provider Collaborative Clinical Summit be included in the next report. Further updates and plans regarding the CDC to be brought to a future meeting.	NA NA	27 July 2023	Completed	This is included as part of the Managing Director's Report.
25 May 2023	BoD/5089	***Board Assurance Framework Report Month 1: 2023/24*** A full update of the BAF review to be provided at the next meeting.	SI	27 July 2023	Completed	A Board Seminar took place after the Board meeting on 27 July setting out the review of risk management. This links to action BoD/5009.
25 May 2023	BoD/5090	***Integrated Performance Report*** Timescales around cancer performance be included in the next report. Updated information regarding staff turnover be included in future reports.	L Hunter L Hunter	27 July 2023 27 July 2023	Completed Completed	This is now included in the IPR report and is presented in the Trust's approved governance and reporting processes.
25 May 2023	BoD/5092	***NHS Workforce Disability Equality Standard (WDES) 2023*** Work be undertaken to identify barriers staff may experience when updating their disability status and what support could be put in place.	S Cook	5 October 2023	Completed	Work continued to review the ESR system and the issues raised regarding barriers staff were experiencing. This was presented to the Board meeting on 5th October 2023.
25 May 2023	BoD/5093	***Utilisation of the University of Hartlepool Elective Hub*** The ACOO to identify areas of support that could be provided for the planned visit on Friday, 23 June 2023.	R Dean	23 June 2023	Completed	Following the recent visit the report had been received and a decision had been made to defer accreditation and that another visit would take place in November 2023. However, the team were very impressed with the Elective Hub. Further work was to be undertaken around the utilisation of
25 May 2023	BoD/5096	***Freedom to Speak Up Annual Report*** A copy of the report to be shared with the Governors.	L Robertson		Completed	The FTSU Annual Report has been sent to Trust Governors via e-mail.
27 July 2023	BoD/5140	***Patient Story*** The ADoF to share inforamtion with colleagues at the Critical Care Board to raise further awareness of the joint work being undertaken. Future stories be named 'Network Stories'.	KHH SH/HH	November 2023 November 2023	 Completed	 Agenda updated.
27 July 2023	BoD/5142	***Matters Arising / Action Log*** Actions BoD/5009, BoD/5048 and BoD/5089 be condensed into one action. Freedom To Speak Up Annual Report to be shared with Governors.	SI SH	November 2023 November 2023	Completed Completed	Actions linked to BAF were condensed. The FTSU Annual Report has been sent to Trust Governors via e-mail.

Agenda Item 6

Board of Directors

Title of report:	Joint Chair's Report										
Date:	9 November 2023										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Sponsor:	Professor Derek Bell, Joint Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

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

- Group and Joint Working
- Trust Annual General Meeting
- ICS FT Chairs Meeting
- Staff Engagement
- Flu and Covid vaccination programme

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

There are no risk implications associated with this report.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Report of the Joint Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Group and Joint Working

We had another positive meeting with both Council of Governors on 26 October 2023 and updated them on key topics including the role of Governors in system working and the Partnership Agreement. The Lead Governors led a discussion session to explore practical solutions to improve communication between both Councils and to learn about each organisation's cultures, structure and values.

The Joint Partnership Board met on 18 October and feedback was provided from the Clinical Summit event on 9 October and stakeholder engagement regarding the Partnership Agreement. Consideration was being given to the reporting of group performance data and progression was being made with the establishment of the Group.

The appointment process for the Group Single Chief Executive concluded on 12 and 13 October with a 'town hall' stakeholder event providing the opportunity for round table discussions with the candidates followed by a formal interview. I am pleased to announce that Stacey Hunter was appointed as the Group Single Chief Executive. She will formally commence in post in January 2024, however, will attend key meetings in the meantime where possible

2.2 Trust Annual General Meeting

The Trust held its Annual General Meeting on Wednesday, 11 October 2023 at the Stockton Baptist Church. Members, Governors and Staff heard a number of interesting presentations including the shared Cardiac CT and MRI services across the Trust and South Tees; a number of service developments from each care group and the Trust's Quality Account. The Trust's Annual Report and Accounts were formally presented and a plea to join the Trust's membership was made.

2.3 NENC ICS FT Chairs Meeting

I attended the North East North Cumbria Integrated Care System (NENC ICS) FT Chairs meeting on 17 October, themes from the meeting included further development of the Digital Strategy and the requirement for greater cooperation between organisations in respect of the request and provision of mutual aid as we enter winter.

2.4 Staff Engagement

I attended another of the Trust's Celebrating Excellence events on 20 October. It was great to hear about the really positive achievements of our staff and the successful improvement projects that enhance the care of our patients.

I had a positive visit to Billingham Health Centre as part of my monthly engagement visits where I had the opportunity to meet with staff and learn about their work

2.5 Flu and Covid Vaccination Programme

The Trust is continuing to encourage the uptake of both the flu and covid vaccines with our staff to protect themselves, their family and our patients. At the time of writing the 18% of staff had received the Covid vaccine and 31% the flu vaccine. I would urge as many people as possible to receive both vaccinations to provide the maximum protection as we enter into the winter.

3. Recommendation

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

Professor Derek Bell
Joint Chair

Agenda Item 7

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Partnership Board Update										
Date:	9 November 2023										
Prepared by:	Stuart Irvine, Director of Strategy, Assurance and Compliance										
Executive sponsor:	Ann Baxter, Vice Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors in respect of the work of the Joint Partnership Board.										
Action required:	Approve		Assurance		Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The report provides an update regarding the work of the Joint Partnership Board.

Key topics discussed in the meeting:

- Chair's report covering the appointment of the Group CEO, Freedom to Speak Up month and the appointment of the Clinical Lead for urgent care as well as a thanks for staff in managing industrial action.
- Group performance management and reporting – an initial project brief and slides setting out a gap analysis between the two trusts' IPRs.
- Communication and engagement including feedback on the Clinical Structure and Strategy Event and Partnership Agreement.
- JPB risk register.
- Legal advice on the formation of the Group Model.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

There are no risk implications associated with this report.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A
Recommendation	The Board of Directors are asked to note the content of the report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors
9 November 2023

Joint Partnership Board Update

1. Introduction

This report provides information to the Board of Directors on the work if the Joint Partnership Board.

2. Key issues and Planned Actions

2.1 Key topics discussed at the meeting:

- Chair's report covering the appointment of the Group CEO, freedom to speak up month and the appointment of the clinical lead for urgent care as well as a thanks for staff in managing industrial action.
- Group performance management and reporting – an initial project brief and slides setting out a gap analysis between the two trusts' IPRs.
- Communication and engagement including feedback on the Clinical Structure and Strategy Event and Partnership Agreement.
- JPB risk register.
- Legal advice on the formation of the Group Model.

2.2 Actions:

- Group performance and reporting – to continue to build joint reporting and to consider as it develops how to reflect the impact of working as a Group, in particular clinical impact – Associate Director of Group Development/Deputy Director Strategy and Planning/Director of Planning and Performance/COOs ongoing.
- Communication and engagement – to consider contribution to communications strategy – all JPB members ongoing.
- Partnership Agreement and Clinical Strategy– to incorporate agreed changes including the addition of a sixth clinical board and to continue engagement and bring final version of the Partnership Agreement to November JPB - Associate Director of Group Development November 2023.
- Risk register – to consider how to make this a dynamic risk management system and incorporate risk appetite- Company Secretaries/ Associate Director of Group Development January 2024.

2.3 Escalated Items:

- Sharing good practice/things to celebrate:
  The staff story was a powerful real world example of the trusts working collaboratively and with partners to develop a bid for the Urgent Care Services in response to the tender issued by the ICB. It was clear that there were real benefits in preparing a joint bid and working as an alliance with others as well as lessons that can be learned to use in future collaborations.

2.4 Risks:

- Reflect increased emphasis on digital strategy and separate out issues in relation to quality in the risk register – Company Secretaries/ Associate Director of Group Development.

3. Recommendation

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

Ann Baxter
Vice Chair

Agenda Item 8

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Report of the Managing Director										
Date:	9 November 2023										
Prepared by:	Stuart Irvine, Director of Strategy, Assurance & Compliance										
Executive sponsor:	Neil Atkinson, Managing Director										
Purpose of the report	The purpose of the report is to provide information and an update 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 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 related news as well as issues that feature at a national, regional and local level.

In addition, information is provided on strategic delivery, positioning and operational issues not covered elsewhere on the agenda of the Board of Directors.

Key issues for this month include:

- Operational Challenges (including elective recovery, industrial action and winter planning);
- Culture and Leadership Development;
- Research and Development;
- Integrated Care System and Integrated Care Board;
- North East and North Cumbria Provider Collaborative;
- Tees Valley Provider Collaborative;
- Clinical Strategy Event;
- Group Chief Executive update;
- NHS England – New Chief Operating Officer;
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy (including RAAC);
- Community Diagnostic Centre;
- Faculty of Learning, Leadership and Improvement;
- Workforce Development,
- Vaccinations Update;
- Consultant Appointments;
- Clinical Support Worker Update;
- Sunderland Medical School; and
- Consideration of the wider national and regional contribution.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
This report relates to all Trust strategic objectives and Board Assurance Framework domains and the content of this report should be considered by Executive Leads and BAF authors.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity, inclusion	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money		Estates and Facilities	x
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
N/A		N/A	
Recommendation	The Board of Directors is asked to note the content of this report including, the pursuance of strategic objectives, work to improve system working and operational resilience.		

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9th November 2023

Report of the Managing Director

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues and is linked to the strategic objectives of the Trust.

2. Strategic Objective: Putting our Population First

2.1 Operational Challenges

The Trust's reported bed occupancy in September 2023 was within the national target, with an average occupancy of 91.65% against a threshold of 92%, compared to a reported bed occupancy position of 92.28% in August 2023. The ward decant programme was completed on the 4th September 2023 and there is a plan for an earlier phased opening of the winter resilience ward on 5th October 2023 to proactively manage demand during the busiest time of the year, with key decisions being clinically led. Linked to the bed occupancy is the reported performance of super stranded patients (21+ days) which has seen a slight reduction from the previous months reporting (the target is 43, compared to an actual of 45). The Trust and local system, continues to be fully committed to proactive management of patient flow and timely discharge, with a number of patients being supported by the Home First Team. The Trust, with system partners, have received further visits from the national and regional teams given the strong performance in this area, to share best practice with the wider system.

A further dimension linked to bed occupancy is length of stay of patients across different planned and unplanned care pathways and the Trust continues to perform positively against this standard. Length of stay for elective (planned patients) was 1.91 against a standard of 3.14 and length of stay for unplanned patients was 2.89 against a standard of 3.35. This has resulted in a combined length of stay of 3.88 days against a standard of 4.41 days.

Readmission rates are higher than the Trust's threshold (the target is 7.70%, compared to an actual of 9.52%), with focused work underway in urology and general medicine. Work is also underway to bring Discharge to Assess (D2A) pathways onto the virtual ward, recognising that readmission rates from this pathway area could be positively impacted by increasing monitoring and support following discharge from hospital.

Within the month of September 2023, there were 33 patients waiting beyond 12 hours. Work is ongoing to review patient flow across all specialities, with speciality specific groups reviewing key pathways, capacity and demand and communications. The launch of the revised fracture neck of femur pathway reported an improvement in August 2023, following its implementation and it is important that this type of pathway improvement be sustained. Mental Health pressures continued in September 2023, and this is being discussed and addressed with Tees, Esk & Wear Valley NHS FT colleagues, not only through operational delivery but also through patient safety and outcomes and this risk (ref. 6607) is being monitored by the Quality Committee.

2.2 Urgent and Emergency Care

The Trust reverted back to reporting against the four-hour standard from May 2023 and continues to exceed the overall four-hour national standard, achieving 86.44% in September 2023 (against a national standard of 76%) with focused work concentrating on Type 1 pathways.

There has been improvements in the performance against the Type 1 metric since focused work commenced, with an over achievement of the in-month improvement trajectory (actual of 52.02%).

In September 2023, the Trust piloted an additional senior decision maker overnight in A&E, with initial analysis showing an improvement in the 4-hour compliance on the days this was in place, particularly for the non-admitted pathway, with mean compliance reporting at 68.35%, compared to 57.83% when the decision maker was not on duty.

Ambulance hand over delays remain in a positive position, achieving 99.43% of patients being handed over in less than 59 minutes for the month of September 2023. There were eight over 59 minute delays in September 2023. The Trust is continuing to focus on the whole pathway, monitoring a 30-minute target internally, which remains at an average handover time of 26 minutes in September 2023. Regionally, the Trust reported 0.6% handovers over 60 minutes, which places the Trust second in the region. Collaborative work with local partners is continuing to ensure patients are at the centre of decision making at times of escalation across the system.

2.3 Elective Recovery

The Referral to Treatment incomplete pathway standard continues to be a challenge nationally and within the Trust. In September 2023, the Trust reported 73.87% against a standard of 92.00%. There was a reduction in 52-week waits in September 2023, however, the impact of ongoing industrial action means the position is below the Trust's internal trajectory. Work is ongoing within all specialities to ensure all patients over 52 weeks are regularly reviewed with a focus on ensuring patients are provided with an appointment date as soon as possible.

Waiting list validation has commenced for patients waiting over 12 weeks in line with the 'Protecting Elective Capacity Programme' which was reported at the Board of Directors meeting on the 5th October 2023. The Trust has provided full assurance to the ICB against the set of activities that NHSE has detailed that will support the drive for outpatient recovery at pace.

The elective hub accreditation revisit from the GIRFT team is scheduled for November 2023 at our Hartlepool site, with a focus group established to take forward additional requirements prior to the accreditation visit. A key action is to ensure increased physical utilisation of the elective hub to 85% occupancy and the requirement to ring-fence staff resource for the hub. Securing elective hub accreditation will not only support and protect the Trust's elective recovery and support the response to winter pressures, but also provide support to the wider system.

2.4 Industrial Action

The Trust continues to plan and respond to ongoing Doctor in Training and Consultant industrial action to ensure that the Trust keeps patients safe and to minimise the impact on normal emergency activity during this period. Trust staff groups, including nursing teams, consultants, community services, pharmacy, allied health professionals and administration staff have worked flexibly to provide cover during these periods. However, the cumulative impact on strike action since December 2022 is having an impact on the Trust's planned programmes of care including a growth in both admitted and non-admitted waiting lists and number of patients waiting over 52 weeks. It is anticipated that the future strike action will continue to result in pressures on delivery.

2.5 Winter Planning

It is recognised that the winter months add additional pressure to operational delivery and work is underway to ensure the planned additional capacity is introduced in the next few months to support anticipated escalation in demand. The Trust is finalising the details of the Full Capacity Protocol to manage an escalated position, with focus on maintaining patient safety and the competing demands of unplanned and planned care delivery and importantly being led by our clinicians.

3. Strategic Objective: Health and Wellbeing

3.1 Culture and Leadership Development

Our Culture programme '*Our Trust, Our Future*' and our recent Pulse Survey has seen a number of actions taken forward, following staff feedback. A communication Plan has been developed which provides staff with an overview of all changes implemented and planned.

The Trust's appraisal process and documentation has been reviewed and updated, factoring in staff feedback. The updated version also includes the '*Scope for Growth*' framework, allowing development conversations to take place with staff, ensuring we retain talent and support development aspirations. The Appraisal '*100 day challenge'* has seen benchmarking data comparisons and work to improve compliance and data capture via ESR.

In addition, a Talent Management strategic plan has been developed, to ensure the Trust supports talent and succession planning across the organisation. Work has commenced to roll out targeted succession planning with initial focus on business critical roles.

The three levels of leadership identified within the Leadership Strategic Plan continue to progress, and the Foundation Programme, *'It all starts with me'* has seen an increase in numbers accessing the training with over 350 staff successfully completing the course. The second level '*Leading with Care'* has commenced with five cohorts launched.

The *'Leading with Unity'* first cohort is in progress, delivered by Teesside University. Twenty-one members of staff are enrolled on the six-month programme.

The Trust held the first Women in Leadership event in September 2023, attended by over 80 delegates, both clinical and non-clinical, from across the Trust. The event, aimed at Band 7 and above, is the first in a planned series of events to engage, inspire and develop our leaders. These events sit alongside the current Leadership offer, within both the Trust and external offers. Following the event, a number of action set learning groups have been established, and a network is being developed. These groups will support operationalising and influencing actions from the event. Further plans are being scoped, so these offers can be extended across the workforce.

3.2 Research and Development

3.2.1 Recruitment

Patient recruitment into clinical research trials remains high with 2,346 patients recruited into the National Institute for Health and Care Research portfolio studies this year (for context 1,883 patients were recruited at this point in 2022).

3.2.2 Embedding Research

The Trust now have "research link nurses" identified in all clinical areas to support the research delivery teams in raising the profile of research and being a point of contact for research. Twelve applications have been received for a PhD Fellowship opportunity with Teesside University for Nurses, Midwives and Allied Health Professionals (NMAHPs) and we are hoping to be able to offer two fellowships in 2024.

The Trust is now part of the Research Support and Best Practice Council (RSBP) initiated by South Tees FT, which will bring together research, interested NMAHPs from across the Trusts. Research animations have been shared with the Trust, one for patients and one for staff to display in public areas highlighting the importance of research and how to get involved.

3.2.3 Middlefield Commercial Trials Facility

The final deed of surrender to terminate the lease of the trials facility in Middlefield with Synexus has been signed and Tees Valley Research Alliance are currently preparing signatures on the replacement lease to Future Meds and a joint press release is due to be released shortly.

4. Strategic Objective: Transforming our Services

4.1 Integrated Care System (ICS)

Chief Executives from across the North East and North Cumbria continue to meet with the ICB Executive Team to support the ongoing development of the system. At the Chief Executive meeting in September, Sam Allen, Chief Executive of the Integrated Car Board updated members on a meeting with the Prime Minister to discuss both the Elective Recovery Plan and 120hour decision to admit standard. It was highlighted there will be national scrutiny on operating standards along with national scrutiny on reporting standards.

4.1.1 North East and North Cumbria Financial Position

The Integrated Care System (ICS) submitted a deficit plan of £49.9m for 2023/24. Within that plan, three providers have a planned deficit, one a planned surplus and the remaining providers have break-even plans, which includes North Tees and Hartlepool NHS Foundation Trust.

At Month 6, the ICS is reporting a year to date deficit of £65.68m against a forecast year-end position of £49.9m deficit, which has reduced from Month 5 reporting as income has been recognised in the year to date position for Elective Recovery Fund income. The year-end forecast position for the ICS remains £49.9m deficit. In terms of contribution to the ICS position, the Trust's breakeven plan is based upon the delivery of a surplus in the first half of the year, impacted by a deficit in the second half of the year (e.g. winter pressures etc.) to achieve an overall breakeven position at year end.

At Month 6, the Trust is reporting a planned year to date surplus of £2.539m and has delivered a £2.514m surplus, which is £25k behind plan. This is a positive movement from Month 5 attributable to the recognition of ERF income and a level on non-recurrent efficiency, which is offsetting the cost of the national pay award and industrial action. The forecast position for the Trust remains breakeven with the Trust expecting to deliver to plan.

4.2 North East and North Cumbria Provider Collaborative (PvCv)

Every month, Chief Executives across our eleven Provider Collaborative Foundation Trusts meet in the Provider Leadership Board (PLB). At the October 2023 meeting of the Board of Directors, a discussion took place on Provider Collaborative Governance, for discussion and feedback at individual Board of Directors meetings. A paper is on the Board of Director's agenda today to provide a detailed update to the Board on the governance arrangements for the NENC Provider Collaborative (the Collaborative), specifically focusing on the Responsibility Agreement (RA) with the ICB and the strategic partnership agreed with the North of England Commission Support (NECS) and progress that has been made.

4.3 Tees Valley Provider Collaborative

Work continues to develop the Group model between North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts. Development meetings continue to take place on a regular basis, chaired by the Managing Directors of both Trusts to sustain momentum for the Group arrangements, which report to the Joint Partnership Board.

4.4 Clinical Strategy Event

On 9th October 2023, we joined our colleagues at South Tees Hospitals as part of our health and care group. Over 200 colleagues met at the Riverside Stadium, in Middlesbrough to discuss our clinical ambitions for the future. In the session, delegates heard more about the plans for a joint partnership agreement and discussed plans for how we prioritise services for development.

Colleagues across both organisations also delivered their progress to date as part of their managed clinical networks. These are working groups, dedicated to individual services that have been working together for a number of years. The sheer level of collaboration and work to date was really impressive as we progress our group working arrangements.

4.5 Trust Directors Performance Meeting

Following the implementation of revised Board and committee governance and reporting arrangements from 1st September 2023, the Trust introduced a Trust Directors Performance Team Meeting on a monthly basis. The meeting is chaired by the Managing Director and reviews the reported monthly performance across all portfolios and CQC domains at the same time. Trust Directors attend the meeting and it ensures oversight, triangulation and challenge is applied, ahead of committee meetings and the Board of Directors meeting. Non-Executive Directors are provided with an open invite to observe the monthly meeting, to obtain assurance from Trust governance processes and to inform challenge and lines of enquiry at the committee meetings.

This further strengthens the Trust's existing governance and reporting arrangements and a planned second line of assurance review will be undertaken later in the year regarding the effectiveness of arrangements and compliance with defined processes.

4.6 Group Chief Executive Officer

Following a competitive recruitment process, Stacey Hunter has been appointed to the post of Chief Executive Officer to lead the Group model for both North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trust. Stacey joins the Trusts from Salisbury NHS Foundation Trust where she has worked as their Chief Executive Officer since September 2020.

4.7 NHS England appoints New Chief Operating Officer

Following the appointment of Sir Jim Mackey as the new Chief Executive of Newcastle Hospitals NHS Foundation Trust, it has been announced that Dame Emily Lawson, former head of the National Covid-19 programme will take over as Interim Chief Operating Officer for NHS England (NHSE) when Sir Jim leaves to take the Chief Executive role at Newcastle FT in the New Year. Sir Jim will leave his role with Northumbria Healthcare NHS Foundation Trust where he has been Chief Executive for more than 18 years. He will however, continue to lead the national elective recovery programme at NHSE.

4.8 Service and Estate Developments

4.8.1 New Hospital Outline Business Case (OBC)

Work on the OBC is being progressed to ensure the Trust is "*ready to bid*" against potential capital and revenue funding announcements that may arise prior to or post General Election. The strategy is to break down the project into phases costing £80-£100m each year to improve our chances of securing funding. From a Group perspective, this core £80-£100m element of our OBC leaves room for a Group Clinical Strategy to emerge before we progress to further phases and increases the likelihood of the Clinical Strategy being aligned with Estates Strategy.

A "kick off" presentation was held on 13th October 2023 where the phased approach was discussed and consideration given with regard to the scope and content for Phase 1 of the OBC. This allows the Trust's priorities for Phase 1 to be set so that more detailed work can be progressed. This will support the Trust to achieve the ambitious target of completing an OBC for both North Tees and Hartlepool Hospital sites by the end of February 2024.

4.8.2 Reinforced Autoclaved Aerated Concrete (RAAC)

Following the update provided to the Board of Directors in October 2023, both Farndale and Everley House roofing structures were identified to have been impacted by RAAC, that required immediate action, work on the left hand side of Farndale was completed at the end of May 2023 and a further eight-week programme of work was undertaken to the right hand side of the building. Similar work commenced on the Everley Block at the end of August 2023 that required a temporary decant of Trust staff into nearby portacabins. The works to Everley are due to be completed by the end of October 2023.

Additional surveys have since been carried out and it was identified that RAAC corrective work is also required Goathland House and Ingleby House. Staff have been temporarily decanted to alternative accommodation and structural supports have been installed. The works are currently being costed and will be commissioned once the ongoing works to the remaining office block has been completed.

Structural reports also indicate that the remaining three blocks (Jervaulx House, Osmotherley House and Helmsley House) also have signs of RAAC, but don't require corrective action at this stage. It is recommended that an annual inspection of each roof will take place to ensure this is monitored and corrective action taken when required. It has been recommended that all roofs are replaced to prevent water ingress.

All corrective RAAC work is being funded from the Trust's annual capital backlog programme and the Trust is waiting for a response from NHSE regarding a funding request for this work. NHSE have confirmed the measures the Trust has taken are as they would expect and consistent with national guidance. Further surveys of all three hospital sites are underway and it has been confirmed that Peterlee Community Hospital has no identified RAAC impact and an update on the University Hospital of Hartlepool and University Hospital of North Tees will follow, once work is completed.

4.8.3 Community Diagnostic Centre (CDC)

A strategic plan for the health system in the Tees Valley to develop diagnostic capacity, including a new build Community Diagnostic Centre (CDC) has been agreed. This is a collaborative approach between North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust. It is a major step forward for the Tees Valley, focusing on early diagnosis and treatment, improved care outcomes and wider economic regeneration in the drive to improve population health and tackle health inequalities.

The joint clinical leads supported by service managers, staff, workforce, digital and finance teams are taking work forward alongside the development of the operating model through a joint operational group. The operating model defines how the CDC will work from a patient and workforce perspective ensuring quality of services and patient experience. Work is also underway to review patient pathways associated with diagnostics and align these with the CDC in operational readiness. The digital systems interoperability work has been scoped and is progressing to ensure that systems are aligned to support the CDC.

Workforce plans are complete and are aligned to meet the capacity and demand planning to coincide with the opening of the community diagnostic centre in 2024. Staff engagement is underway across both Trusts building on previous communication. All clinical and operational management teams receive regular updates and have copies of the architectural design plans for the CDC in their areas to share and communicate with colleagues. The construction work on the community diagnostic centre continues to progress.

5. Strategic Objective: Valuing our People

5.1 Staff Survey

The National Staff Survey launched on the 19th September 2023. The Trust currently has a 21% completion rate. Results are shared weekly, within Care Group Senior Management Teams and corporate areas and also circulated to key stakeholders. Areas of poor response have been identified and targeted support is being provided from the Organisational Development Team to improve engagement and completion.

5.2 Faculty for Learning, Leadership and Improvement

The Trust is full committed to the Quality Service Improvement Redesign (QSIR) Foundation programmes and these have continued with a positive uptake across the Trust. In order, for the Trust to continue to develop capacity, capability and a sustainable approach to delivering QSIR, more associates will be developed in conjunction with AQUA.

The fifth cohort of the QSIR Practitioner course is in the planning stage and will take place in spring 2024. The Quality Improvement team are collaborating with Quality Improvement Leads on pieces of work and supporting the actions to operationalise the strategic plan.

Cohort 3 of the NTH100 programme launched on the 26 September 2023. The focus was on operational challenges, which were identified through triangulation of data across the Trust, aligned to strategic objectives. The approach will also incorporate the QSIR Foundation training ensuring we continue to build capability and capacity across the Trust.

The five areas of focus are;

- flexible/agile working;
- patient communication;
- improving patient lifestyles;
- engaging service users in quality improvement; and
- Weight management (staff).

Each of the five ‘packs’ will have a Mentor and an assigned ‘subject matter expert’ to support the projects.

The first of our Faculty Launch Events took place at the University Hospital of Hartlepool on 26 October with a second event planned for 9 November 2023. The formal launch showcases a range of offers for learning and development for staff, including Quality Improvement, Leadership development, organisation development as well as research and innovation.

5.3 Workforce Development

Positive progress has been made in the development of the Health and Social Care Academy. The grant funding agreement is now in place between the Trust and Hartlepool Borough Council which will enable the project to progress at pace. The facility will be located within the University Hospital of Hartlepool that will support growing our own talent and ensuring we have a robust, sustainable workforce plan across the wider health and social care economy. The tender process is now complete with the appointment of a main contractor. The academy supports the Trust’s commitment to provide our workforce with the skills needed to support high quality patient care.

In addition to the capital funding (circa £1.2m), a submission has been made to the Local Skills Improvement Fund (LSIF) to support with costs associated with additional equipment. The bid for funding is specifically focused around technology and will support the academy having the latest immersive technology available for staff / students.

5.4 Vaccinations Update

As a Trust we have a duty to protect both patients and staff through the use of vaccinations. Evidence shows that healthcare professionals are an important part of communicating information about vaccinations and they are highly trusted by patients. A high level of knowledge and a positive attitude in relation to vaccinations is acknowledged as being important determinants in achieving and maintaining high vaccine uptake.

As with previous years, Covid and Influenza vaccinations are been offered to staff led by the People Directorate, supported by a range of staff across the Trust, volunteer vaccinators and peer vaccinators.

Current uptake for Covid vaccination is 18% with Influenza uptake at 33.7%. An action plan has been developed with the focus being on areas of low uptake and providing access to vaccines in the wards/departments as well as at the dedicated vaccination hub. Vaccines are also offered at shift handovers and weekends.

5.5 Consultant Appointments

Following the decision of the Chief Medical Officer to temporarily step away from his incumbent role as CMO/Deputy Chief Executive for North Tees and Hartlepool NHS Foundation Trust, Elaine Gouk, Deputy Medical Director will be acting up for a short period of six months, following an internal recruitment process. Elaine has served as Chief Medical Officer on an interim basis over the last few weeks and brings with her a wealth of experience. Having worked at the Trust for many years as a consultant obstetrician and gynaecologist, she has also worked in various other roles including as a Clinical Director, and as Deputy Chief Medical Officer.

Elaine will not only be closely supported by Deputy Chief Medical Officer, Narayanan Suresh but also by the wider Board of Directors, to ensure the continued delivery of safe, quality patient care to our population.

5.6 Independent Advisor

The Trust has welcomed Dr Hamish McLure (MB, ChB, FRCA) to North Tees and Hartlepool NHS Foundation Trust as Independent Advisor to the Acting Chief Medical Officer. Hamish will work with Trust for two days a week, working across the Trust. He brings a wealth of experience from across a number of organisations which we welcome as we work to progress our ambitions for our group model with South Tees Hospitals NHS Foundation Trust.

Alongside his prominent NHS roles, Hamish has worked within the Royal College of Anaesthetists, where he held the position of Deputy Chair and then Chair of the College Clinical Director network. Within the College, he is also the England representative on their Workforce Strategy Group and chaired the 2020 census group which produced the census last year describing the anaesthesia workforce across the UK.

Hamish is also a Regional Medical Appraiser, in which role he appraises Responsible Officers across the North of England. This support role is key to ensure we continue to deliver safe, quality care to our patients and communities across the region.

5.7 Clinical Support Worker (Band 2/Band 3)

Following the release of updated Agenda for Change national profiles for clinical support workers (in the combined nursing job family), there were concerns were raised that the duties and tasks in some clinical support worker (CSW) and maternity support worker (MSW) roles had changed significantly over time and job descriptions may not have been reviewed regularly and updated. As a consequence some banding outcomes may have become out of date and inconsistent when viewed against other NHS Jobs.

Factors such as staffing and recruitment challenges, combined with an increasing trend for clinical, patient care tasks and activities being delegated to CSWs/MSWs has resulted in some cases to significant changes to these roles.

The Trust reviewed its position and in March 2023, the Trust Board of Directors approved the option to apply an uplift to July 2021 when new AfC National Profiles were published and a provision was made for the estimated costs.

The Trust received a collective grievance at the Board of Directors meeting on 5th October 2023, seeking back dated pay, beyond July 2021. The Trust has been liaising closely with Union representatives and this has now been escalated to regional level for resolution to ensure a fair and consistent decision across the ICS.

5.8 Sunderland Medical School Expansion

The Trust has confirmed its support 'in principle' to the news that Sunderland Medical School intend to increase the number of undergraduate medical student places as part of the national plan to achieve the ambition of the NHS Long Term Workforce Plan.

5.9 Wider National and Regional Contribution

5.9.1 New booking system being piloted

We are making life easier for gastroenterology outpatient patients by offering more control over their appointments using the free NHS app. Patients will be able to access a new appointment function, which allows the patient to book, rearrange or cancel their appointment at their convenience. The Trust aims to offer the service to all outpatients' users by February 2024.

5.9.2 Wolviston couple honour trainee doctor by naming new born after him

Local couple Laura and Arron Gardiner, who were planning for the birth of their second child, had not planned on a middle name. Nevertheless, that quickly changed when they met one trainee doctor assisting Laura with her delivery. So impressed with the work of Dr Channell during an elective caesarean section, the happy couple chose to add his name as the middle name of their new arrival. So, on Thursday 10 August 2023, Rory Wes Gardiner was introduced to the world, weighing in at 5lb 13oz.

6. Recommendation

The Board of Directors is asked to note the content of this report including, the pursuance of strategic objectives, work to improve system working and operational resilience.

Neil Atkinson
Managing Director

Agenda Item 9

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Retrospective Approval of Documents Executed Under Seal										
Date:	9 November 2023										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Executive sponsor:	Neil Atkinson, Managing Director										
Purpose of the report	The purpose of the report is to obtain retrospective approval from the Board for a number of documents executed under seal.										
Action required:	Approve	x	Assurance		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		Caring		Effective	x	Responsive		Well Led		

Executive Summary and the key issues for consideration/ decision:

The NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required.

A number of transactions were carried out that required documents to be executed under seal. These are detailed below:

1. A licence to assign, to approve the transfer of the under lease currently held by Fresenius Medical Renal Services Limited to Diaverum Facilities Management Ltd for the remainder of the term of the lease, which ends in December 2027. The transaction is in respect of the Renal Diabetic Unit at the University Hospital of North Tees. There is no financial impact to the Trust.

Document	Date Sealed	Signed By
A licence to assign the underlease relating to: Renal Diabetic Unit, University Hospital of North Tees, Hardwick Road, Stockton on Tees TS19 8PE Between: 1. North Tees and Hartlepool NHS Foundation Trust 2. Orchard (Clinics 3) Limited 3. Fresenius Medical Care Renal Services Limited 4. Fresenius Medical Care (Holdings) Limited 5. Diaverum Facilities Management Limited	28 September 2023	Neil Atkinson Managing Director Witnessed by: Steven Taylor

2. A deed of surrender, to remove Synexus as tenant in respect of part of the ground floor, Middlefield Centre, University Hospital of North Tees with effect from 31 October 2023. Synexus paid a surrender premium equal to 1 years rent, therefore there is no adverse financial impact to the Trust.

Document	Date Sealed	Signed By
Deed of Surrender relating to: Part of Ground Floor, Middlefield Centre, University Hospital of North Tees, Hardwick Road, Stockton on Tees TS19 8PE Between: 1. North Tees and Hartlepool NHS Foundation Trust And 2. Synexus Limited	27 October 2023	Kate Hudson-Halliday Acting Director of Finance Elaine Gouk Acting Chief Medical Officer

3. A grant of new lease and Master Collaboration Agreement, to add Future Meds as tenant in respect of part of the ground floor, Middlefield Centre, University Hospital of North Tees with effect from 1 November 2023. There is no adverse financial impact to the Trust.

Document	Date Sealed	Signed By
A grant of new lease and Master Collaboration Agreement for: Part of Ground Floor, Middlefield Centre, University Hospital of North Tees, Hardwick Road, Stockton on Tees TS19 8PE Between: 1. North Tees and Hartlepool NHS Foundation Trust And 2. Future Meds	27 October 2023	Kate Hudson-Halliday Acting Director of Finance Elaine Gouk Acting Chief Medical Officer

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
There are no risk implications associated with this report.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	

Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
N/A		N/A	
Recommendation	The Board of Directors is requested to grant retrospective approval for the signing of this document.		

Agenda Item 10

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Report to the Board of Directors

Title of report	Board Assurance Framework Report – Quarter 2 (2023/24)										
Date	9 November 2023										
Prepared by	Stuart Irvine, Director of Strategy, Assurance & Compliance Stephen Green, Associate Director of Risk Management										
Executive sponsor	Susy Cook, Chief People Officer and Director of Corporate Affairs										
Purpose of the report	The aim of this paper is to provide assurance to the Trust Board on the progress made to mitigate and manage the strategic risks within the Board Assurance Framework (BAF). This is report covers the period 1st July 2023 to 30th September 2023 and includes actions for addressing the identified gaps in controls and assurance during that period.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
CQC Domain(s) supported by this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Following the Trust's implementation of revised governance and reporting arrangements at Board of Directors and Committee level, the Trust has undertaken a review of its Board Assurance Framework in terms of the domains and content.

The BAF was also reviewed in line with the independent governance review, with the final report being presented to the Board of Directors meeting on 5th October 2023. This resulted in the Trust considering the current domains and to take the opportunity to streamline the domains, linked to the review of the Trust's Committee structure. There are clear lines of reporting of the BAF domains into the Trust's Committee structure. The Trust is currently in a transitional stage of moving from 12 domains to 7 domains, with governance oversight from the Committees of the Board of Directors. The future state of the BAF domains is contained in the report.

A key development is the decision to create a separate BAF domain to specifically focus on the Trust's Estate due to this being a long standing and strategic red risk. This will enable this strategic risk to be fully understood due to the multi-faceted nature of this risk e.g. service delivery, impact on quality and safety and finance. The Trust's Chief Medical Officer will be the responsible Executive Director and the lead author will be the Assistant Director of Estates and Capital (NTH Solutions LLP). This will be reported to the Resources Committee.

Applicable content from BAF domains that will no longer continue will be transferred to appropriate BAF domains that will continue to be maintained, monitored and reported. It is anticipated that this will be completed by 30th November 2023, with Committees and Board of Directors having full oversight of the process.

There are currently two principal risks identified with a current high risk rating that are outside of the approved risk appetite (Open – which is a current score range of 8 - 12) of the Resources Committee. The

two red risks relate to the delivery of the strategic objective of Transforming our Services, with aim of ensuring financial stability and sustainability.

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	3C	16	16	9
6581	Ageing Estate	3C	25	20	9

Full details of the mitigating actions and planned actions are contained within the body of the report.

Strategic Risk linked to the Board Assurance Framework this report relates to:
This paper relates to all domains of the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and Facilities	X
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Board committees where this item has been considered	Management Group meetings where this item has been considered
• Relevant BAF domains have been reported to the Quality Committee on 23rd October 2023. • Relevant BAF domains have been reported to the Resources Committee on 24th October 2023. • Audit Committee on 30th October 2023.	• Directors Performance Meeting (19th October 2023).

Recommendation	The Board of Directors is asked to;
	• Note the content of the Board Assurance Framework Report Quarter 2 (2023/24), the transitional period of the Board Assurance Framework, and the two red risks that are outside of approved risk appetite, linked to the delivery of the Trust's strategic objectives. • Note the decision to create a separate BAF domain to specifically focus on the Trust's Estate due to this being a long standing and strategic red risk. • Note that the two red risks in this report have been presented to the Resources Committee and Audit Committee prior to reporting to Board of Directors. • Risks identified within the Trust continue to be identified, recorded, reported and managed via Business Team and Risk Management Group, Committee level and Board of Directors.

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Board Assurance Framework – Quarter 2 2023/24

Report of the Director of Strategy, Assurance & Compliance

1 Purpose

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

2 Background

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

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

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

- Assignment of oversight of specific BAF domains
- Identified risks and causes of risk
- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to mitigate risk and support the movement towards targeted risk scores
- Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board of Directors.

2.4 Board Committees receive BAF reports aligned with their delegated responsibility at each meeting and are presented by the responsible Director (or nominated deputy). This enables the review and scrutiny of the management and mitigation of strategic risk via the committees and for upward reporting to the Board of Directors.

2.5 The Board Assurance Framework and broader governance processes were subject to an independent governance review, following the findings of the Care Quality Commission (CQC) report in September 2022. The independent review was commission in November 2022 and the final report has been provided to the Trust and presented to the Board of Directors meeting on 5th October 2023.

2.6 The review focused on the Trust's responsibility for maintaining a sound system of internal control and governance that supports the delivery of strategy within the context of system working and the achievement of the Trust's strategic aims and objectives, and that those systems remain fit for purpose.

2.7 The Trust continues to receive positive external assurance relating to the Board Assurance Framework, with Good Assurance being provided by AuditOne in 2022/23 (the Trust's Internal Auditors). The next planned audit will take place in Quarter4 of 2023/24.

2.8 The Trust has concluded a full internal review of the risk management process including the Board Assurance Framework to ensure that the process and procedures remain fit for purpose and to ensure that the process of risk management is embedded at all levels within the Trust.

2.9 Following the review of the BAF, the Trust is now in a controlled and transitional stage of moving from 12 original BAF domains to 7 and this has taken into account benchmarking of a number of NHS Foundation Trusts (including an NHS FT rated outstanding by CQC, overall and for being well led).

2.10 A key development is the decision to create a separate BAF domain to specifically focus on the Trust's Estate due to this being a long standing and strategic red risk. This will enable this strategic risk to be fully understood due to the multi-faceted nature of this risk e.g. service delivery, impact on quality and safety and finance. The Trust's Chief Medical Officer will be the responsible Executive Director and the lead author will be the Assistant Director of Estates and Capital (NTH Solutions LLP). This will be reported to the Resources Committee.

2.11 Applicable content from BAF domains that will no longer continue will be transferred to appropriate BAF domains that will continue to be maintained, monitored and reported. It is anticipated that this will be completed by 30th November 2023, with Committees and Board of Directors having full oversight of the process.

2.12 The table below sets out the future state of the BAF domains, the responsible authors and Directors and importantly, the Committee of the Board of Directors that will be responsible for oversight of the BAF domains. The BAF remains under constant review and remains subject to change.

BAF Domain	Responsible Director	BAF Author	Committee oversight
Quality	Chief Nurse/Director of Patient Safety & Quality	Associate Director of Patient Safety	Quality Committee
Performance	Director of Planning & Performance	Director of Planning & Performance	Resources Committee
People	Chief People Officer/Director of Corporate Affairs	Head of Workforce Planning, Quality & Projects	People Committee
Integrated Support – Long Term Conditions	Chief Operating Officer	Care Group Director, Healthy Lives	Quality Committee

BAF Domain	Responsible Director	BAF Author	Committee oversight
Finance	Director of Finance	Deputy Director of Finance	Resources Committee
Digital	Chief Information & Technology Officer	Deputy Chief Information & Technology Officer	Resources Committee
Trust's Estate	Chief Medical Officer	Associate Director of Estates & Capital (NTH Solutions LLP)	Resources Committee

2.13 The Trust's Business Team meets on a weekly basis, which is chaired by the Chief Operating Officer and the Director of Planning & Performance. This meeting reviews all newly proposed risks, providing scrutiny and oversight, supporting challenge and the development of risks, the controls and assurances, prior to approving the risk. This also facilitates the consideration of risk across care group/corporate areas and the links between operational risks and strategic risks.

2.14 A formal Executive Risk Management Group meet on a monthly basis and reviews all risks that where approved In the preceding month, corporate and strategic, to provide oversight and assurance to the Trust Board. This also includes a review of all red risks.

2.15 The Board Assurance Framework continues to be managed through the Committee structure, Audit Committee and Trust Board and further updated will continue to be presented.

3 Details

3.1 In support of the production of the Quarter 2 BAF report, all BAF domains have been reviewed and updated by the responsible authors and Directors and has been reported via the relevant assurance committee in September 2023 and also to the Audit Committee on 30th October 2023.

3.2 Acknowledging the BAF transition stage, the Quarter 2 BAF report continues to report **12 risk domains** associated with delivery of the four strategic objectives;

Within the 12 risk domains, there are **47 threats** and are set out in the risk radar continued within this report **(see Appendix 1).**

3.3 There are currently two principal risks identified with a current high risk rating that are outside of the approved risk appetite (Open – which is a current score range of 8 - 12) of the Resources Committee. The two red risks relate to the delivery of the strategic aim of Transforming our Services, with the objective to ensure financial stability and sustainability. These risks are highlighted below;

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	3C	16	16	9
6581	Ageing Estate	3C	25	20	9

3.4 **Risk 6188** (Delivery of savings) remains a current risk score of 16 and relates to the delivery of savings within the Trust's Cost Improvement Programme (CIP) for 2023/24 which is £20.7m. This reported position acknowledges the significant challenge to deliver the CIP programme for 2023/24 and the potential impact of increased CIP that is required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions and the external system requirement to deliver additional savings in year.

3.5 Controls in place to mitigate this risk include CIP workshops and support to Care Groups from the PMIO team to identify and delivery of schemes to deliver the cost improvement plan, supported by QUAD meetings. Further work is ongoing to scope and cost identified schemes to support overall delivery. This is underpinned by the established Financial Management Performance Framework and the associated levels of escalation to the Executive Team. The Resources Committee receive monthly reports on the financial position for 2023/24, including CIP delivery and future planning. This is likely to remain a red risk throughout 2023/24.

3.6 **Risk 6581** (Trust's ageing estate) is a current risk score of 20 (increased from a score of 16 in 2022/23) and relates to the ongoing concern linked to the Trust's ageing estate at University Hospital of North Tees following an independent 6 Facet Survey of Tower Block, South Wing and North Wing whereby the buildings were identified as having a useful economic life of 10 years. A 6 Facet Survey was undertaken over 12 months ago, therefore the effective lifespan of the buildings is rapidly reducing year on year, with approximately eight years remaining. The buildings are deemed to be beyond their UEL by 2031 and this was highlighted at Board of Directors Seminar on 16 March 2023.

3.7 This presents a significant risk to the Trust from 1) a health and safety perspective i.e. condition of concrete within the fabric of the buildings which could endanger staff, patients and the general public if left unmaintained, and 2) the ability or inability to secure capital funding to regenerate/rebuild purposeful buildings within the North Tees site and the subsequent cost of the strategic business case process required to proceed further.

3.8 The annual capital allocation to deliver backlog maintenance to the three buildings on an annual basis only supports maintenance of the estate and is estimated to rise to circa £300m by 2030/31 (when the current lifespan of the buildings is exhausted). An application to the Government's New Hospital programme for capital funding to develop an estate that is fit for purpose was submitted and was unsuccessful and an OBC is being developed in 2023/24 to split the capital requirement across a five year period in order to take advantage of any additional capital funding that may be made available.

3.9 There is the risk that if a funding solution is not identified to support the redevelopment of the Trust's estate, this may result in the Trust being unable to deliver safe and effective healthcare services in future years. Following a recent water leak, it has been identified that there is reinforced autoclaved aerated concrete (RAAC) in all seven residences, with 4 requiring make safe action, which is underway (Farndale House, Everley House,

Goathland House and Ingleby House) at the North Tees site and this is being addressed by backlog maintenance capital. Work on Farndale House and Everley House has now been completed and corrective work has commenced on Goathland House and Ingleby House and decanted staff have been provided with suitable alternative accommodation. The remaining 3 residences are in good condition and will be monitored in accordance with national RAAC advice.

4 Recommendations

4.1 The Trust Board is asked to note the content of the Board Assurance Framework Report Quarter 2 (2023/24), the transitional period of the Board Assurance Framework, and the two red risks that are outside of approved risk appetite, linked to the delivery of the Trust's strategic objectives.

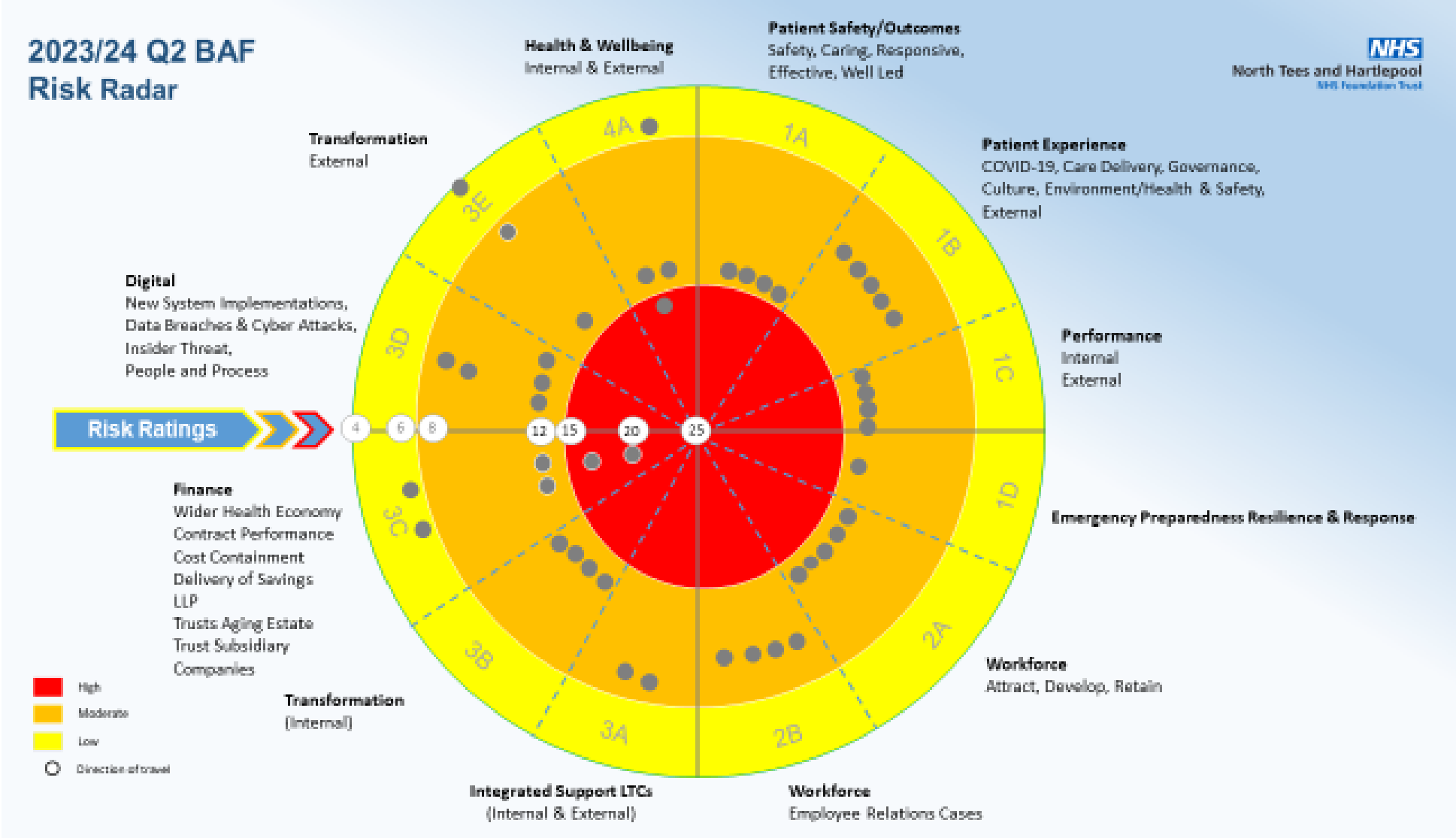
4.2 Note the decision to create a separate BAF domain to specifically focus on the Trust's Estate due to this being a long standing and strategic red risk.

4.3 Note that the two red risks in this report have been presented to the Resources Committee and Audit Committee, prior to being presented to Board of Directors.

4.4 Risks identified within the Trust continue to be identified, recorded, reported and managed via Business Team and Risk Management Group and also reported at Committee level.

Stuart Irvine
Director of Strategy, Assurance & Compliance/Company Secretary

Appendix 1


2023/24 Q2 BAF
Risk Radar
NHS
North Tees and Hartlepool
NHS Foundation Trust
Health & Wellbeing
Internal & External
Patient Safety/Outcomes
Safety, Caring, Responsive, Effective, Well Led
Transformation
External
Patient Experience
COVID-19, Care Delivery, Governance, Culture, Environment/Health & Safety, External
Digital
New System Implementations, Data Breaches & Cyber Attacks, Insider Threat, People and Process
Performance
Internal
External
Risk Ratings
4
6
8
12
15
20
25
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings
LLP
Trusts Aging Estate
Trust Subsidiary Companies
Emergency Preparedness Resilience & Response
Workforce
Attract, Develop, Retain
Transformation
(Internal)
High
Moderate
Low
Direction of travel
Integrated Support LTCs
(Internal & External)
Workforce
Employee Relations Cases
4A
1A
3E
1B
3D
1C
3C
1D
3B
2A
3A
2B

Agenda Item 11

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Integrated Performance Report										
Date:	9 November 2023										
Prepared by:	Lynsey Atkins, Head of Planning and Cancer Delivery										
Executive sponsor:	Linda Hunter - Director of Planning and Performance Lindsey Robertson - Chief Nurse/ Director of Patient Safety and Quality Susy Cook - Chief People Officer & Director of Corporate Affairs Kate Hudson - Halliday– Director of Finance										
Purpose of the report	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing 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 following is a summary of the performance for September 2023:

Safe
The Trust reported three high risks, two financial with a further high risk in regard to Neonatal and Children and Young people's acute service delivery and associated pathways which has now reduced from high to moderate following work undertaken within the Healthily Lives Care Group. All risks continue to be monitored through the appropriate governance structures. A reduction in infections continues to be a significant focused piece of work. The ongoing work within the trust on validation of pressure ulcers and the skin integrity collaborative all contribute to this positive move in reducing patient harm.

Effective
Trust bed occupancy came back in line in September with an average occupancy of 91.65% against a threshold of 92% compared to a raised occupancy of 92.28% in August.

The Trust continues to perform positively in relation to target for length of stay with a combined (emergency and elective) length of stay of 3.88 days against a standard of 4.41.

Readmission rates are higher than the Trusts threshold (Standard 7.70% Actual 9.52%). The Care groups continue to audit readmission rates at speciality level and undertake deep dives in areas above target.

Caring
The number of Friends and Family Test (FFT) returns seen a reduced response rate this month compared to previous months, however with a Very Good/Good rate at 92.22%. All Friends & Family Test metrics, aside from Maternity, fall within their relevant control limits and above the minimum standard of 75%. The Complaint Improvement Project is continuing, with an evaluation of the revised

Stage 2 and Stage 3 process now complete. Overall feedback has been positive and the teams have opted to continue with this revised process. The Project Group have completed a review of the Stage 1 process and this will trialled with the introduction of the new InPhase system.

Responsive

Within the month of September, there were 33 patients waiting beyond 12 hours. Work is ongoing in this area with regard to patient flow across all specialities with speciality specific groups being taken forward looking at key pathways, capacity and demand and communications.

The Trust began reporting against the four-hour standard from May 2023. Whilst the Trust continues to exceed the overall four-hour national standard, achieving 86.44% in September, focused work continues with a particular focus on type one pathways. There have been 2 improvements in this specific metric since the work has commenced with an over achievement of the in-month improvement trajectory (52.02%).

Ambulance hand over delays remain in a positive position, achieving 99.43% of patients being handed over in less than 59 minutes for the month of September.

Referral to Treatment incomplete pathway standard continues to be a challenge nationally and within the Trust. In September, the Trust reported 73.87% against a standard of 92.00%. 52- week waits (97) have seen a slight reduction in September.

The elective hub accreditation revisit from GIRFT team is scheduled for November and there is a steering group focusing on the areas, which required further work prior to accreditation. A key action was to ensure increased physical utilisation of the elective hub to 85% occupancy.

The cancer two week rule standard (August 2023) showed a reduced performance compared to previous months. However, the Trust reported above the regional average with the third highest in performance.

Whilst the Trust reported below the regional position, an improvement in performance was noted from the previous month with respect to the new 62-day standard and 62-day screening standard. Key themes for breaches delays to diagnostic procedures and multiple diagnostic procedures required.

Well Led

Care groups continue to undertake People Clinics overseeing management of cases and providing support and advice appropriately where staff are experiencing significant health and well-being challenges. In order to support an improvement in Appraisal compliance, the Organisation Development (OD) Team have undertaken a 100 day project. The aim of the project was to understand the data, the impact of reporting in RAG report versus ESR and barriers to improving compliance.

Finance

The Trust has a breakeven financial plan for 2023/24 with reported risks relating to inflationary pressures and efficiency requirements. At month 6, the Trust is reporting an in-month surplus of £1.439m against a planned deficit of £0.432m, which is £1.891m ahead of plan.

The improved in month position is driven by recognition of the year to date elective recovery over performance of 1.799m. The Trust is reporting a year to date surplus of £2.514m against a plan of £2.541m, which is £0.027m behind plan.

Total Trust income in month 6 is £35.655m (including donated asset income and finance income), with pay expenditure totalling £23.914m and non-pay expenditure totalling £9.236m.

The month 6 year to date net contribution from Optimus is £0.128m against a plan of £0.086m (£0.043m ahead of plan) and the year to date net contribution from the LLP is £1.267m against a plan of £1.163m (£0.104m ahead of plan).

The Trust's cash position is £66.7m, against a plan of £68.7m, which is slightly behind plan.

The key risks at month 6 relate to the reduction of run rates and identification and delivery of CIP within the Care Groups. Industrial action continues to have a financial impact on the Trust's financial position and the delivery of elective recovery.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
The IPR relates to a number of BAF areas 1A, 1B, 1C, 2A, 2B And 3C.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	X
Workforce	X	Environmental	
Financial/value for money	X	Estates and Facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
Resource Committee – 24th October 2023 Quality Committee – 27th October 2023 Audit Committee – 30th October 2023	Directors Performance Meeting – 19th October 2023

Recommendation	The Board is asked to note: • The performance against the key operational, quality and workforce standards. • Acknowledge the on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation.

North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report (IPR)

October 2023 Report

(September 2023 data)

Executive Summary

Domain	Summary
Safe Page 6 to Page 11	The Trust reported three high risks, two financial with a further high risk in regard to Neonatal and Children and Young people's acute service delivery and associated pathways which has now reduced from high to moderate following work undertaken within the Healthily Lives Care Group. All risks continue to be monitored through the appropriate governance structures. A reduction in infections continues to be a significant focused piece of work. The ongoing work within the trust on validation of pressure ulcers and the skin integrity collaborative all contribute to this positive move in reducing patient harm.
Effective Page 12 to Page 17	The Outpatient Transformation work continues with the Health Inequalities project where patients or carers from low deprivation areas are contacted prior to their appointment. If the patient is unable to attend, they are re-booked for one that they can. This falls within our aligned approach with the CORE 20 PLUS 5 NHS initiative. Gastroenterlogy has now gone live with PEP - allowing patients to effectively manage their appointments. This will be rolled out to other services as part of a phased plan. PIFU activity has continued to increase, particularly within Orthopaedics, Urology and Pain services. There are further developments linked to 'straight from theatre' PIFU and consideration of procedures from the elective hub.
Caring Page 18 to Page 21	The number of Friends and Family Test (FFT) returns seen a reduced response rate this month compared to previous months, however with a Very Good/Good rate at 92.22%. All Friends & Family Test metrics, aside from Maternity, fall within their relevant control limits and above the minimum standard of 75%. The Complaint Improvement Project is continuing, with an evaluation of the revised Stage 2 and Stage 3 process now complete. Overall feedback has been positive and the teams have opted to continue with this revised process. The Project Group have completed a review of the Stage 1 process and this will trialled with the introduction of the new InPhase system.

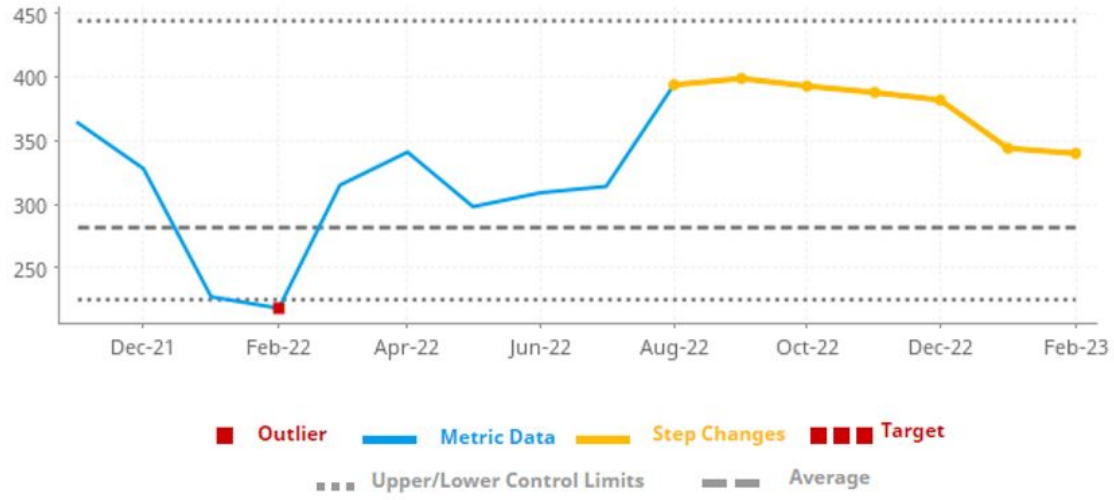
Executive Summary

Domain	Summary
Responsive Page 22 to Page 29	Trust ambulance handover performance continues to be one of the best in region. The Trust continues comfortably meet the national 4-hour standard. A steering group continues to review progress with improvements already being seen in this position, with the over-achievement of the in-month improvement trajectory. The Trust remains on plan to meet the 2023/2024 planning submission for Trust occupancy. The Trust is achieving three out of nine Cancer standards, the a change to the metrics to be reported from October following a national consultation, reducing from the current 9 standards down to 3. Key breach themes across the cancer standards this month reported as a result of delay to diagnostic procedures /reporting and multiple investigations required.
Well-Led **People** Page 30 to Page 33 **&** **Finance** Page 34	Care Groups continue to undertake People Clinics overseeing management of cases and providing support and advice appropriately where staff are experiencing significant health and well-being challenges. In order to support an improvement in Appraisal compliance, the Organisation Development (OD) Team have undertaken a 100 day project. The aim of the project was to understand the data, the impact of reporting in RAG report versus ESR and barriers to improving compliance. The Trust has a breakeven financial plan for 2023/24 with reported risks relating to inflationary pressures and efficiency requirements. At month 6, the Trust is reporting an in-month surplus of £1.439m against a planned deficit of £0.432m, which is £1.891m ahead of plan. The improved in month position is driven by recognition of the year to date elective recovery over performance of 1.799m. The Trust is reporting a year to date surplus of £2.514m against a plan of £2.541m, which is £0.027m behind plan.

Executive Summary

Domain	Summary
Maternity Page 35 to Page 46	The Trust local population reside in one of the most deprived areas in the country, with the rates of smoking one of the highest in the North East and is reflected in the maternity population. The Trust continues to support patients in reducing smoking to help optimise the health of the newborn and mother. The Trust has noted a decline in the VTE compliance with a review undertaken which has identified some specific issues whcih are being addressed by the team. The Trust continues to reduce Postpartum Hemorrhage (PPH) rates, which can be attributed to the recent introduction Quality Improvement (QI) project. Breast feeding rates within the Trust fall below the North East & North Cumbria average and one of the lowest in the region. To improve the take up rate throughout 2023, the Trust has employed an infant feeding specialist midwife with as key focus on gaining breast feeding initiative (BFI) accreditation.

Statistical Process Control (SPC) Charts



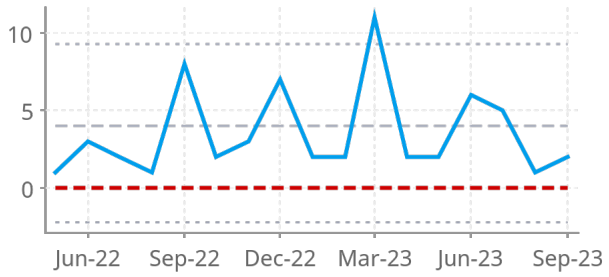
A **Step Change** occurs when there are 7 or more consecutive points above or below the *average*.
Outliers occur when a single point is outside of the Upper or Lower Control Limits. The adjust automatically so they are always 2 Standard Deviations from the .

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

Safe

North Tees and Hartlepool NHS Foundation Trust

Serious Incidents

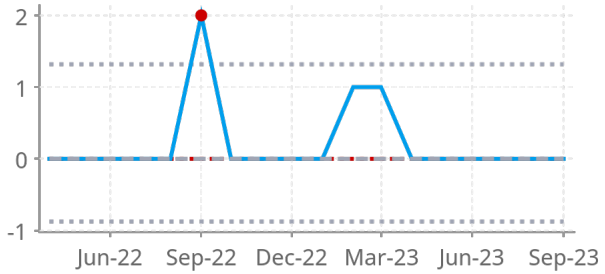


Month	Sep-23
Actual	2
Standard	0

Summary of Current Issues/ Recovery Plans

During September, the Trust reported two serious incidents in line with the Serious Incident framework; both cases are under review using the appropriate safety processes, the Trust has initiated the candour regulations and also deployed Family Liaison Officers.

Never Events

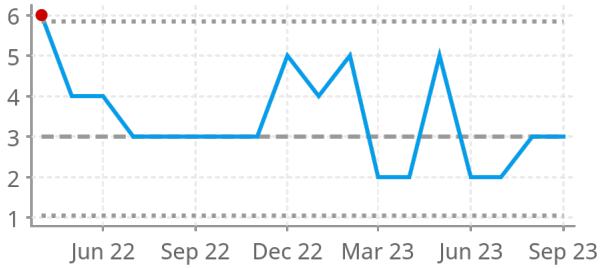


Month	Sep-23
Actual	0
Standard	0

Summary of Current Issues/ Recovery Plans

During September 2023, there were zero Never Events reported.

High Risks



Month	Sep 23
Actual	3
Standard	N/A

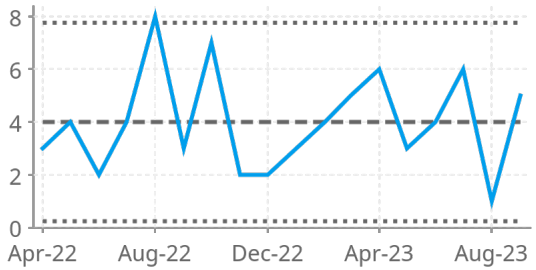
Summary of Current Issues/ Recovery Plans

All risks are approved through the agreed governance structure and are reviewed in line with Trust Policy. There were three high risks in September 2023, two financial risks relating to Trusts Aging Estate and the Delivery of Savings. One risk relating to Neonatal and Children and Young people's acute service delivery and associated pathways due to potential Consultant vacancies has now reduced from high to moderate following work undertaken within the Healthily Lives Care Group.

Safe

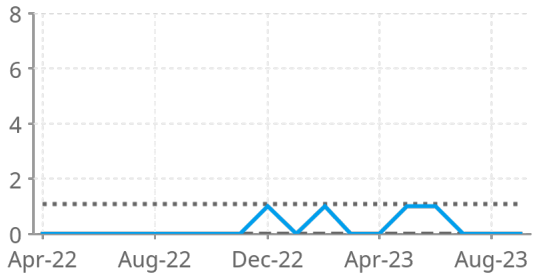
NHS
North Tees and Hartlepool
NHS Foundation Trust

Clostridium difficile (C. diff)



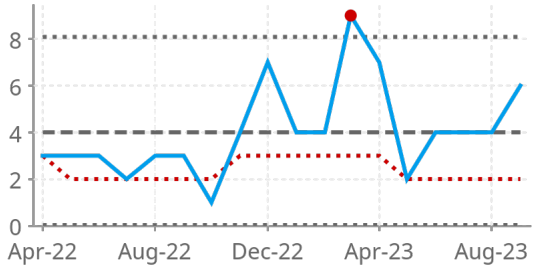
Month	Sep-23
Actual	5
Standard	4

MRSA



Month	Sep-23
Actual	0
Standard	0

MSSA



Month	Sep-23
Actual	6
Standard	2

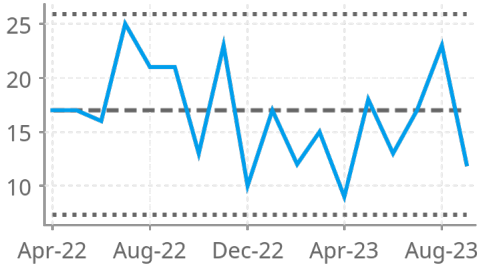
Summary of Current Issues/ Recovery Plans

C.diff reduction remains a focus as a regional and national priority. The trust continue to engage and take part with the Intergrated Care Board C.Diff reduction strategy and currently report 25 cases against our threshold of 46 cases for 2023.

MSSA bacteraemias do not have an external threshold associated but the trust currently reports 28 cases against an internal threshold of 29. Out of the six cases reported in September none were linked to intravascular devices. The implementation of the non-ported venflons has demonstrated a reduction in intravascular as a source with only one incident reported within the last four months. There have been no further MSSA breast cases since the implementation of decolonisation treatment for complex breast surgeries was introduced.

A reduction in CAUTI was reported in September after catheter training delivered in July and August.

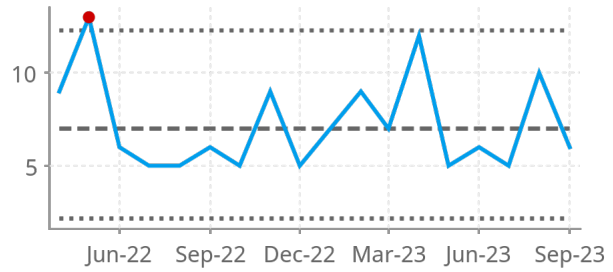
CAUTI



Month	Sep-23
Actual	12
Standard	17

Safe

Escherichia coli (E. coli)

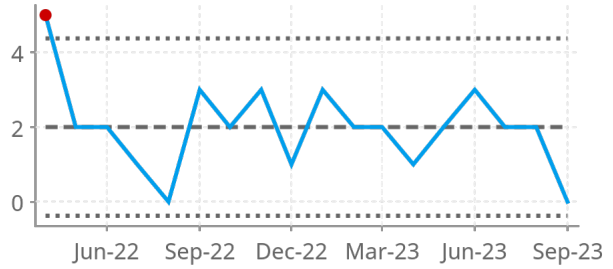


Month	Sep-23
Actual	6
Standard	6

Summary of Current Issues/ Recovery Plans

An Integrated Care Board (ICB) reduction strategy for Gram Negative Bloodstream Infections (GNBSI) is also underway. An increase across the region is noted in E-coli bacteraemias and nearly all local partners are performing above their expected trajectory. Currently the Trust reports 45 cases against a threshold of 69 cases for E-coli, with lower urinary tract remains the highest reported source.

Klebsiella

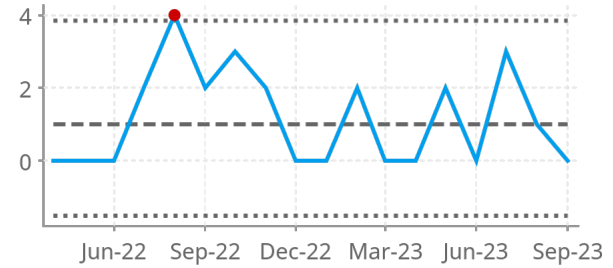


Month	Sep-23
Actual	0
Standard	2

Summary of Current Issues/ Recovery Plans

Klebsiella bacteraemias across the ICB remains above trajectory with the trust currently reporting 11 cases against a threshold of 20 at the end of month six.

Pseudomonas aeruginosa



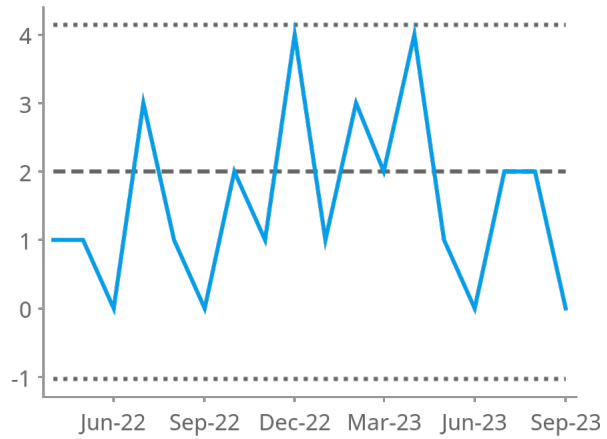
Month	Sep-23
Actual	0
Standard	1

Summary of Current Issues/ Recovery Plans

Pseudomonas infections remain above trajectory within the ICB, with the trust reporting a total of six cases against a threshold of 11, with zero cases reported in September.

Safe

Falls with Moderate Harm



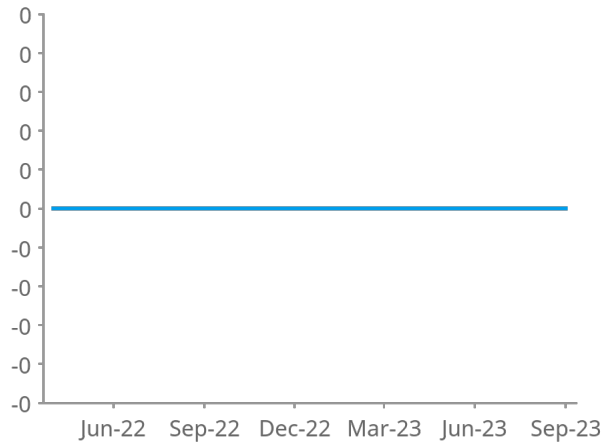
Month	Sep-23
Actual	0
Standard	2

Summary of Current Issues/ Recovery Plans

There have been no reported falls resulting in moderate harm or severe harm in September 2023.

Staff continue to appropriately assess patients and implement any risk mitigation strategies in a timely manner.

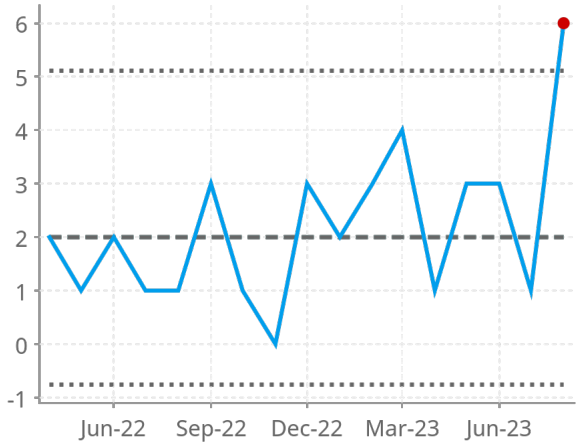
Falls with Severe Harm



Month	Sep-23
Actual	0
Standard	0

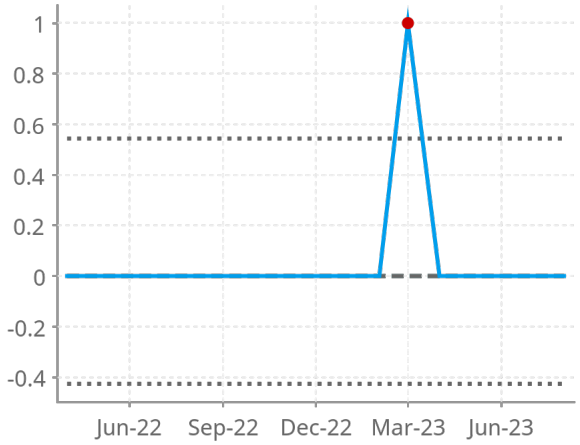
Safe

Pressure Ulcers Category 3



Month	Aug-23
Actual	6
Standard	2

Pressure Ulcers Category 4



Month	Aug-23
Actual	0
Standard	0

Summary of Current Issues/ Recovery Plans

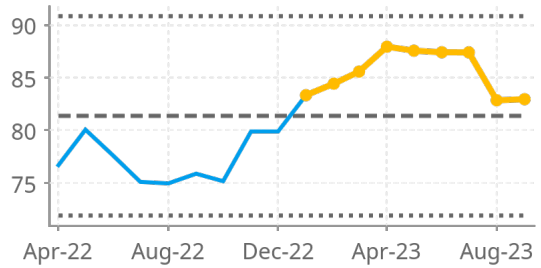
During August, there has been an increase in Category 1 reported ulcers supporting early identification of pressure damage. Reporting of category 2 pressure ulcers remains stable over the last three months with little variation.

The ongoing work within the trust on validation of pressure ulcers and the skin integrity collaborative all contribute to this positive move in reducing patient harm. An increase in Category 3 reports is unusual and review of the incidents demonstrates that they are from differing specialities and not one identified area.

There was one device-related incident reported with the patient making a full recovery of the wound. Anatomically, a higher number of the reported incidents occurred in the buttock/sacrum/coccyx region and further investigation is underway to ensure that care planning involves assessment and implementation of seated cushions and dynamic position changes.

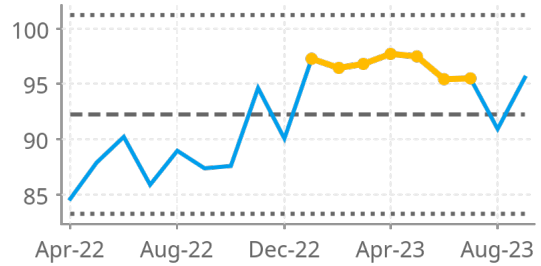
Safe

UNIFY Day RCN



Month	Sep-23
Actual	82.94%
Standard	>=80% and <=109.99%

UNIFY Night RCN



Month	Sep-23
Actual	95.58%
Standard	>=80% and <=109.99%

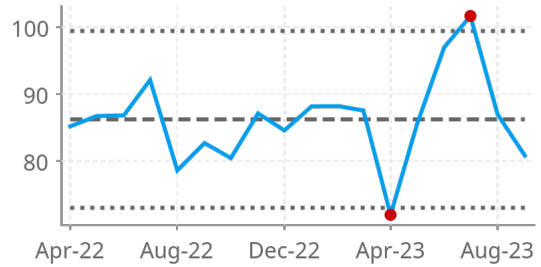
Summary of Current Issues/ Recovery Plans

Nursing fill rates have been sustained and sit within the recommended standard of >80%. The demand rates to NHSP continue to reduce each month. Nurse vacancy levels continue to reduce in line with the planned trajectory. Monthly recruitment remains on going for both registered and unregistered nurses and midwives and all newly registered nurses from the September 2023 cohorts have taken up their positions across the Trust.

January 2024 cohort are now being placed into vacancies and on boarding has commenced to engage and support this group during this phase. International recruitment (IR) of nurses continues with 86wte nurses now deployed to the UK.

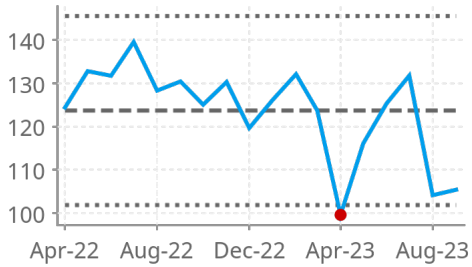
The recruitment of IR midwives continues with support from NHSIE. All planned recruitment will further increase the shift fill rate across establishments and will reduce the overarching nursing and midwifery vacancy level from November 2023

UNIFY Day HCA



Month	Sep-23
Actual	80.79%
Standard	>=80% and <=109.99%

UNIFY Night HCA



Month	Sep-23
Actual	105.41%
Standard	>=110% and <=125.99%

Effective

North Tees and Hartlepool NHS Foundation Trust

Summary Hospital-level Mortality Indicator

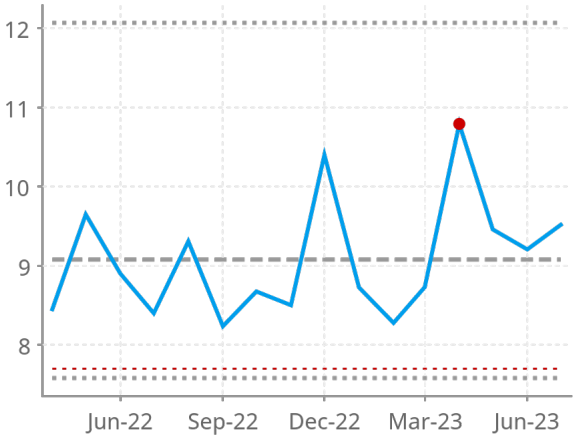
Month	May 22 - Apr 23
Actual	95.03
Standard	100

Summary of Current Issues/ Recovery Plans

The latest SHMI value is now 95.03 (May 2022 to April 2023) which has decreased from the previous rebased value of 95.66 (April 2022 to March 2023)

The value of 95.03 is 5th lowest in the region, which ranges from 86.95 to 114.72, with the national range falling between, 71.70 to 121.47.

Re-admission Rate



Month	Jul-23
Actual	9.52%
Standard	7.70%

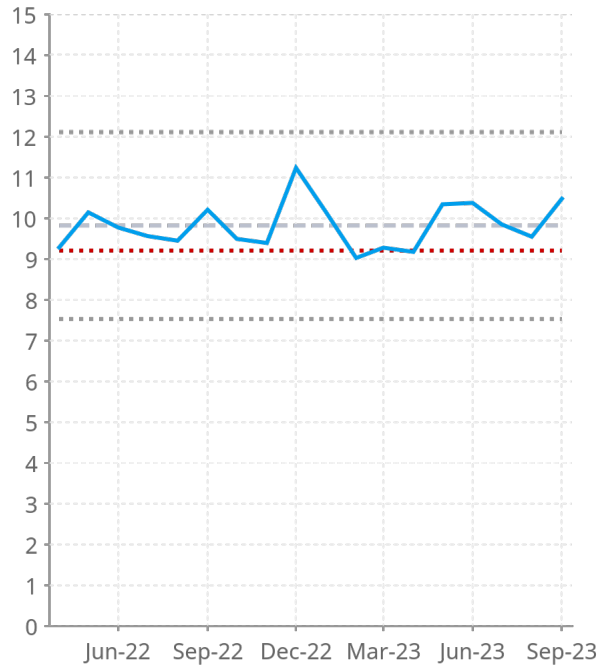
Summary of Current Issues/ Recovery Plans

The Care Groups continue to audit readmission rates across each of the speciality areas undertaking deep dives in areas above the target with focussed work being undertaken in Urology and within General Medicine in regard to emergency health care plans to support the on-going management of appropriate patients.

Work to bring Discharge to Assess (D2A) pathways onto virtual ward has commenced, recognising that readmission rates from this pathway area could be positively impacted by increased monitoring and support following discharge from hospital.

Effective

Outpatient Did Not Attend - Combined



Month	Sep-23
Actual	10.47%
Standard	9.20%

Summary of Current Issues/ Recovery Plans

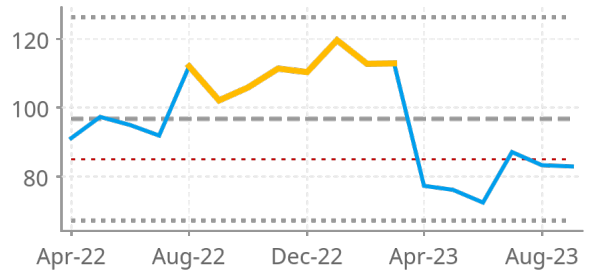
The Health Inequalities project continues where patients or carers from low deprivation areas are contacted prior to their appointment. If the patient is unable to attend, they are re-booked for one that they can. This falls within our aligned approach with the CORE 20 PLUS 5 NHS initiative.

Following evaluation of Phase 1 which demonstrated a positive impact, phase 2 of this project, which incorporates additional service areas, went live in Sept 23. and evaluation of phase 1 is in final draft.

Gastroenterlogy has gone live with PEP - allowing patients to effectively manage their appointments. This will be rolled out to other services as part of a phased plan.

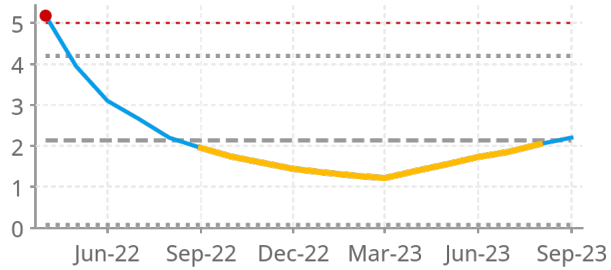
Effective

Reducing Reviews



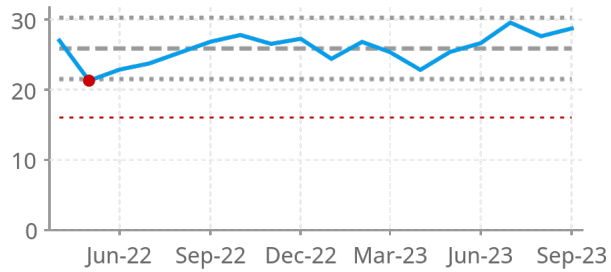
Month	Sep-23
Actual	82.93%
Standard	85.00%

Patient Initiated Follow-Up (PIFU)



Month	Sep-23
Actual	2.20%
Standard	5.00%

Advice and Guidance



Month	Sep-23
Actual	28.70%
Standard	16.00%

Summary of Current Issues/ Recovery Plans

There is continued focus on reducing review outpatient appointments to free up capacity for long waits. Whilst some of this reduction is likely to be attributed to reduced activity resulting from industrial action, the Trust is on track to meet the agreed 15% reduction agreed against the annual planning submission and continues to strive towards national best practice in line with GIRFT guidance. Waiting list validation is a project underway to identify patients who no longer require an appointment with all new patients to be validated by end of October and "Online forms" is another NHSE funded project underway with Dr doctor, to stratify follow-up activity in cancer pathways and offer alternative communication (such as online forms) to reduce the need for reviews. This project will run for 18 months and went live at the end of Q2.

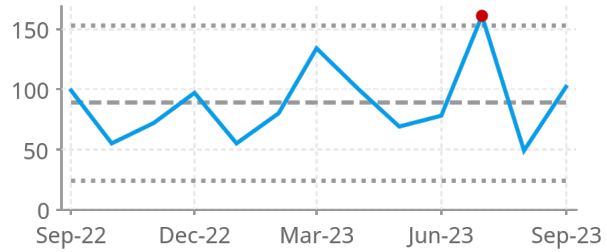
PIFU activity has continued to increase, particularly within Orthopaedics, Urology and Pain services. There are further developments linked to 'straight from theatre' PIFU and consideration of procedures from the elective hub. The Pain team are developing a clinical protocol and are due to undertake training on the system. Initial discussions have commenced with Care Groups for continued growth within general surgery and respiratory.

The Trust continues to perform positively in this area with further increased uptake in Orthopaedics and Urology since last month.

Effective

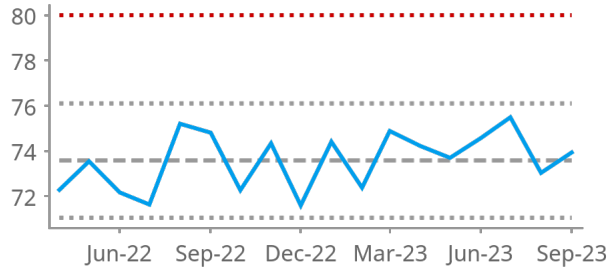
North Tees and Hartlepool NHS Foundation Trust

Theatre - Reportable Cancellations



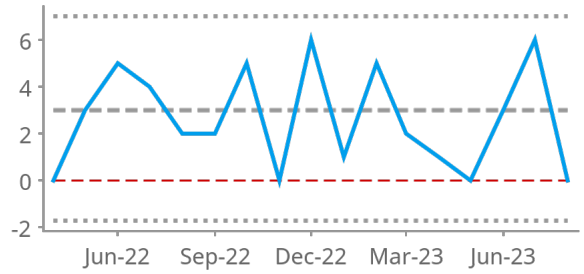
Month	Sep-23
Actual	102
Standard	N/A

Theatre Utilisation (%)



Month	Sep-23
Actual	73.93%
Standard	80.00%

Not Re-appointed within 28 days



Month	Aug-23
Actual	0
Standard	0

Summary of Current Issues/ Recovery Plans

Cancellations have been particularly impacted this month with Industrial action despite trying to offer alternative capacity although cancers have not been affected. Cancellations have also been affected by Anaesthetics resource and the ability to cover lists which is risk on the register.

As a Trust we are beginning to see an increase in cancellations to accommodate more urgent patients (28 during Sept), although this hasn't yet identified as a step change, 8 of the cancellations were to allow for Trauma patients and 15 then there's the strikes (15), which is also likely contributing to the increasing number of cancellations to accommodate more urgent patients. During September theatres delivered 268 lists which equated to 942 patient procedures. The 6:4:2 is now embedded however acknowledging more work is needed for full engagement.

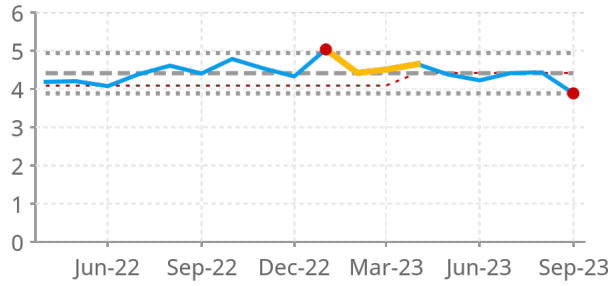
Patients are being booked to 4 weeks at the moment rather than 6 to prevent cancellations and improve patient experience. Work remains on going to increase theatre utilisation at Hartlepool with lists transferring across in breast, general surgery, urology and gynaecology.

All patients were re-appointed within 28 days.

Effective

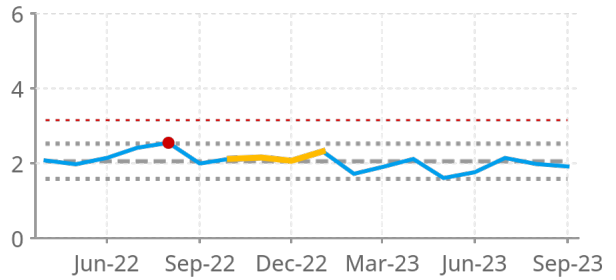
North Tees and Hartlepool NHS Foundation Trust

Length of Stay (Combined)



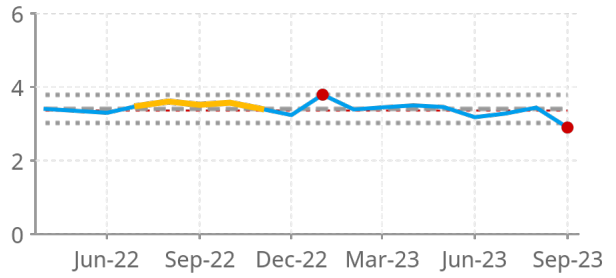
Month	Sep-23
Actual	3.88
Standard	4.41

Length of Stay (Elective)



Month	Sep-23
Actual	1.91
Standard	3.14

Length of Stay (Emergency)



Month	Sep-23
Actual	2.89
Standard	3.35

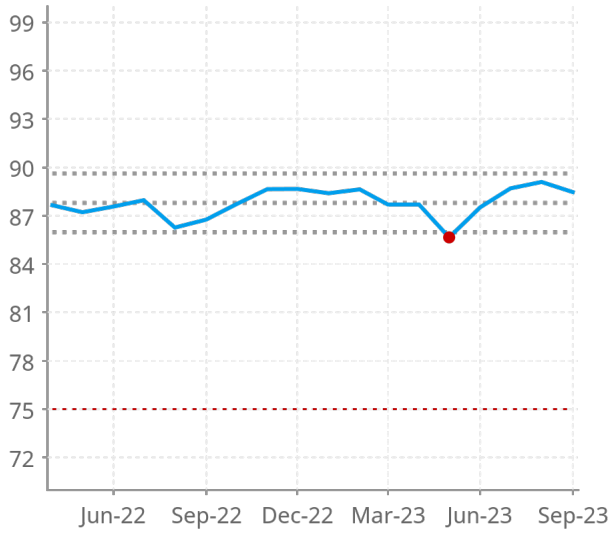
Summary of Current Issues/ Recovery Plans

The Trust continues to achieve targets for Length of Stay, whether the patient be on a elective or emergency pathway. This works is supported by both effective In-hospital care teams and Community working closely with system partners

Effective

North Tees and Hartlepool NHS Foundation Trust

Day Case Rates



Month	Sep-23
Actual	88.46%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

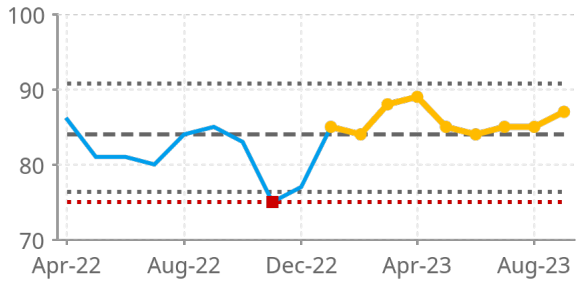
The Trust continues to achieve this standard aided by the High Volume Low Complexity type procedures . Day case rates have increased in Urology with rates now above that peer and national benchmarking position (85.2% vs 67.8% national).

A focussed piece of quality improvement work has been undertaken for TURBT patients. A work stream is underway to increase the day case arthroplasty rate in line with GIRFT recommendations a sustained improvement

Caring

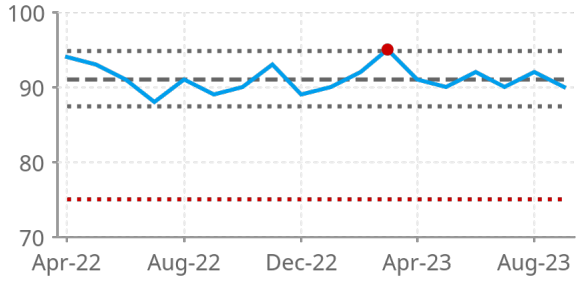
North Tees and Hartlepool NHS Foundation Trust

Friends & Family Test - A & E



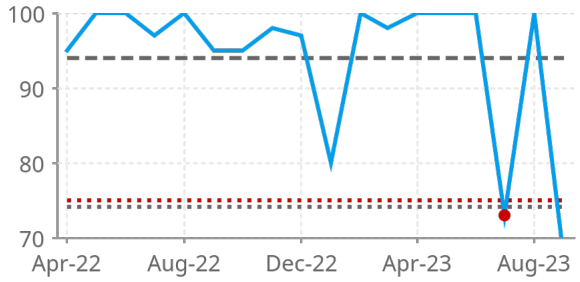
Month	Sep-23
Actual	87.00%
Standard	75.00%

Friends & Family Test - Inpatient



Month	Sep-23
Actual	90.00%
Standard	75.00%

Friends & Family Test - Maternity



Month	Sep-23
Actual	67.00%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

The Trust received 1,954 Friends & Family Test returns this month, this is a decrease on the previous month's updated return of 2,583 and remains between the control limits.

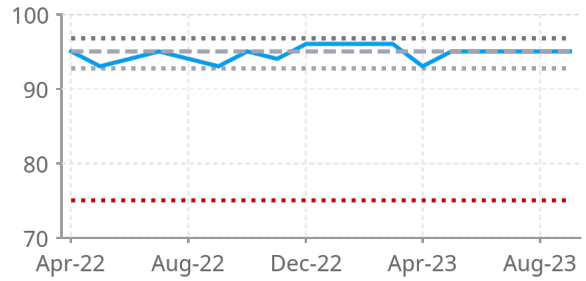
The Very Good or Good responses returned for September 2023 is 92.22%.

All Friends & Family Test metrics, aside from Maternity, fall within their relevant control limits and above the minimum standard of 75%. Work to improve FFT returns across maternity services is being supported by Maternity Assistants, HCA's and Team Support Workers. All staff are aware of the importance of encouraging FFT feedback.

Caring

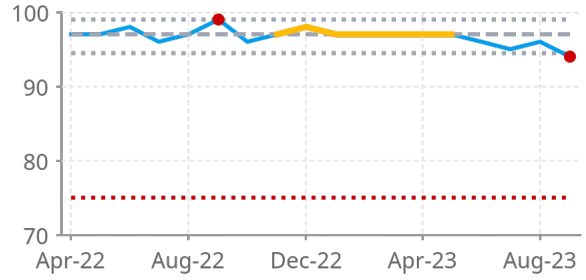
North Tees and Hartlepool NHS Foundation Trust

Friends & Family Test - Outpatient



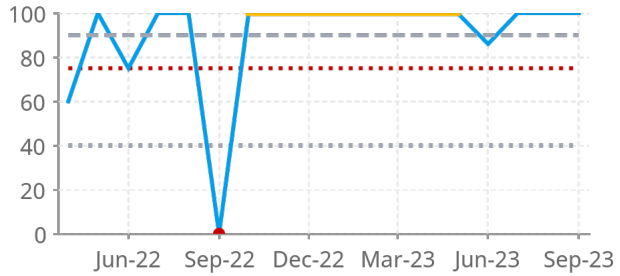
Month	Sep-23
Actual	95.00%
Standard	75.00%

Friends & Family Test - Community



Month	Sep-23
Actual	94.00%
Standard	75.00%

Friends & Family Test - Long Covid



Month	Sep-23
Actual	100.00%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

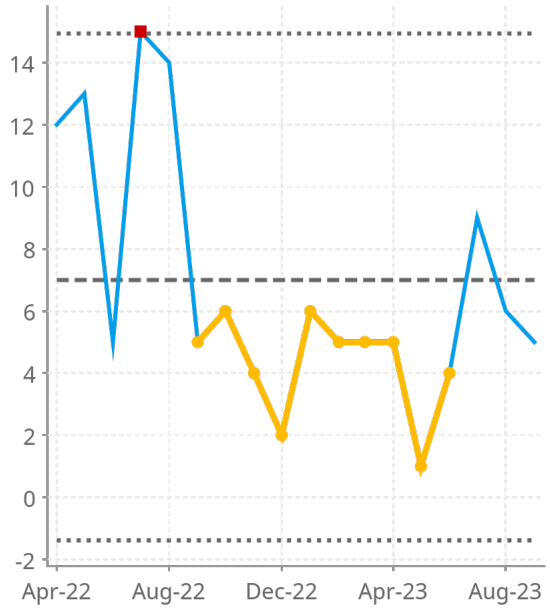
All three metrics falling within their relevant control limits with the recent trends displaying natural cause variation.

Work continues, with the help of the Volunteer Service, to promote the Friends & Family Test, particularly from the in-patient areas to improve the amount of feedback.

Caring

North Tees and Hartlepool NHS Foundation Trust

Complaints - Stage 3



Month	Sep-23
Actual	5

Summary of Current Issues/ Recovery Plans

Complaint themes continue to be monitored on a daily basis, with the Trust continuing to drive for local and face to face resolution of concerns. Of the 170 complaints received in September, 93% were to be resolved locally, 3% are to be resolved with a face to face meeting, and 4% have opted for a written response.

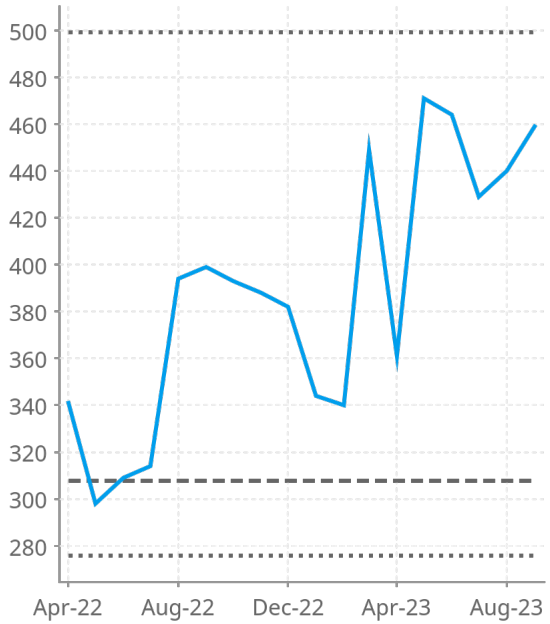
Complaints data and analysis is presented and discussed during the weekly Safety Panel meetings, and a Patient Experience Report presented on a quarterly basis.

Complaint analysis is also raised during weekly Senior Clinical Professional (SCP) Huddles. This robust process continues to support timely identification of the themes, which enables faster resolutions.

The Complaint Improvement Project is continuing, with an evaluation of the revised Stage 2 and Stage 3 process now complete. Overall feedback has been positive and the teams have opted to continue with this revised process. The Project Group have completed a review of the Stage 1 process and this will trialled with the introduction of the new InPhase system.

Caring

Compliments



Month	Sep-23
Actual	459

Summary of Current Issues/ Recovery Plans

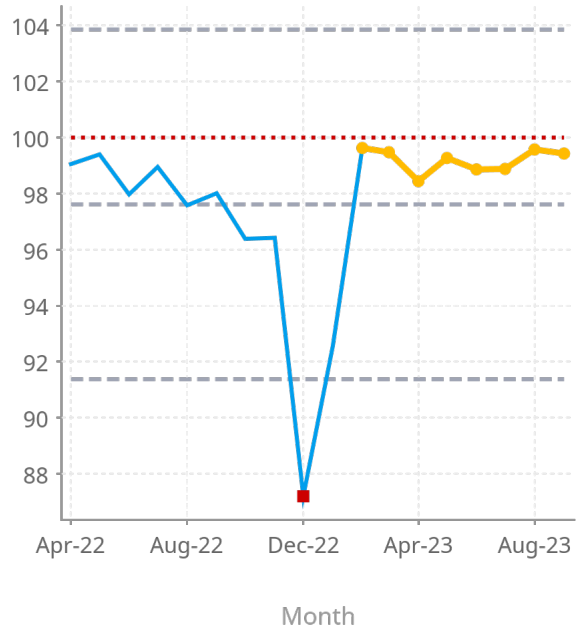
The number of compliments received in September 2023 (467) decreased from August 2023 (545). However, the total amount of compliments received in Q2 2023/24 is 1,543 which is slightly higher than the number received in Q1 2023/43 when 1,512 were received.

As with complaints, identification of themes arising from compliments is also shared at the weekly SCP huddles for shared success across all teams. Leading themes were care provided (385), followed by compassion (28), and communication (17). Additionally, the number of the compliments received for the previous week is presented at the weekly Safety Panel meeting, together with a number of compliments in detail.

The promotion of Greatix continues to ensure all positive feedback received by clinical teams is recorded to support the overarching trust position and the positive balance of complaints and compliments.

Responsive

Ambulance Handovers <59minutes



Month	Sep-23
Actual	99.43%
Standard	100.00%

Summary of Current issues /Recovery Plan

Ambulance handovers continue to remain in a positive position with the SPC showing 7 consecutive months above the mean. There were 8 over 59 minute handovers in September, leading to a compliance of 99.43%.

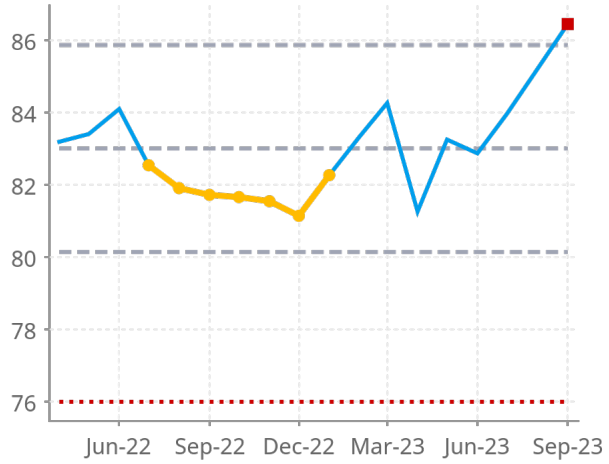
As a Trust we continue to focus on the whole pathway, including monitoring 30 minute target internally. In September we had a mean Ambulance handover time of 26 minutes.

The Trust reported 0.6% handovers over 60 minutes, which places second in the region, with a regional average of 2.9% (range 0.0% - 9.4%).

Improving waiting times is a key focus within our 4 Hour Standard Improvement Plan

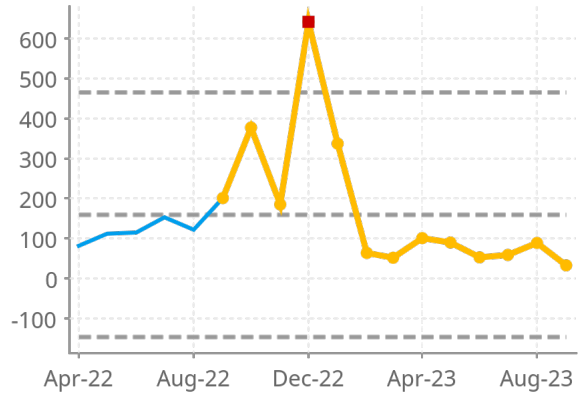
Responsive

4 hr Accident & Emergency Waiting Times



Month	Sep-23
Actual	86.44%
Standard	76.00%

12 Hour Waits in Accident & Emergency



Month	Sep-23
Actual	33
Standard	0

Summary of Current Issues/ Recovery Plans

Whilst the Trust continues to comfortably meet the National standard of 76% of the overall 4-hour standard, there is an acknowledgement that pressures remain within Type 1 pathways. A steering group continues to review progress with improvements already being seen in this position, with the over-achievement of the in-month improvement trajectory (52.02% - September 2023) aligned to the target outlined in the annual planning round to achieve 90% by March 2024.

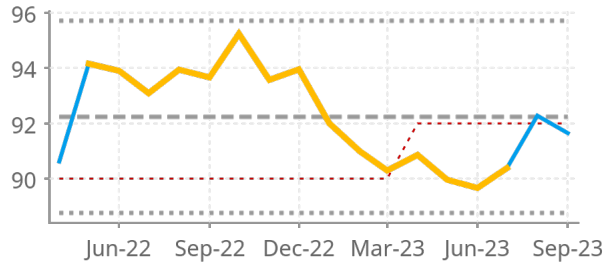
During September as part of our focussed work, a pilot of two senior decision makers overnight was trialled, with initial analysis showing improvement in 4 hour compliance on the days this was in place, particularly in the non-admitted pathway, with mean compliance of 68.35% (max 79.45%) compared to 57.83% when they were not on shift.

Over a third of 12 hour delays are due to bed waits - work is ongoing with the discharge team to ensure timely discharge and transfer of patients to support flow. Actions continue to be progressed through the steering group and associated workstreams, looking at key pathways, capacity and demand and communications.

Responsive

North Tees and Hartlepool NHS Foundation Trust

Trust Occupancy

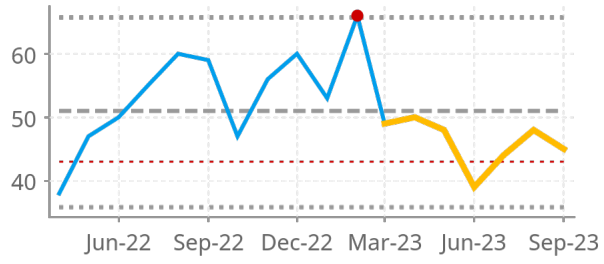


Month	Sep-23
Actual	91.65%
Standard	92.00%

Summary of Current Issues/ Recovery Plans

Bed occupancy remains within target, with the decant programme completed on the 4th September, which had seen a reduction of 7 beds during this period. There is flexibility to utilise further surge beds based on demand and availability of the required staffing to support which is monitored and managed through daily OPEL meetings. Ward 37 will be opening on 5th October and initially staffed for 13 beds and can increase to 29 beds as demand increases. We have invested in opening our resilience ward for 7 months this year to reflect the sustained demand.

Super Stranded Patients (21+days)

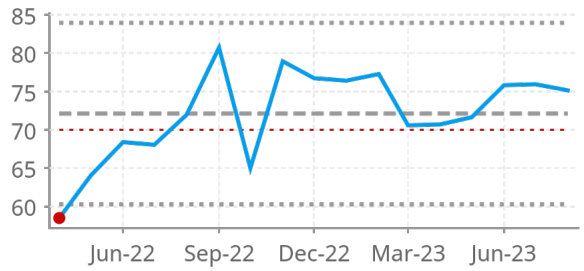


Month	Sep-23
Actual	45
Standard	43

Summary of Current Issues/ Recovery Plans

Despite continued work focussed on effective management of patient flow, inclusive of work in the community and with system partners, the Trust had 45 patients who remained in hospital over 21 days. This is a reduction from the prior months reporting. The Trust is fully committed to proactive management of patient flow and timely discharge, with a number of patients supported by the Home First team. The Trust, with system partners, has received further visits from the national and regional discharge teams given the strong performnce in this area.

2 hour Community Response



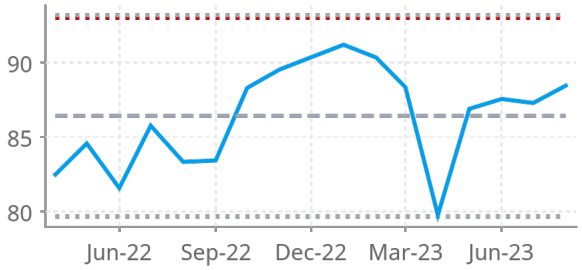
Month	Aug-23
Actual	75.14%
Standard	70.00%

Summary of Current Issues/ Recovery Plans

The Trust continues to exceed the national target of 70% of urgent community response referrals being seen within two hours of referral. Work continues with NEAS to ensure that appropriate patients awaiting response from the ambulance service are streamed into urgent community response services to ensure that patients are seen in the right place, by the right team at the right time with positive patient outcomes being demonstrated. local UCR pathways remain an important part of our Home First approach. The ICB continues to underreport our position.

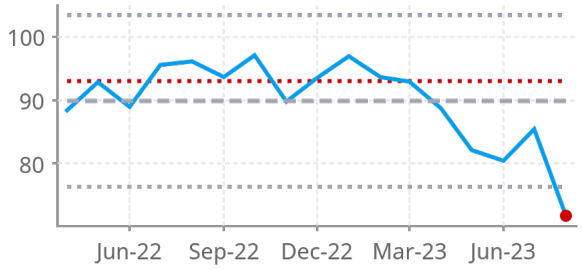
Responsive

New Cancer Two Week Rule



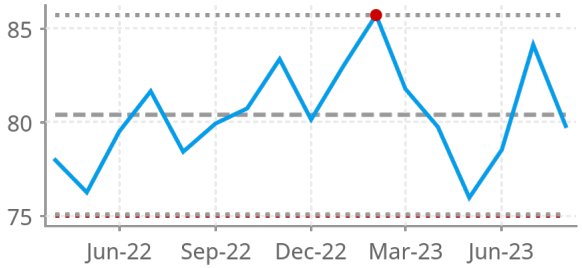
Month	Aug-23
Actual	88.46%
Standard	93.00%

Breast Symptomatic Two Week Rule



Month	Aug-23
Actual	71.78%
Standard	93.00%

Cancer 28 day Faster Diagnosis



Month	Aug-23
Actual	79.79%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

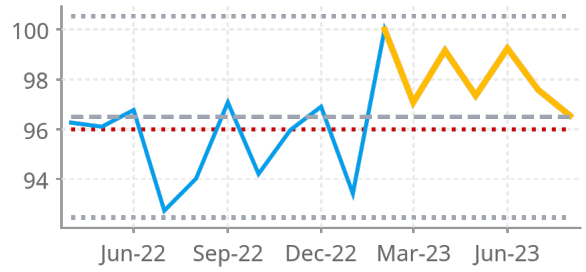
An impoved position this month, reporting above the *regional* average, with the third highest performance. Both respiratory and urology achieved the standard, with some focussed work being undertaken with gynaecology. The Trust continues to manage the impact of industrial action with the absolute minimal number of 2 week rules appointments cancelled as a result. Appointments cancelled were re-appointed within 7 days.

Significant workforce pressures have been seen across the Breast Symptomatic service with a clear plan to maximise capacity in the coming months, aligned to the full recruitment programme.

A reduction in performance can be seen in August compared to the previous month, however noting a continued achievement of the standard.

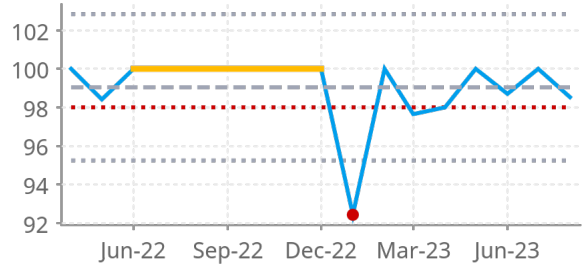
Responsive

New Cancer 31 Days



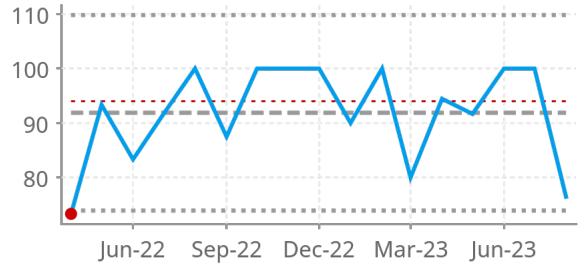
Month	Aug-23
Actual	96.55%
Standard	96.00%

New Cancer 31 Days Subsequent Treatment (Drug)



Month	Aug-23
Actual	98.53%
Standard	98.00%

New Cancer 31 Days Subsequent Treatment (Surgery)



Month	Aug-23
Actual	76.47%
Standard	94.00%

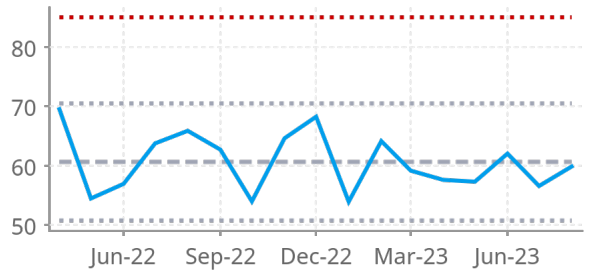
Summary of Current Issues/ Recovery Plans

The Trust was one of two Trusts across the Region to achieve the standard and reported above the regional position in August.

Small numbers impacted on performance in August. Breaches were as a result of elective capacity.

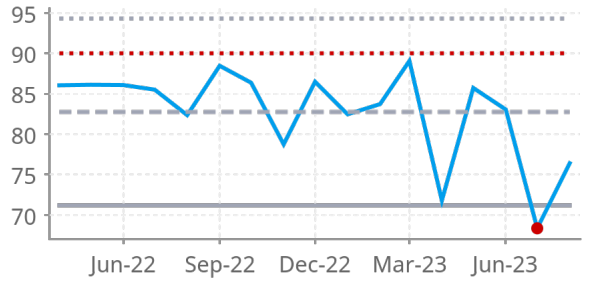
Responsive

New Cancer 62 Days



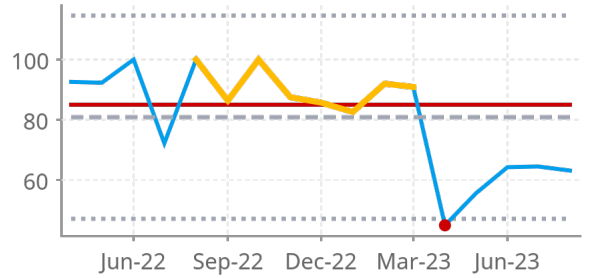
Month	Aug-23
Actual	59.88%
Standard	85.00%

New Cancer 62 Days (Screening)



Month	Aug-23
Actual	76.40%
Standard	90.00%

New Cancer 62 Days (Consultant Upgrade)



Month	Aug-23
Actual	63.16%
Standard	85.00%

Summary of Current Issues/ Recovery Plans

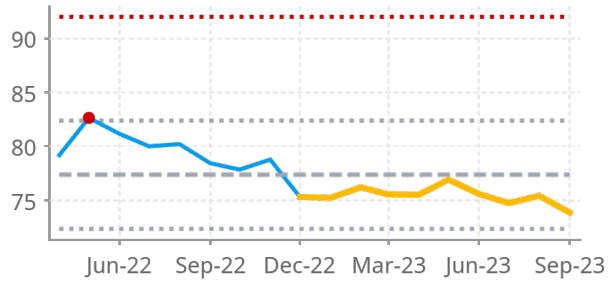
Whilst the Trust reported below the regional position an improvement in performance is noted from the previous month. Key themes from breaches in August reported to be delay to diagnostic procedures/reporting and multiple diagnostic procedures required. Diagnostics waiting times remain a key focus area within the Cancer Improvement Plan across all the specialties, with the implementation of Best Practice Timed Pathways. Capacity and demand continues across all specialities and diagnostic services with teams looking at creating additional 'ring fenced' slots that only consultants/nurse specialists can book into to ensure pathway delays are kept to a minimum. Weekly face to face meetings between the cancer tracking team and respiratory clinical team is currently being piloted with the overall aim to progress individual pathways in the most timely manner, with the plan to roll out across all specialties.

The Trust is showing an improvement in performance against the 62 day screening standard compared to the previous month and reporting above the regional position of 70.01%, second highest in the region. A multitude of breach reasons were reported including diagnostic delays, multiple diagnostics, and elective capacity.

Small numbers treated in August impacted on performance.

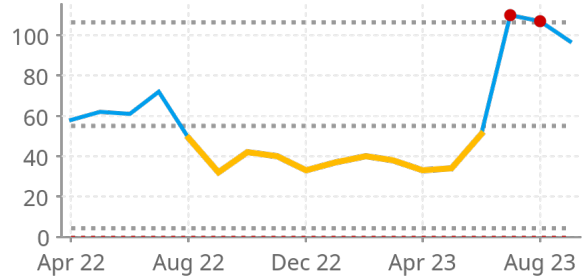
Responsive

Referral to Treatment Incomplete Pathways Wait (92%)



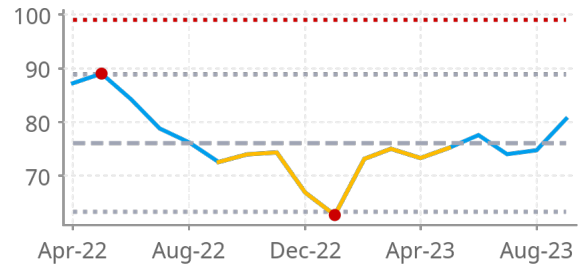
Month	Sep-23
Actual	73.87%
Standard	92.00%

Incomplete Pathways Wait (>52 Week Wait)



Month	Sep 23
Actual	97
Standard	0

Diagnosis <6 Weeks (DM01 %)



Month	Sep-23
Actual	80.61%
Standard	99.00%

Summary of Current Issues/ Recovery Plans

52 week waits have seen an increase this month with the ongoing industrial action continuing to impact on capacity. Work is on-going within all specialities to ensure that all patients over 52 weeks are regularly reviewed with a focus on ensuring that these patients are appointed as soon as possible.

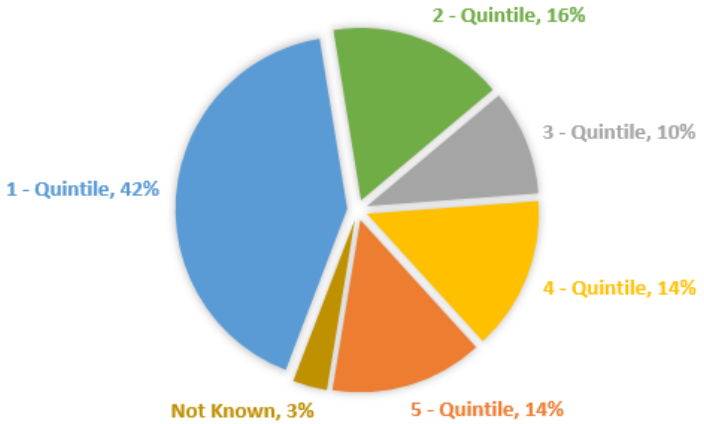
Waiting List Validation has commenced for all patients waiting over 12 weeks in line with the protecting elective capacity programme

Patient Initiated Digital Mutual Aid Programme going Live in October.

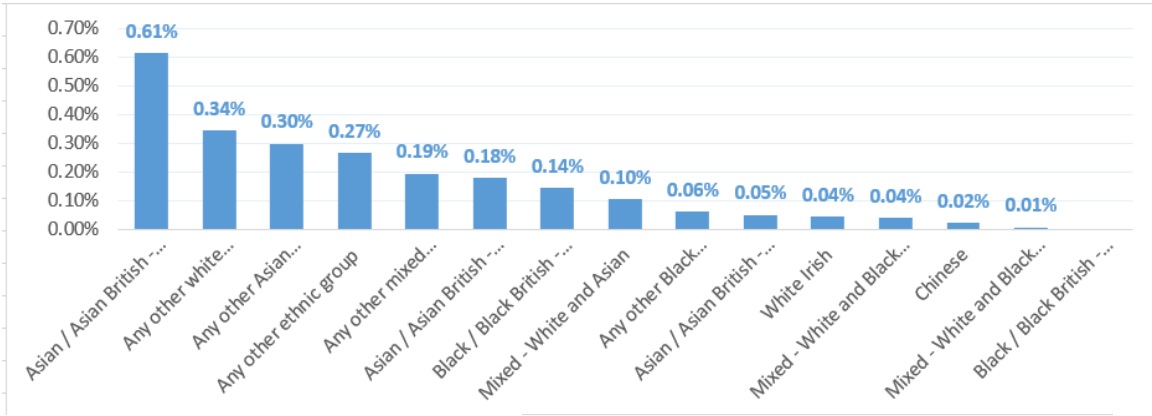
As a result of the Greater MRI capacity that has been in place specifically the mobile unit at Hartlepool, an improvement can be seen in the compliance against the standard. Community Diagnostic activity continues to take place in Lawson Street Health Centre, supporting an increase in Capacity.

Responsive - Health Inequalities - RTT Waiting List

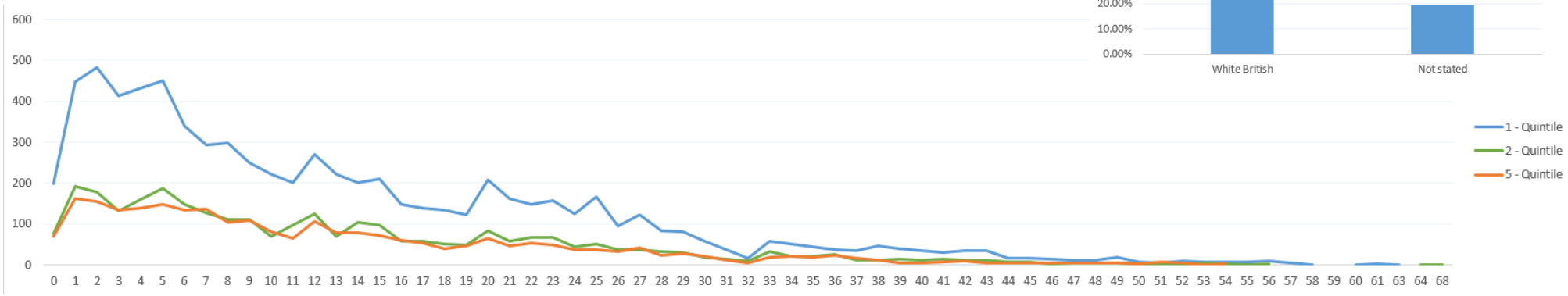
By Deprivation Quintile (1 Most - 5 Least Deprived)

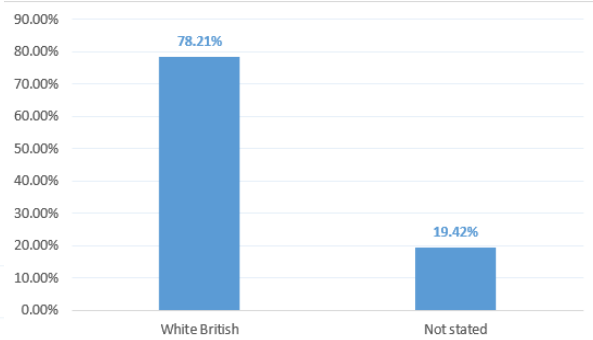


By Ethnicity



Waiting List by Weeks Waiting and Deprivation Quintile 1, 2 & 5

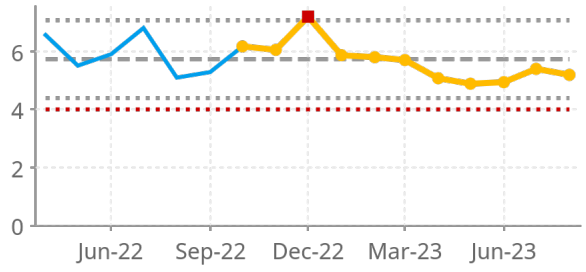




Well-Led People

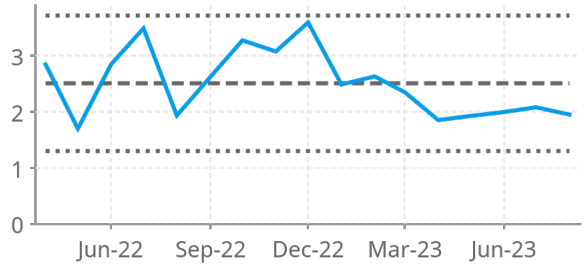
North Tees and Hartlepool NHS Foundation Trust

Sickness % - Trust



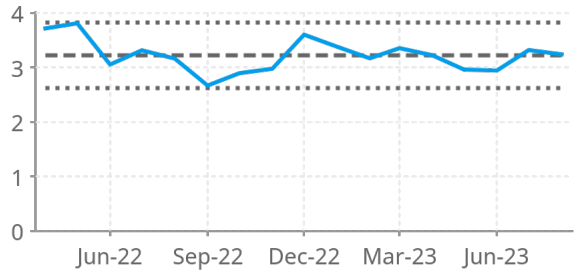
Month	Aug-23
Actual	5.19%
Standard	4.00%

Sickness % - Short Term



Month	Aug-23
Actual	1.95%

Sickness % - Long Term



Month	Aug-23
Actual	3.24%

Summary of Current Issues/ Recovery Plans

The Trust has a sickness absence threshold of 4%.

The sickness absence rate reduced from 5.39% in July 2023 to 5.19% in August 2023. Stress/Anxiety/Depression remains the highest reason for absence and accounts for 33.34% of all absence. Covid absences saw a slight increase to 0.13% in August 2023.

Long-term sickness accounted for 3.24% of overall sickness with short term being 1.95%.

To ensure ownership and reassurance of policy application and case management, the care groups continue to undertake People Clinics overseeing management of cases and providing support and advice appropriately where staff are experiencing significant health and well-being challenges.

Due to the continued increase in reason for absence identified as stress, anxiety and depression, a review of the current offer of mental health support is being undertaken to ensure that this meets current and future staff health needs and support.

A refresh of the action plan has been undertaken to incorporate recently identified issues and emerging themes. These actions are in process for address. Focus on the management of absence of medical staff and standardisation is a newly identified action for address and is being taken forward by the medical staffing manager.

Well-Led People

Appraisal %

Month	Sep-23
Actual	87.33%
Standard	95.00%

Summary of Current Issues/ Recovery Plans

The Trust has a target of 95% compliance for staff annual appraisals. The position for appraisal compliance for September 2023 stands at 87.33% which is an increase of 0.09% from the previous month.

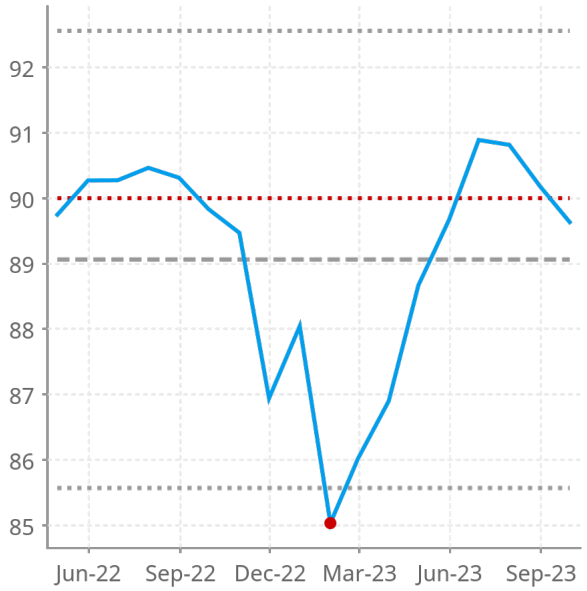
In order to support an improvement in compliance, the Organisation Development (OD) Team have undertaken a 100 day project. The aim of the project was to understand the data, the impact of reporting in RAG report versus ESR and barriers to improving compliance. The project has strengthened understanding of how data is reported and allowed the people business managers to work closely with the care groups to target specific areas. In order to support manager awareness and planning for appraisals, the education team provide monthly summary reports by department and directorate levels to aide in application of process and achieve compliance.

Following the engagement and improvement workshops, the appraisal document is now fully rolled out across the organisation. The documentation incorporates talent management, utilising the 'scope for growth' framework. The OD team are co-producing training materials with the ESR team and Education teams to empower managers to effectively use the ESR platform to record appraisal completion, which was highlighted as a barrier.

The OD team have collaborated with the People Business Managers to review recorded line managers and has provided an opportunity for ensuring accurate records.

Well-Led People

Mandatory Training %



Month	Sep-23
Actual	89.63%
Standard	90.00%

Summary of Current Issues/ Recovery Plans

Mandatory training compliance for September 2023 is 89.63% which represents a decrease on the previous month of 0.55%.

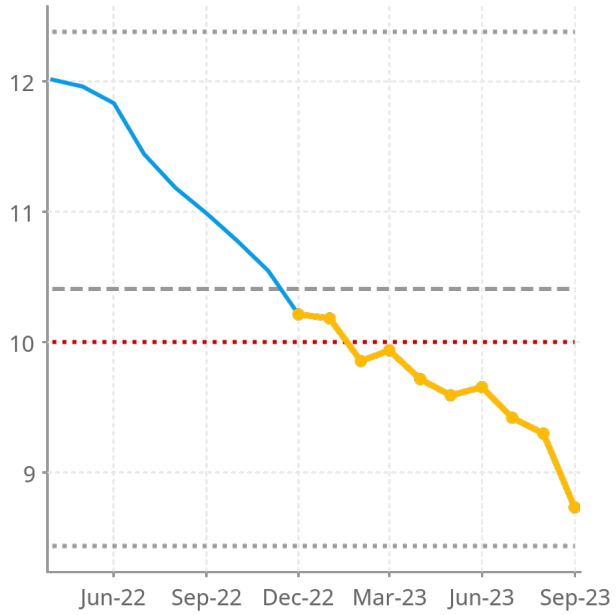
Resuscitation topics remain a compliance challenge and specifically Intermediate Life Support (ILS). Following a review of Training Needs Analysis, work has been undertaken to update competency requirements for specific roles to ensure staff undertake the most appropriate level of training depending on their role. The transition has not impacted on overall compliance for ILS or BLS. A targeted approach to improving ILS compliance has been taken, with an additional 78 spaces being created from October-December - 30% of each session has been ring-fenced for front of house (ED & EAU). Plans have been put in place to improve capacity across 2024, with bookings currently open for staff.

Care Groups and Corporate services are cited on departmental and individual level mandatory training requirements and are being supported via the relevant clinical educators in order to ensure address and improvements in compliance. Mandatory training for medical staff remains an area of low compliance. The appointment of a new Medical Staffing Manager role will support both the care groups and educators in identifying and addressing areas of concern and improvements required to achieve compliance. Following a comprehensive review of mandatory training, agreement has been reached to move to a ‘core' and' non-core' approach and a single reporting system via ESR for individual and department level.

The Education team and BI team are co-producing a dashboard within Yellowfin which will allow oversight of the 'core' topics at Trust, Care group and Department level. This work is in progress and is expected to be in place by December 2023.

Well-Led People

Staff Turnover %



Month	Sep-23
Actual	8.73%
Threshold	10.00%

Summary of Current Issues/ Recovery Plans

The Trust recognises and acknowledges a healthy turnover is good for the organisation as staff develop within their careers and specialism and others who decide to retire after years of service to patients. The Trust therefore accepts a healthy turnover rate at 10% of the workforce.

Turnover for September 2023 is 8.73% which is 0.57% lower than August 2023.

Turnover rates in clinical roles including registered nursing and midwifery and medical and dental are all below the 10% threshold.

A key focus is on going to identify route cause of reason for leaving where staff have resigned within 12 months of commencement.

Well-Led Finance

North Tees and Hartlepool NHS Foundation Trust

Overview - Month 6

Income/Expenditure	Plan (£000)	Actual (£000)
In Month	(432)	1439
Year to Date	2,541	2,514

Capital	Plan (£000)	Actual (£000)
In Month	731	1,104
Year to Date	2,513	7,338

Balance Sheet	£m
Cash Actual	66.7
Cash Plan	68.7

*Broadly on plan.

NHS Oversight Framework	Issued 27 June 2022

Financial Efficiency

Financial Stability

Mental Health Investment

Agency Spending

The Trust has a breakeven financial plan for 2023/24 with reported risks relating to inflationary pressures and efficiency requirements.

At month 6, the Trust is reporting an in-month surplus of £1.439m against a planned deficit of £0.432m, which is £1.891m ahead of plan. The improved in month position is driven by recognition of the year to date elective recovery over performance of 1.799m.

The Trust is reporting a year to date surplus of £2.514m against a plan of £2.541m, which is £0.027m behind plan.

Total Trust income in month 6 is £35.655m (including donated asset income and finance income), with pay expenditure totalling £23.914m and non-pay expenditure totalling £9.236m.

The month 6 year to date net contribution from Optimus is £0.128m against a plan of £0.086m (£0.043m ahead of plan) and the year to date net contribution from the LLP is £1.267m against a plan of £1.163m (£0.104m ahead of plan).

The Trust's cash position is £66.7m, against a plan of £68.7m, which is slightly behind plan.

The key risks at month 6 relate to the reduction of run rates and identification and delivery of CIP within the Care Groups. Industrial action continues to have a financial impact on the Trust's financial position and the delivery of elective recovery.

Maternity

Maternity Overview

Antenatal				
	Current Month	Actual	*National Standard or Average*	*NENC Average*
Smoking at Booking	Aug-23	10.55%	*n/a*	*11.00%*
VTE Compliance	Aug-23	79.29%	*95.00%*	*n/a*
Right Place of Birth	Aug-23	100.00%	*100%*	*n/a*
Birth				
1:1 Care in active Labour	Aug-23	100.00%	*100.00%*	*n/a*
Number of babies born	Aug-23	203	*n/a*	*n/a*
Induction of Labour	Aug-23	49.25%	*46.90%*	*46.90%*
PPH >1500mls (%)	Aug-23	1.51%	*3.30%*	*3.30%*
3rd & 4th Degree tears	Aug-23	0.00%	*n/a*	*2.70%*
Assisted Birth	Aug-23	10.84%	*n/a*	*12.90%*
Still Births	Aug-23	0.00%	*0.40%*	*0.45%*
Postnatal				
Smoking at Delivery	Aug-23	9.55%	*n/a*	*11.00%*
Breast Feeding Initiated within 48 hours	Aug-23	46.80%	*n/a*	*74.40%*
Neonatal				
ATAIN Neonatal Admissions >=37 weeks	Aug-23	4.95%	6.00%	*n/a*
Feedback				
Complaints	Aug-23	4	*n/a*	*n/a*
Compliments	Aug-23	59	*n/a*	*n/a*

The overview is split into the following sections:

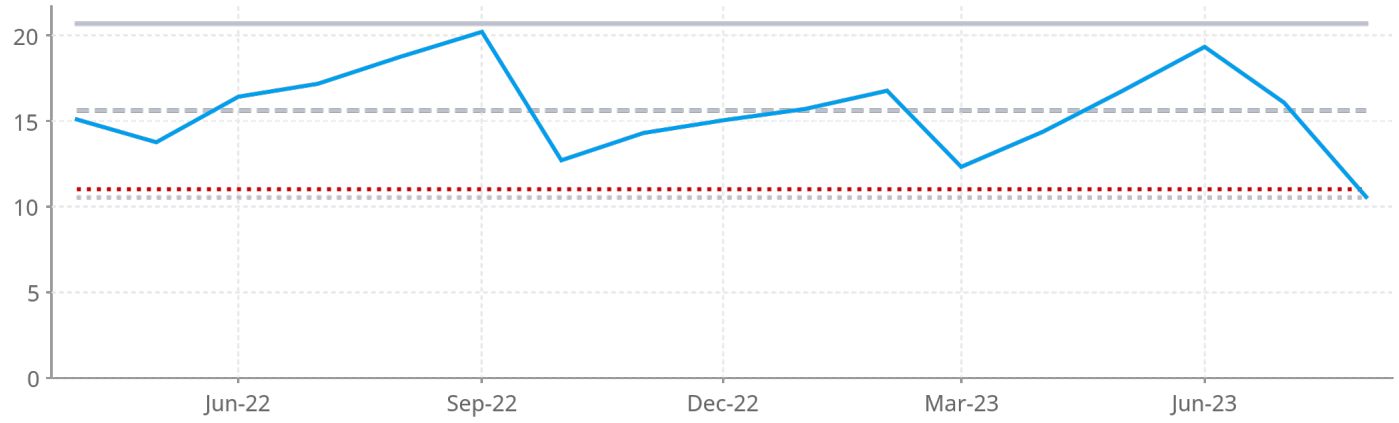
- **Antenatal**
- **Birth**
- **Postnatal**
- **Neonatal**
- **Feedback**

The following maternity sections details measures, with the narrative to support if the Trust is achieving or not against the relevant standard and what the next steps and actions will be.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Smoking at Booking (%)



Month	Aug-23
Actual	10.55%
NENC Average	11.00%

Measure Summary

Smoking is a Public Health priority as it is a determinant of health, including being a potential contributing factors of stillbirths.

The Trusts local population rates of smoking are one of the highest in the North East of England and is reflected in the maternity population. To optimise health of the newborn and mother, there is a National recommendation to support a reduction in smoking or a cessation.

It is to be noted the data for smoking at booking and smoking at delivery are not the same cohort of women.

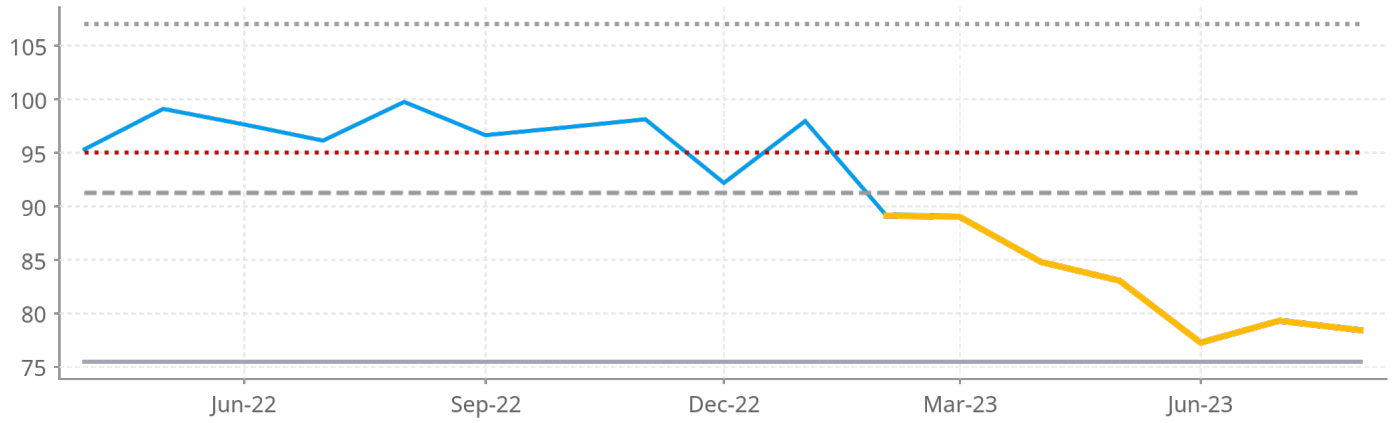
Actions

The Quality Improvement lead has initiated 4 projects:

1. Community led 12 week quit programme - initial results are positive although this will be reflected in the coming months.
2. Increasing the rate of measuring Co2 levels on admission
3. Increasing Referrals on admission to Tobacco dependency
4. Issuing Nicotine Replacement Therapy within maternity services

Maternity - Safe

VTE compliance (%)



Month	Aug-23
Actual	78.41%
Trust Standard	95.00%

Measure Summary

A decline in performance against the Trust standard has been seen over the last few months, with the latest value just above the lower confidence limit (LCL).

The maternity team has undertaken a review in July to explore and understand the reasons for this decline in compliance. The review identified administration teams have supported clinical teams to upload completed VTE assessments onto Trakcare. Administration support has been limited due to workforce pressures over a period of a couple of months. This has informed an action plan to increase compliance. An additional review has been undertaken and potential coding errors have been identified.

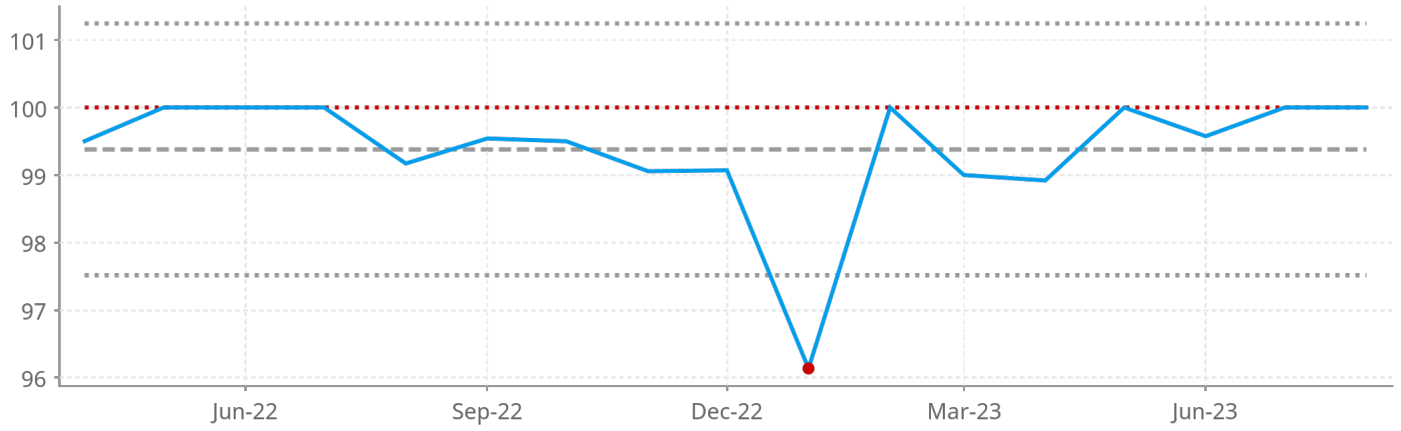
Actions

1. A review of VTE Compliance started in July 2023.
2. Action plan has been developed and implemented in August.
3. Ongoing with with Information Management regarding potential coding errors

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Right place of birth (%)



Month	Aug-23
Actual	100.00%
National Standard	100.00%

Measure Summary

The above chart represents the percentage of babies born in the right maternity service based on clinical indications for gestation.

In order to optimise outcomes for babies born with less than 30 weeks gestation, care should be delivered at a maternity service with a Neonatal Intensive Care Unit (NICU).

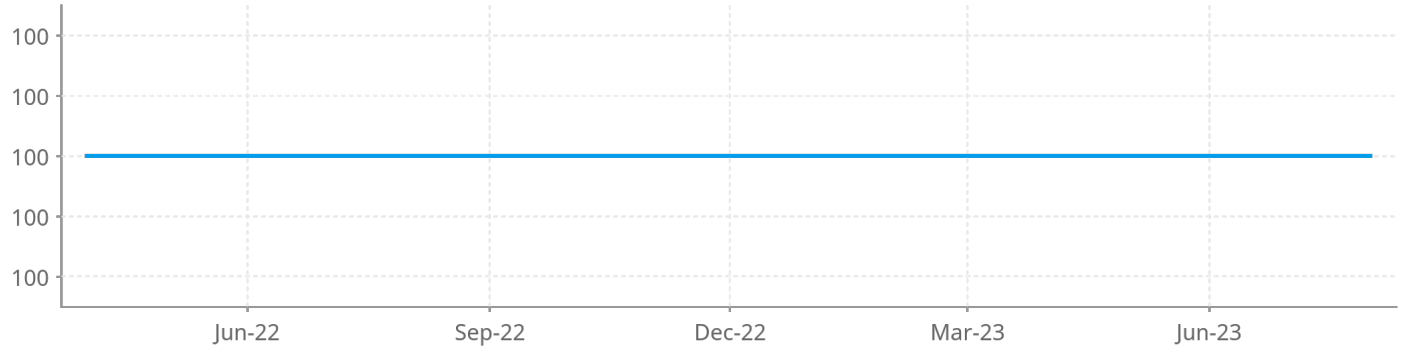
Actions

1. Metric to be developed further once the new Badgernet Electronic Patient Record (EPR) system is implemented (Phase 1 October 2023), this will enable reporting of the achievement of preferred place of birth.
2. Continue to undertake a Multi Disciplinary Team case review for babies born at North Tees who had less than 30 weeks gestation period to identify themes and learning points.

Maternity - Safe

North Tees and Hartlepool NHS Foundation Trust

1:1 care in active labour (%)



Month	Aug-23
Actual	100.00%
National Standard	100.00%

Measure Summary

1:1 care in active labour is monitored and reported weekly, with the data acquired from the Birth Rate plus (BR+) acuity app. Daily huddles are held by the Senior Clinical Matrons (SCMs) where a review and planned forecasting of staffing and activity occurs with information at that point in time. A key element of this review is to provide mitigation around red flags associated with staffing.

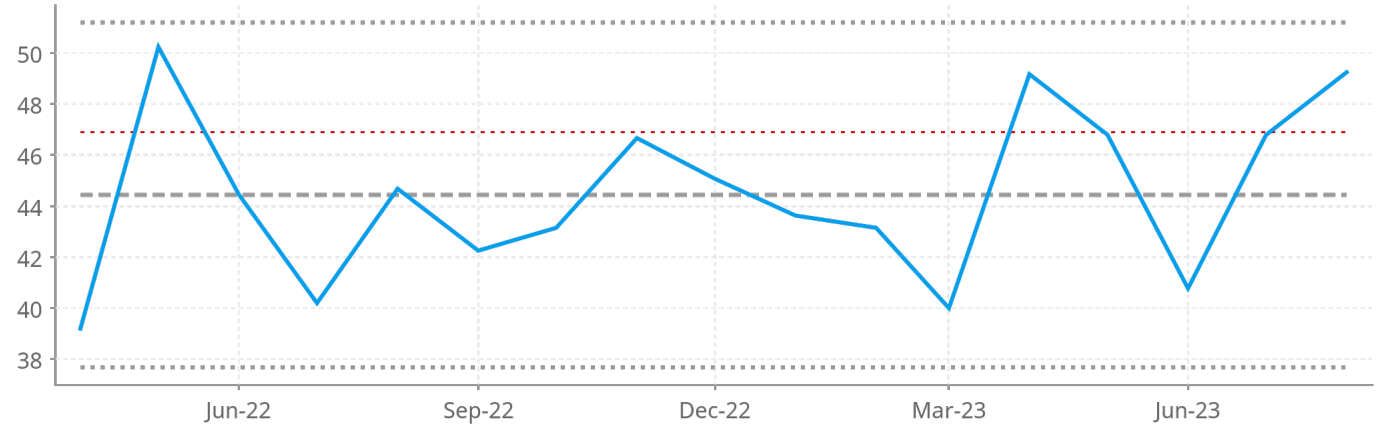
Actions

1. On-going work with the Labour ward Coordinators to ensure appropriate use of the acuity app and clinical decision making.
2. Typical escalation and mitigation include:
   - Redeploying staff
   - Utilisation of on-call staff
   - Reviewing and temporarily pausing elective activity

   At time of escalation mainly around out of hours, a midwife can oversee care of a postnatal women awaiting transfer whilst supporting a woman in active labour.
3. A full data validation process has commenced after a full data validation process has commenced and initial findings have shown there are 2 data sources; BR+ acuity tool and Trakcare. The questions on Trakcare will be removed in time for Badgernet EPR implementation. Data will sourced from the BR+ acuity tool will be the only data source.

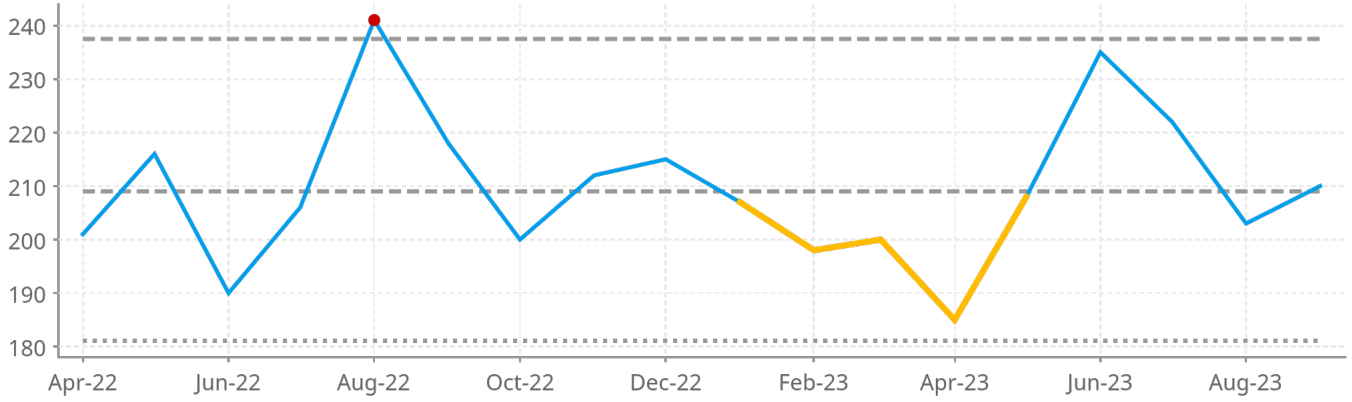
Maternity - Safe

Induction of Labour (%)



Month	Aug-23
Actual	49.25%
NENC Average	46.90%

Total Births



Measure Summary

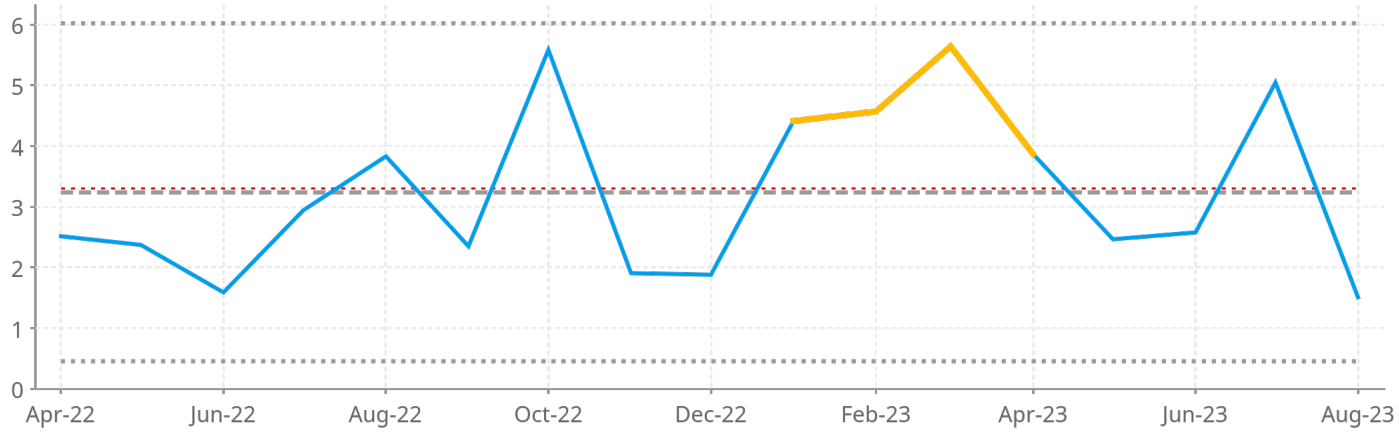
The Induction of Labour (IOL) rate at North Tees and Hartlepool is representative of the national increase in rates.

There is no local or National standard associated with this metric.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Postpartum hemorrhage > 1500mls (%)



Month	Aug-23
Actual	1.51%
NENC Average	3.30%

Measure Summary

The decrease in Postpartum Hemorrhage (PPH) rates is attributed to the recently introduced Quality Improvement (QI) project which accurately measures blood loss rather than estimating.

Actions

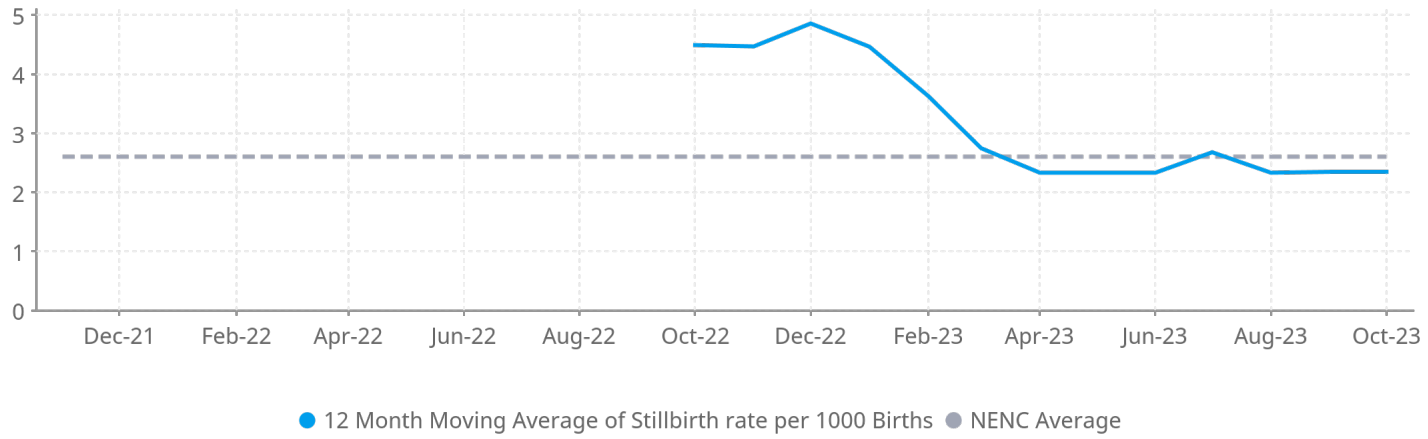
Next steps of the project include:

1. Introducing an enhanced risk assessment tool to promote earlier intervention and assess impact of this on major haemorrhage rates.
2. A thematic case review did not identify any themes. The rise in PPH rates corresponds to the QI project to measure blood loss.
3. Relaunch of QI project to include real time measurement.

Maternity - Safe

North Tees and Hartlepool NHS Foundation Trust

Still births (%)



Month	Aug-23
Actual	0.00%
NENC Average	0.45%

Measure Summary

A thematic review was undertaken and the commonality was smoking in pregnancy. The Smoking in Pregnancy QI work will be evaluated to include any change in outcomes for those women who experience a stillbirth.

From April 2023, a bereavement midwife commenced with the Trust.

This measure was changed to a 12 month rolling average per 1000 births, in line with national reporting standards.

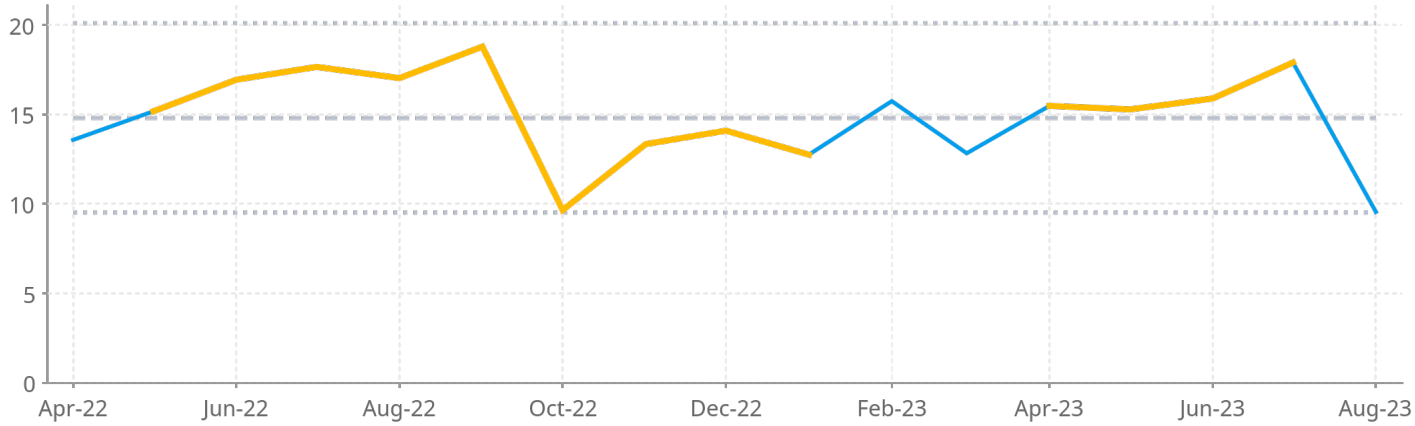
Actions

1. Key focuses include support offered to women and their families and benchmarking services against the National Bereavement Care pathways.
2. Continue with Smoking in Pregnancy Quality Improvement Project.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Smoking at Delivery (%)



Month	Aug-23
Actual	9.55%
NENC Average	11.00%

Measure Summary

To optimise health of the newborn and mother, it is a recommendation to support a reduction in smoking or a cessation.

Local population rates of smoking are one of the highest in the North East of England and is reflected in the maternity population.

Actions

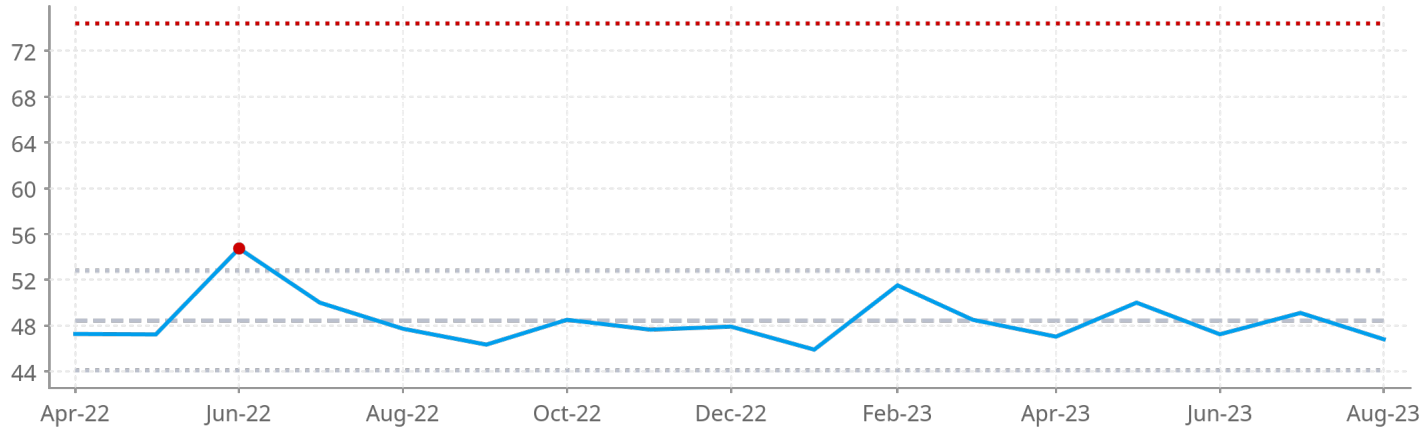
The Quality Improvement lead has initiated 4 projects:

1. **Community led 12 week quit programme**
2. **Increasing the rate of measuring Co levels on admission**
3. **Increasing Referrals on admission to Tobacco dependency**
4. **Issuing NRT within maternity services**

Maternity - Effective

NHS
North Tees and Hartlepool
NHS Foundation Trust

Breast feeding initiated after birth



Month	Aug-23
Actual	46.80%
NENC Average	74.40%

Measure Summary

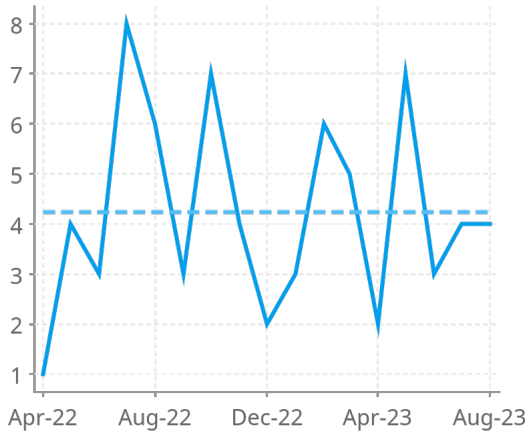
The Trust has some of the lowest rates of breast feeding in the North East.

To provide assurance and to increase rates through knowledge and support, the Trust employed an infant feeding specialist midwife who commenced this role at the start of 2023, with the key focus to gain Breast Feeding Initiative (BFI) accreditation. The service has achieved BFI stage 1 acreditation, Stage 2 acreditation plans are in developement .

Maternity - Responsive

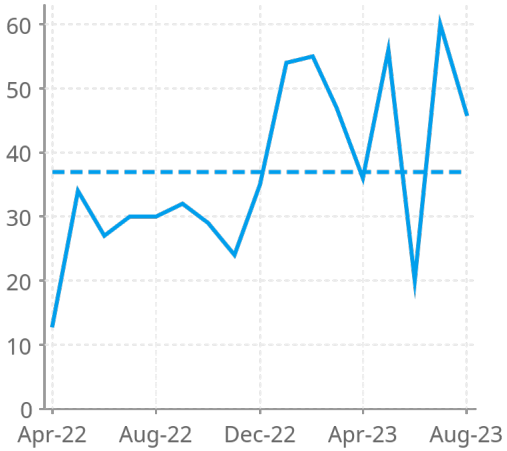
North Tees and Hartlepool NHS Foundation Trust

Complaints



Month	Aug 23
Actual	4

Compliments



Month	Aug-23
Actual	46

Measure Summary

There were 4 complaints in August around maternity services with themes of:

1. **Communication**

Staff attitude and communication was identified as a theme in 3 complaints. Information not shared through departments. This will be actioned via mandatory training, staff briefings, staff handovers and meetings. Lack of flexibility for an antenatal booking was received.

Actions

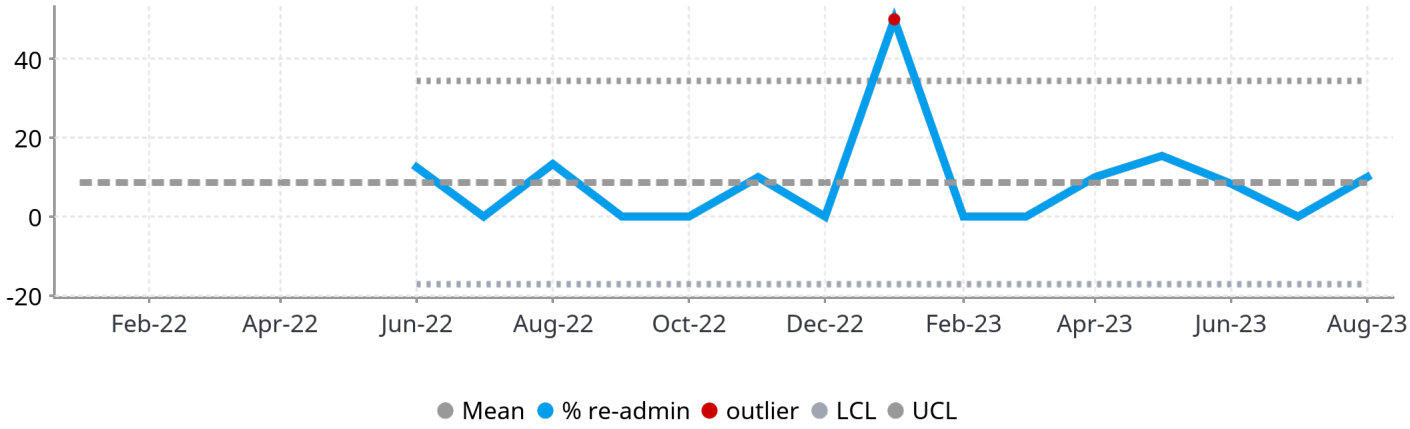
Maternity services recieved 35 compliments in August, the themes of compliments were:

1. **Friendliness**
2. **Kind and caring department**

Maternity

North Tees and Hartlepool NHS Foundation Trust

Re-admissions of babies



Month	Aug-23
Actual	10.00%
Standard	N/A

Measure Summary

As a quality metric the perinatal team are being proactive in monitoring and reviewing readmission of babies to identifying any themes and learning points.
The maternity services have appointed an Infant Feeding Specialist Midwife and undertaking the Breast Feeding Iniative (BFI) accreditation programme. Infant feeding training and education is a possible contributory factor for readmissions for weight loss.

Actions

1. Continue with ongoing thematic reviews
2. A seperate review for weight loss and juandice to be conducted by the Infant Feeding Specialist Midwife

Agenda Item 12

Board of Directors

Title of report:	Fit and Proper Person Framework Requirements										
Date:	9 November 2023										
Prepared by:	Stuart Irvine, Director of Strategy, Assurance and Compliance										
Executive sponsor:	Susy Cook, Chief People Officer & Director of Corporate Affairs										
Purpose of the report	The purpose of the report is to provide an update to the Board of Directors regarding the implementation of the revised requirements for the Fit and Proper Person Test process for board members.										
Action required:	Approve		Assurance		Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People	x	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:											

Background

On 2 August 2023, NHS England published revised requirements in respect of the Fit and Proper Person Test (FPPT) for board members following recommendations in the Kark Review (2019) by Tom Kark KC into the FPPT. A FPPT Framework has been introduced, which sets out new and more comprehensive requirements both for new board appointments and annual review. It is applicable to integrated care boards, NHS trusts, foundation trusts and arms-length bodies - the Care Quality Commission and NHS England.

The purpose of strengthening the FPPT is to prioritise patient safety and good leadership within NHS organisations. A portfolio of evidence will be collected for board members to demonstrate meeting the requirements as well as highlighting those deemed unfit and preventing them from moving between NHS organisations.

The portfolio of evidence for each board member will be held locally and entered onto ESR, which has been updated with new fields to reflect the additional requirements. Before commencing the collection of any evidence, organisations must issue a privacy notice to each board member advising them how the information will be used and stored. This has been carried out for all current board members and Directors employed by the Trust and was issued on 6th October 2023.

It is the Chair of an organisation who has overall accountability for the FPPT, however, nominated individuals such as the Company Secretary and workforce staff can assist to carry out and record the outcome of the assessment for each board member against the FPPT requirements based upon the evidence collected. Organisations are required to make an annual submission to NHS England confirming the outcome of FPPT for their board members. There is also a new FPPT attestation form for board members to complete. These checks are carried out as part of the appointment process and repeated on an annual basis.

Included at **Appendix A** is the FPPT checklist, which details what information is required, the source and additional notes for information.

A new reference template has also been introduced for any new board member appointments with effect from 30th September 2023. The template should also be completed and retained locally for any board members leaving the organisation.

To help inform the fitness assessment in the FPPT a new Leadership Competency Framework (LCF) for board roles will be introduced to support the development of a diverse range of skilled and proficient leaders. A new board appraisal framework is also being produced which will incorporate the LCF. It is expected that the new appraisal template will be used to appraise 2023/24 performance with appraisals taking place in Quarter 1: 2024/25. The Messenger Review (NHS Leadership) reinforced the importance of implementing the FPPT recommendations from the Kark Review and to develop a single set of unified, core leadership and management standards, for which the LCF is a critical part.

Trust Approach

The Trust is applying the new F&PPT guidance to existing staff and this will be undertaken in 2 phases;

- **Phase 1:** The new F&PPT requirements will be applied to the Joint Chair, the newly appointed Joint Chief Executive, Non-Executive Directors, Executive Directors and Directors (without an executive portfolio) as if they were new appointments.

- **Phase 2:** The new F&PPT requirements will be applied to Care Group Directors and Deputy Directors.

The approach above goes above and beyond the requirements of the F&PPT guidance, which is only required to be applied from 30th September 2023, for new employees or those leaving the Trust. This approach has been taken by the Trust to demonstrate and evidence the significant importance that its Directors comply with the new F&PPT requirements.

Included at **Appendix B** is a timeline setting out the stages of implementation for the new requirements.

Considerations/Complexities

The F&PPT guidance now includes a number of new requirements, including a social media check, a check on the removal as a Charitable Trustee from the Charities Commission register and a check regarding information relating to finalised and ongoing investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member.

There are also assurance arrangements required to be followed for instances where secondments between organisations are in place an instances where joint appointments are in place between organisations.

The Trust has secondment arrangements in place, which requires the Trust to seek third party assurance from the host organisation for compliance with the F&PPT guidance.

The Trust also has joint appointment arrangements in place for the joint Chair and the joint Chief Executive, with South Tees Hospitals NHS Foundation Trust. Within the new F&PPT guidance, there is a Letter of Confirmation that is required to be completed and signed by the Chair of the host organisation to confirm the outcome of the new F&PPT checks. In the case of the joint Chair, this would be signed by the Managing Director or the Chief People Officer.

External Support (NHSE)

As the guidance has only recently been issued (and may be subject to further amendment), there is the potential to incorrectly or inconsistently apply the guidance, the Trust has arranged an informal meeting with the NHSE Lead for the new F&PPT guidance to share the Trust's approach to undertaking the tests and receive feedback.

External Assurance

The Trust is currently subject to an internal audit based on the F&PPT guidance up to 30th September 2023, with audit findings expected to be reported in November 2023. The Trust will also be recommending the inclusion of an audit based on the new guidance in 2024/25.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
This paper relates to the People BAF domain.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity, inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	Trust Directors Team – 17th October 2023

Recommendation	• The Board of Directors is asked m are asked to note the updated Fit and Proper Person Test Framework requirements and proposed implementation plan for the Trust.

Appendix A: FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	
Date of medical clearance* (including confirmation of OHA)	✓	X	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	X	✓	✓	✓	X	Eg NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Other templates to be completed								
Board Member Reference	✓	✓	X	X	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest. Appendix 2 in Framework.
Letter of Confirmation	X	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	X	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.
Privacy Notice	X	✓	X	X	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix B

Fit and Proper Person Test (FPPT) Implementation Timeline

Item	Effective date	Status
1. Communicate to all Board members (including interim appointments) the new requirement to retain electronic records on ESR in relation to FPPT (using the new standard privacy notice template), an individual may object.	As soon as possible	Completed
2. Use of a new standardised reference template for all new Board appointments and for any board member leaving the organisation, to be retained locally should another NHS organisation request a copy.	30 September 2023	In place
3. Issue all board members with the revised FPPT attestation form.	31 October 2023	Completed
4. Undertake a gap analysis of current details held for each board members against new requirements and obtain the additional information.	30 November 2023	Planned
5. Upload the required information onto ESR for each board member and assess against the FPPT requirements.	31 December 2023	Planned

6. Report the FPPT findings to Board prior to the completing and submitting the annual NHS FPPT submission reporting template to NHS England.	1 February 2024	Planned
7. A new NHS Leadership Competency Framework (LCF) is being developed.	To be confirmed (delayed release)	Not yet started
8. A new board appraisal framework is being developed incorporating the LCF, to be used to appraise 2023/24 performance.	31 March 2024	Not yet started

Agenda Item 13

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report	Provider Collaborative Responsibility Agreement										
Date	9 November 2023										
Prepared by	Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary										
Executive sponsor	Neil Atkinson, Managing Director										
Purpose of the report	To provide the Board of Directors with an update regarding the governance arrangements for the NENC Provider Collaborative (the Collaborative) specifically focusing on the responsibility agreement (RA) with the ICB and the strategic partnership agreed with NECS.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
CQC Domain(s) supported by this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Background

In July 2022 the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trust's in NENC to formally work together set out in the 'Collaboration Agreement'. This agreement was supported by an aims and aspirations document as well as an operating model. All Trust Boards approved these by September 2022. In presenting the formal collaborative approach, it was noted that the final element of these arrangements was a responsibility agreement (RA) with the ICB which was under discussion at that point in time. That agreement is now in place for 2022/23, with the following summarising the requirements and the full RA attached at **Appendix A** of this report.

Main Points

NHSE guidance on the functions and governance of the integrated care board (August 2021) stated that:

- Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.
- The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

To meet this requirement the Collaborative and ICB have established a responsibility agreement (RA) which defines and describes the working relationship between the ICB and the Collaborative.

It provides a framework for building an ongoing relationship recognising that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.

The RA also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments. It is an annual arrangement that will be reviewed and refreshed in year, with an agreement for 24/5 to be in place for 1st April 2024.

The RA recognises that the Collaborative's Provider Leadership Board will determine programme governance structures required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams. Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

The RA recognises that areas of work will evolve over time and there will be a need to respond to emerging and ad hoc requirements. However it does set out the specific work programmes agreed between the ICB and the Collaborative for 2023/4, which are summarised below:

- Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.
- Delivery of a diagnostics plan and programme.
- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.
- Continued implementation of the aseptic manufacturing hub.
- Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital.
- Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements.

The RA established a Collaborative operational budget of £1.3m for 2023/4. This is comprised of;

- £600K contribution from the NECS (on behalf of ICB)
- £200K roll over of underspend from previous years
- £550K contribution from Trusts (£50k contribution per Foundation Trust)

Strategic Partnership with NECS

As part of evolving working arrangements the Collaborative has agreed to form a strategic partnership with NECS. This recognises the role and support which NECS has offered in the establishment of the Collaborative and the ongoing alignment of priorities and work areas for the Collaborative and NECS, with areas of focus set out in the attached report.

This relationship will enable the Collaborative to draw upon the capabilities of NECS and its wider expertise and experience via its comprehensive supply chain as well as being able to shape the direction and development of NECS' strategic direction and priorities.
Strategic Risk linked to the Board Assurance Framework this report relates to:
This report links to all domains in the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and Facilities	X
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	x

Board committees where this item has been considered	Management Group meetings where this item has been considered
N/A	This has previously been discussed at Executive Team.

Recommendation	The Board of Directors is asked to; • Note the Responsibility Agreement between the ICB and Collaborative; and • Note the strategic partnership between the Collaborative and NECS.

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

October 2023

1. Purpose

1.1. The purpose of this note is to update Boards on the governance arrangements for the NENC Provider Collaborative (the Collaborative) specifically focusing on the responsibility agreement (RA) with the ICB and the strategic partnership agreed with NECs.

1.2. Trust Boards are asked to note progress in these areas.

2. Context

2.1. In July 2022 the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trust's in NENC to formally work together set out in the 'Collaboration Agreement'. This agreement was supported by an aims and aspirations document as well as an operating model. All Trust Boards approved these by September 2022.

2.2. In presenting the formal collaborative approach it was noted that the final element of these arrangements was a responsibility agreement (RA) with the ICB which was under discussion at that point in time. That agreement is now in place for 2022/3, with the following summarising the requirements and the full RA attached at appendix A.

3. Responsibility Agreement

3.1. NHSE guidance on the functions and governance of the integrated care board (August 2021) stated that:

> *Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.*
>
> *The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.*

3.2. To meet this requirement the Collaborative and ICB have established a responsibility agreement (RA) which defines and describes the working relationship between the ICB and the Collaborative. It provides a framework for building an ongoing relationship recognising that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.

3.3. The RA also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments. It is an annual arrangement that will be reviewed and refreshed in year, with an agreement for 24/5 to be in place for 1st April 2024.

3.4. The RA recognises that the Collaborative's Provider Leadership Board will determine programme governance structures required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams. Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

3.5. The RA recognises that areas of work will evolve over time and there will be a need to respond to emerging and ad hoc requirements. However it does set out the specific work programmes agreed between the ICB and the Collaborative for 2023/4, which are summarised below:

i. Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

ii. Delivery of a diagnostics plan and programme.

iii. Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

iv. Continued implementation of the aseptic manufacturing hub.

v. Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital.

vi. Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements.

3.6. The RA established a Collaborative operational budget of £1.3m for 2023/4. This is comprised of:

- £600K contribution from the NECS (on behalf of ICB)
- £200K roll over of underspend from previous years
- £500K contribution from Trusts.

4. Strategic Partnership with NECS

4.1. As part of evolving working arrangements the Collaborative has agreed to form a strategic partnership with NECS. This recognises the role and support which NECS has offered in the establishment of the Collaborative and the ongoing alignment of priorities and work areas for the Collaborative and NECS focusing on, specifically:

- The deployment of resources and support across system programmes and areas, covering people, digital and analytical requirements;
- The identification of economies of scope and scale in corporate, clinical and clinical support services;
- The delivery of system priorities where there is appropriate congruence (e.g. elective recovery);
- The building of capacity and capability to ensure future resilience through the identification, development and deployment of digital tools and AI to the mutual benefit of the partners;
- Developing population-based approaches to the management of patients to facilitate better care, outcomes and utilisation of resources;
- Mutual development of skills, leadership and associated development for clinical and non-clinical staff.

4.2. This relationship will enable the Collaborative to draw upon the capabilities of NECS and its wider expertise and experience via its comprehensive supply chain as well as being able to shape the direction and development of NECS' strategic direction and priorities.

5. Recommendation

5.1. The FT Boards of the eleven NENC Provider Collaborative members are asked to:

i. Note the Responsibility Agreement between the ICB and Collaborative
ii. Note the strategic partnership between the Collaborative and NECS

Matt Brown
Managing Director
North East and North Cumbria Provider Collaborative
26th September 2023

Appendix A: Responsibility Agreement

North East and North Cumbria Provider Collaborative

North East and North Cumbria

PROVIDER COLLABORATIVE RESPONSIBILITY AGREEMENT

2023/24

1 PURPOSE

This Responsibility Agreement defines and describes the working relationship between the North East and North Cumbria (NENC) Integrated Care Board (ICB) and the NENC Foundation Trust Provider Collaborative (the Collaborative). It provides a framework for building an ongoing relationship and collaboration, which recognises that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.
- It also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments.

2 BACKGROUND

The Provider Collaborative provides a formal mechanism for collective decision making across all 11 FTs on important 'whole system' issues in NENC. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, through an approach that will be additive, tackle unwarranted variation and enhance working at Place.

The Collaborative began working together in 2019 with

arrangements formally endorsed by Trust Boards over the summer of 2022.

3 MEMBERSHIP OF THE PROVIDER COLLABORATIVE

The Members of the Collaborative are all of the foundation trusts (FTs) within NENC:

- County Durham and Darlington NHS FT
- Cumbria, Northumberland, Tyne and Wear NHS FT
- Gateshead Health NHS FT
- Newcastle Upon Tyne Hospitals NHS FT
- North Cumbria Integrated Care NHS FT
- North East Ambulance Service NHS FT
- North Tees and Hartlepool NHS FT
- Northumbria Healthcare NHS FT
- South Tees Hospitals NHS FT
- South Tyneside and Sunderland NHS FT
- Tees, Esk and Wear Valleys NHS FT

3 REMIT

3.1 General

The Collaborative will identify and deliver a programme of mutual benefit and that:

- Contributes to the delivery of the NENC Integrated Care Strategy, in particular its long term goal of 'Better Health and Care Services' by identifying opportunities to improve the quality and sustainability of the health services in the Region, towards a goal of all statutory organisations regulated by the Care Quality Commission being rated either 'Good' or 'Outstanding'.

- Supports the efficient and effective use of resources within its member organisations, with a focus on opportunities to collaborate and/or share resources and to identify and reduce unwarranted variation

- Undertakes collective strategic workforce planning in collaboration with national and regional teams

- Develops opportunities to act as 'anchor institutions', including supporting economic development by leveraging their power as large employers and purchasers.

- Supports the achievement of the integrated care strategy goals of 'longer, healthier life expectancy' 'fairer outcomes'.

3.2 Specific work programmes agreed between the ICB and the Collaborative for 2023/24

- Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

- Delivery of a diagnostics plan and programme

- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

- Continued implementation of the aseptic manufacturing hub

- Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital

- Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements

3.3 As appropriate the Provider Collaborative and the ICB will identify in issues and opportunities where a collective provider response is required. This could include specific service issues (for example development and deployment of response to CMDU) to cross cutting issues (e.g. developing an approach to repatriations).

3.4 The ICB will support the Collaborative in its work which will include access to appropriate resourcing for system objectives as well access to appropriate data and analytics to inform work, where the ICB holds this information, on the principle of 'do it once'. The ICB will also ensure appropriate officer involvement in Collaborative work programmes as agreed with the Collaborative.

4 GOVERNANCE ARRANGEMENTS

It is recognised that these arrangements may evolve over time.

The Provider Collaborative operates as a formal partnership of all 11 NHS Foundation Trusts (FTs) in NENC. It is a whole system collaborative acting, at scale across multiple FTs with individual FTs continuing to work with each other in collaborative arrangements on a geographical or sectoral basis and play full roles within their relevant place-based partnerships, working closely with local communities and partner organisations.

It is underpinned by a formal collaboration agreement, operating under a provider leadership model, with formal mechanisms for collective decision making across all FTs on important 'whole system' issues. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, rather than being a separate formal entity. Individual organisations remain accountable in line with NHS governance and regulatory requirements.

The PLB will determine the programme governance structure required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams.

Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

5 RESOURCES

Based on the work programme contained within this agreement, the resources for 23/24 are set out below in summary, together with the funding sources. A programme staff organisation chart is provided as appendix 1

Costs banded at top of grade, or actual where available.

Post	WTE	Band	Annual cost £k	23/24 cost £k
Managing Director (hosted by NUTH)	1.0	VSM	130	130
Director of Elective Recovery & Transformation (NHSE)	0.4	VSM	60	60
Elective Programme Director (NECS)	1.0	8D	605	605
Corporate Programme Director (NECS)	1.0	8D		
Senior Development Lead (NECS)	1.0	8D		
Senior Project Manager (NECS)	1.0	8A		
Programme Support Officer (NECS)	1.0	5		
Mutual Aid Lead (STSFT)	0.4	8A	30	30
Project Support Officer (NECS)	1.0	5	60	60
Senior Programme Support Officer (Gateshead)	1.0	6	55	30
Subtotal (filled)			***940***	***915***
Vacant				
Clinical Programme Lead	1.0	8C	95	70
Project Manager	4.0	7	240	180
Performance & Intelligence Lead	0.6	8A	45	30
Finance Lead	0.2	8A	15	10
Comms Lead	1.0	6	60	45
Administrative Assistant	1.0	3	30	20
Clinical Leadership & Backfill			30	30
Subtotal (vacant)			***515***	***385***
Non pay (inc corporate support eg HR, finance)			30	30
Total Costs			**1,485**	**1,330**
Income				
Carry over from 22/23				180
NECS contribution				500
ICB contribution				100
FT contribution (£550k/11 = **c£50k per FT**)				550
Total Income				**1,330**

Note – the right-hand column, denoted 23/24 cost (£k), takes account of likely actual in-year costs, for example due to recruitment taking place mid-year

Separate funding streams are in place in 23/24 for:

- Aseptics Project Director

- Aseptics Project Manager
- Cancer Programme Manager
- Diagnostics Programme

There will be other potential posts through the Provider Collaborative, such the Digital Diagnostics Implementation Leads, pharmacy and procurement opportunities e.g., diabetic devices.

In addition, the ICB and will support the Collaborative in the following ways:

- A shared approach to the use of BI resources, including a commitment to 'do once and share'
- Support from the ICB Programme Management Office, and access to a suite of project management and quality improvement tools
- Support for the team, with a link executive and team (the Chief of Strategy and Operations)

6 AGREEMENT

Insert signature	Insert Signature
Ken Bremner Chair, Provider Collaborative Insert Date	Sam Allen CEO, Integrated Care Board Insert Date

Agenda Item 14

Board of Directors

Title of report:	Maternity Board Report Quarter 2: 2023/24										
Date:	9 November 2023										
Prepared by:	Stephanie Worn - Associate Director of Midwifery										
Executive sponsor:	Lindsey Robertson - Chief Nurse										
Purpose of the report	The purpose is to update the Board of Directors on Maternity Services, in line with the national recommendations										
Action required:	Approve	x	Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing				
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 purpose of the report is to inform and provide assurance to North Tees and Hartlepool Foundation Trust (NTHFT) Trust Board that there is an effective system of clinical governance monitoring of the safety of our maternity services with clear direction for learning and improvement.

Section 1 - 5

The report identifies reporting for a safety event that meets the criteria for:

- Perinatal Mortality Review Tool (PMRT)
- Healthcare Safety Investigation Branch (HSIB)
- Serious Incidents
- Incidents graded moderate above.

The maternity services undertake a rapid response to learning following any of the above events and an investigation is commenced in line with the required processes and timeframes. In quarter 2, it was identified there was an opportunity to enhance training in relation to antenatal assessment and this has been actioned. The aforementioned local intelligence and is triangulated with the Trusts claims scorecard to inform a shared learning plan for targeted interventions and included in the developing plans for patient safety incidence response plan. The improvement plan is reviewed and discussed through the governance structures.

Section 6 – 9

The report identifies the Trusts position against national maternity safety recommendations:

- Ockenden 7 IEAs
- Maternity Incentive scheme (MIS)
- Saving babies lives care bundle (SBLCBv3)
- Avoidable term admissions in neonates (ATAIN)

The report identifies the governance approach to progress position using the RAG; interventions remains amber until evidence has been reviewed and approved. On the 19th October the Trust received an Ockenden Insights visit led by the ICB. The Trust reported we are either on track or compliant for all 7 IEAS (section 6). The initial feedback was positive, there has been noticeable improvement made since the visit in 2022 including feedback from service users and staff and strengthened governance and leadership structures. The report is expected within 21 working days.

MIS compliance is identified in Section 7. In September discussions were held with members of the MQAS relating to the technical guidance for safety action 4 and 8 for agreement, the outcome was that both safety actions are on track for compliance with. A validated evidence was published on the 26th October for MSDS data quality, supporting compliance of safety action 2.

Section 8 identifies the Trusts positon with SBLCBv3, acknowledging the nationally published implementation tool to support progress and assurance went 'Live' in September and some errors have been identified and escalated to the LMNS and SBLCB management team. In the interim a local database will replicate the required fields.

Section 9 identifies an improvement in ATAIN rates. There are ongoing monthly MDT reviews and the outcomes inform the development of an action plan. Developments in services towards implementing a transitional care pathway for late preterm babies are continuing with a detailed action plan.

Section 10 – 11

Section 10 identifies the funded establishment is compliant with BirthRate+ recommendations. Staffing levels have continued to be challenging, the report details the mitigations, and escalation processes in place. The report identifies safe staff staffing through the BR+ acuity app red Flag system. The provision of 1-1 care in labour was 100%. 7 red flags on a shift basis were submitted for loss of labour ward coordinator (LWC) supernumerary status. A review identified that this was for a short period as internal escalation to provide additional staff was activated and the LWC did not provide 1-1 care. Section 10.2 provides further information. Recruitment continues at pace and the forecasted trajectory demonstrates an improvement for November. Section 10.2 describes the escalation plans to mitigate against high acuity and or staffing pressures.

The report identifies the Neonatal services have undertaken an annual nurse staffing standards review with an action plan to achieve compliance (section 10.5).

Section 10.4 identifies a revised standard operating procedure, which is in line with RCOG guidance on compensatory rest for consultants: Compensatory Rest Following Night On-Call Consultants in Obstetrics & Gynaecology (section 10.4) The quarter audit is planned as part of the MIS submission. A local audit for long term locums has been undertaken with a corresponding action plan to strengthen the process for feedback.

Section 11 identifies the training requirements for both national and trust requirements. Maternity specific training to improve safety in maternity services is directed by the national Core Competency Framework (CCFV2) and is a requirement of MIS. The training is delivered following the NENC maternity syllabus and the current trajectory is on course for compliance. On the 23rd October, NHSR published an update to inform Trusts the compliance for MDT obstetric emergencies skills has been revised to 80% following the potential impact of medical availability due to Industrial action, though an action plan is to be submitted to achieve 90% by March 2024

Section 12 – 13

In section 12 and 13, feedback from complaints, compliments and Maternity and Neonatal Voice Partnership (MNVP) provide themes for learning opposites which are shared with all staff groups. The

MNVP continue work on their work plan and are actively involved with the LMNS. The Trust continue to offer a Maternity Continuity of Care team with a choice of place of birth.

Section 14

The report identifies the work priorities and achievements for the specialist midwifery roles. The Trust has achieved accreditation stage 1 for Breast Feeding Initiative as has SCBU. Bereavement services are progressing well, with collaboration from internal and external partners. The Quality improvement lead has develop projects to improve care and outcomes for mothers and babies, with a successful project for post-partum haemorrhage being showcased the Project has been showcase at the International Federation of Gynaecology and Obstetrics. The research midwives team have demonstrated research can be embedded into practice and maternity services are one of the top performing Trusts, currently they have recruited 3662 in 18months. Sharon Gowans has been recognised as the top recruiter in the NENC.

Section 15

The NTHFT quadrumvirate have joined the national Perinatal Culture and Leadership Programme (PCLP) and have received support from the Board Maternity Champion and Non-Executive Director Maternity Champion. There is organisational planning underway for the SCORE (Safety Culture, Operational risk, Reliability/burnout and Engagement) staff survey scheduled for October 2023 which is being supported by the PCLP. The Board Maternity Champion and Non-Executive Director Maternity Champion have bi-monthly meetings with the quadrumvirate. The Board Safety Champions have joined the related Futures platform workspace (sections 9 and 16).

Section 16 – 18

These sections summary the current risk register and recommendations which are outlined the following document.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
Risk 6643, Risk 6644			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Quality Committee 23.10.2023		Maternity Quality Assurance Council 11.10.2023	
Recommendation	The Board are asked to receive and note the significant on-going work to meet National Maternity recommendations and workforce challenges.		

	The Board are asked to receive and note the culture and leadership developments. The Committee are asked to receive and approve: • Trust claims scorecard and triangulation of data for shared learning • MSDS scorecard • ATAIN action plan • Neonatal transitional care for late preterm babies action plan • Midwifery staffing safety measures • SOP compensatory rest for consultants following night on-call • Long term locum audit and action plan • Neonatal nurse staffing standards report and action plan

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Maternity Board Report Quarter 2: 2023/24

Report of the Chief Nurse

1. Introduction/Background

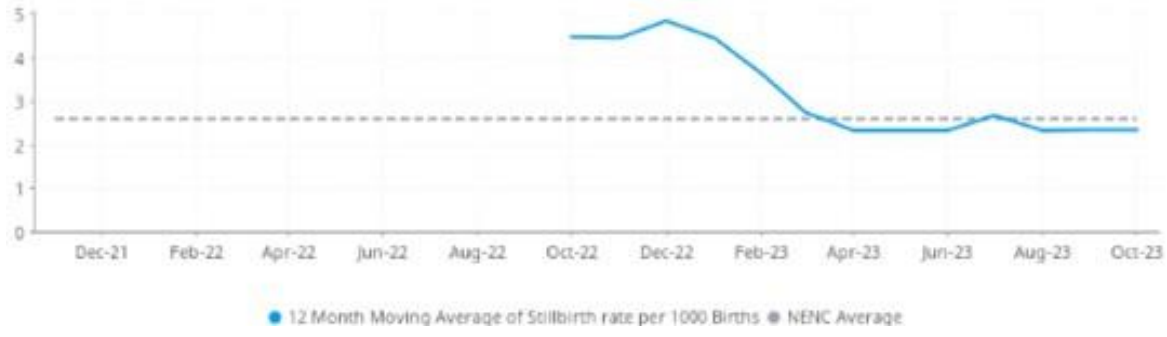
The purpose of the report is to inform and provide assurance to North Tees and Hartlepool Foundation Trust (NTHFT) Board that there is an effective system of clinical governance in place monitoring the safety of our maternity service with clear direction for learning and improvement.

The data within this report is for Q2 of 2023/24. Where any data provided sits outside this reporting timeframe this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

2. Perinatal mortality rate

In Q2, there were three stillbirths reported and zero neonatal deaths. The rolling annual stillbirth rate per 1000 births is demonstrated in graph 1. The monthly neonatal death rate per 1000 births, inclusive of early and late neonatal deaths is demonstrated in graph 2. On average the Trust has 200 births per month

Graph 1. Rolling annual Stillbirth rate per 1000 births



Graph 2. Monthly neonatal death rate per 1000 births

2.1 Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. Stillbirths are defined from 24 weeks.

All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. To meet the requirements of Maternity Incentive Scheme (MIS), the outcome of reviews are reported monthly to the Quality Assurance Committee and quarterly to the Trust Board.

2.2 Learning from PMRT reviews Q1 and Q2

A rapid response to learning is undertaken to identify and action any immediate learning until the full PMRT review has been completed within the expected timeframe. In Q2, a rapid response to learning identified a training requirement for an aspect of antenatal assessment, and this has been actioned.

Completed case reviews that have occurred in the preceding months identified there were no issues with care likely to have made as difference to the outcome of the baby. An incidental finding highlighted there is an inconsistency of prescribing aspirin in the antenatal period. This is being actioned and will involve collaboration with primary care.

3. Healthcare Safety Investigation Branch and Maternity Serious Incidents

3.1 Background

Healthcare Safety Investigation Branch (HSIB) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018).

3.1.1 Babies

Babies who meet the criteria for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes are:

- Intrapartum stillbirth.
- Early neonatal death.
- Severe brain injury diagnosed in the first seven days of life.

3.1.2 Mothers

Mothers who meet the criteria for investigation are direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy. HSIB do not investigate cases where suicide is the cause of death.

3.2 Reported and investigation progress update

There were zero cases that qualified for notification to HSIB during Q2 and less than five investigations completed.

3.3 Safety recommendations and learning from completed investigations from Q2

In Q2 the Trust received a recommendation for learning. Table 1 demonstrates recommendations.

Table 1. HSIB recommendations

Recommendation	Action	On-going monitoring
The Trust to ensure that clinicians are aware that clinical handovers do not occur during a procedure in the maternity operating theatre unless this is essential and if this is unavoidable, a robust handover is required.	Disseminate information to all staff through several communication mechanisms such meetings, newsletters, handovers	To monitor through incident system

3.4 Coroner Reg 28 made directly to Trust

No requests made in this reporting period.

4. Maternity Serious Incidents

In addition to HSIB cases the service has investigated zero incidents under the serious incident framework for Q2. One incident was graded as moderate or above. Further breakdown of incidents is included in Table 2 and 3. Duty of candour occurred for all cases.

Table 2 . Incidents graded as moderate or above

	July 2023	August 2023	September 2023	Total
Near Miss	2	6	5	13
No Harm	78	46	65	189
Low Harm	4	6	5	15
Moderate Harm	0	0	1	1
Total	85	58	76	219

Table 3. Description of Moderate or above incidents in Q2

Incident Category	Outcomes
Labour Delivery	Injury sustained to baby. Case review in progress

5. HSIB/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust.

In October 2022 the Maternity Services were placed on the Maternity Safety Support Programme (MSSP) following a review by the CQC which rated Maternity Services as Requires Improvement. The Trust are working with the Simon Mehigan - named Maternity Improvement Advisor. In May 2023 the exit criteria from the MSSP was agreed by Trust, ICB and NHSE. There are six elements are:

1. Workforce.
2. Leadership.
3. Quality, risk and safety.
4. Digital.
5. Improvement plan.
6. CQC.

The Maternity team have actions plans to achieve each of the six criteria with an expected date of completion by March 2024.

6. Ockenden update

In response to failures at Shrewsbury and Telford NHS Trust, the initial Ockenden report (2020) set out recommendations and highlighted 7 Immediate and Essential Actions (IEAs) for all maternity services to enable them to improve safety for mothers and babies. The final Ockenden report was subsequently published in March 2022 and included 15 additional IEAs for all Trusts to act upon.

In 2022 Insights visits were undertaken by NHSE to all Trusts to gain assurance against the 7 IEAs. The insights visits benchmarked the maternity services position against the 7 IEAS and each IEA has sub sections which formed enquiry lines of questions. NTHFT progress is outlined in Table 6 and a detailed report and the progress tool has been provided as appendices 1 and 1i.

Amber rated progress for IEA3-7 are on track for compliance, however, evidence is currently being collated within the required monitoring period.

To strengthen the existing reporting on Ockenden within the Care Group and to the Trust Board, compliance status will be incorporated within the overall safety action plan and further updates being appended to the monthly Maternity Improvement Group, Maternity Quality Assurance Council chaired by Chief Nurse, the Quality Assurance Committee chaired by a Non-Executive Director (NED) and then to the Trust Board of Directors. Table 4 provides a summary of progress towards the Ockenden 7 IEAs. An Ockenden insights progress visit by the ICB is expected on the 19th October 2023.

Table 4. Ockenden 7IEAs progress

On Track	Compliant and on track with evidence
Partially Compliant	Work ongoing
Not compliant	Not currently compliant

Immediate & Essential Action		Oct-23	Nov-23	Dec-23	Jan-23	Feb-23	Mar-23
IEA 1	Enhanced Safety						
IEA 2	Listening to Women & Families						
IEA 3	Staff Training & Working Together						
IEA 4	Managing Complex Pregnancy						
IEA 5	Risk Assessment Throughout Pregnancy						
IEA 6	Monitoring Fetal Wellbeing						
IEA 7	Informed Consent						

7. NHS Resolution Maternity Incentive Scheme

The starting point for year 5 MIS is that we will be non-compliant with all 10 safety actions. This ensures that there is ongoing monitoring of compliance against the safety actions for year 5 and will ensure that assurance given to the board is robust and not based on an assumption that previous years compliance applies (Table 5). It also reflects that compliance is linked to dates within the coming months. We have been encouraged to adopt this approach by the Maternity Improvement Advisor from NHSE. The following work has been undertaken:

- Named Leads identified for each Safety Action.
- Work sheet identified for each safety action outlining the evidence required to reach compliance.
- Regular progress and reporting meetings scheduled to include all named leads.
- Evidence repository: Share point access for staff to upload data.
- Membership of the National MIS peer network.

The current position of compliance is outlined in Table 7, and a detailed report in appendix 2 and 2i.

Table 5. MIs current position

Compliant	Compliant and all evidence in place
On Track	Compliant and on track with evidence
Not compliant	Not currently compliant or compliant over the last 12 month

MIS Monthly Summary

Safety Action	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23	Mar-23	Apr-23
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

7.1 Potential non –compliance with MIS safety actions

It was reported in July 2023 that the status of achieving compliance with the 10 MIS safety actions had been reviewed and there were 2 safety actions at risk of non-compliance at the end of the reporting period due to ongoing workforce pressures and validation of data. In September, an update of progress and current position was discussed at the Maternity Quality Assurance Council attended by the Trust's named Maternity Improvement Advisor. The following reflects the current position:

- Safety Action 5c

The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. In Q2 there were seven red flags on a shift basis. Each red flag was reviewed to include the narrative from the acuity tool, safety huddles and from discussions with the labour ward coordinator (LWC), and it was identified in all cases that due to high acuity, internal escalation had been activated and the LWC oversaw care for a woman not requiring 1-1 care and it was for a short period of time until assistance arrived. Members of the council agreed the labour ward co-ordinator did not lose supernumerary status. Safety huddles will be increased to capture night shift activities as an additional support mechanism and all LWC have been asked to continue to provide narrative within the acuity tool to strengthen reporting.

- Safety Action 8

The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups. This should be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme. The technical guidance is not specific as to the definition for MDT attendance; for example it does not state each training session must be a quorate. January to July training had MDT attendance but not all four disciplines. Since July there has been much work undertaken across the MDT disciplines and training from September onwards will be quorate and this is planned into the forward plan for 2024/25. Members of the council agreed that training is compliant with a robust plan in place for the forthcoming months to sustain progress made.

7.2 NHSR claims scorecard

In August, an update of the Trusts scorecard was published. Triangulation of data along with the scorecard has informed a shared learning plan. This is shared in line with the maternity governance processes, and presented to the Board safety champions at directorate meetings (appendix 3).

7.3 Maternity Services data Set (MSDS)

The Trust submit monthly submission to the Maternity Services data Set (MSDS) in relation to the 11 Clinical Quality Improvement Metrics (CQIMS). For the purpose of MIS, a scorecard of data quality is assessed, with the month activity related to July 2023. Confirmation of compliance was approved on the 26 October 2023 (appendix 4).

8. Saving Babies Lives Care Bundle v3

The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. Saving Babies Lives Care Bundle Version 3 (SBLCBv3) was published on the 30th May 2023 with a revised version published July 2023. There are six elements with a total of 70 interventions. The expectation is to be compliant with all elements by March 2024. Local Maternity and Neonatal Systems (LMNS) will provide oversight on behalf of NHSE.

In September 2023, NHSE published a 'Live' implementation tool to monitor progress. The current position is outlined in Table 6, monthly reviews are planned and progress reported through the maternity governance processes. A highlight report outlining action plans is detailed in appendix 5.

Table 6 SBLCBv3

Assurance Summary on Implementation of the Saving Babies Lives Care Bundle (Version 3)

6 Elements Covering 70 Interventions

October 2023 Asessement

Element	Number of Interventions	Fully Implemented	Partially Implemented	Not Implemented	None Compliant Intervention
1	10		8	2	1.7, 1.10
2	20	10	9	1	2.5
3	2	1	1		
4	5	2	3		
5	27	7	18	2	5.10, 5.13
6	6		6		

9. Avoiding Term Admissions in Neonates (ATAIN) rates

This is a programme of work to reduce avoidable admissions to a neonatal unit (NNU) for infants born at term (over 37 weeks gestation) paralleled by reducing separation of mother and baby. The National ambition is a rate below 6%.

In Q2, a total of 28 babies >37weeks gestation were admitted to SCBU = 4.45 %. The reasons for admission were for respiratory support or observation. An improvement action plan of learning is shared at the maternity and neonatal safety champions meetings. The perinatal quadrumvirate (Obstetric Clinical Director, Care group Manager, Associate Director of Midwifery and Senior Clinical Matron for Neonates) have membership to this meeting. Monthly updates are reported at the Quality Assurance Committee, Trust Board of Directors and quarterly to the LMNS (appendix 6). An additional measure planned is a further deep dive of all respiratory admissions to identify if there are any modifiable factors led by an Advanced Neonatal Nurse Practitioner. Development to support transitional care services for late preterm babies is on-going with an expected date for implementation in Q1 2024 (appendix 7).

10. Minimum safe staffing maternity services

Safe Maternity Staffing Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop

procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. In addition the final Ockenden report (2022) states minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the Local Maternity and Neonatal System (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure Trusts are able to safely meet organisational MIS and CQC requirements.

10.1 Midwifery Staffing

NICE (2017) recommend that an assessment is carried out every three years Ockenden (2022) recommends minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. Birth-rate Plus was commissioned and the final report received in January 2023. The Trust board agreed we are compliant with the funded established and approved an increase in headroom of 23% in April 2023 to support the additional training required by midwifery staff.

The registered midwifery (RM) vacancy position is 16.73 wte. The monthly fill rates are shown in Table 7. Substantive RM positions offered and accepted by newly qualified midwives equates to 12.36 wte, with the forecasted vacancy position for December 2023 being 4.37 wte. Further forecasting to March 2024 expects to see this position improve to a vacancy position of 1.87 wte. Specialist midwives have been recruited to reflect BR+ recommended establishment. The birth to midwife ratio is recommended to be 19.5: 1WTE, due to the vacancy rate the ratio has not been met (Table 8) and section 10.2 outlines actions and mitigations to minimise risks.

Table 7. Fill rates for qualified staff across maternity inpatient services

	July	August	September
RM fill rate %	83%	81%	82%

Table 8. birth to midwife ratio

July	August	September
25:1	23:1	23:1

10.2 Midwifery staffing safety measures.

The BR+ acuity app is used to provide indicators for safe staffing via a red flag system. In Q2, 1-1 care in labour achieved 100% compliance. There were 16 red flags on a 12hr shift basis:

6 x Delayed or cancelled time critical activity.
3 x Delay between admission for induction and beginning of process. 7 x Labour Ward Coordinator not supernumerary.

Midwifery staffing compliance is reviewed weekly and it has been identified that a decrease in compliance occurs out of hours or when the unit is in high acuity and escalation. On these occasions the escalation policy has been followed with the Clinical Site manager (CSM) and manager on call contacted, staff being redeployed internally and the community midwives being brought in. These measures were taken

for very short periods and the situation rectified at the earliest opportunity.

Mitigations and escalation process to address staffing shortfalls have continued during this reporting period. A risk assessment of midwifery staffing is complete and on the risk register for the service with actions and controls in place to mitigate risks as listed below.

- Daily staffing huddles with Senior Clinical Matrons.
- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically.
- Relocate staffing to ensure one to one care in active labour and dedicated supernumerary Labour Ward Co-ordinator (LWC) roles are optimised.
- Activate the on call midwives from the community to support labour ward.
- Adopted the RESET tool.
- Supporting LWC in the appropriate use of BR+ acuity tool and escalation decision making.

In addition the midwifery team have led a proactive recruitment and retention campaign including, enhancing the existing preceptorship programme, 1-1 discussions for those considering leaving the profession or Trust, promoting staff wellbeing offers from the Trust, regular recruitment marketing, hosting recruitment cafes and a commitment to International recruitment.

10.3 Community midwifery services

An external review of community services is being undertaken by members of the NEY Regional Midwifery team supported by the designated Maternity Improvement Advisor (MIA). There have been several staff engagement sessions and a survey. The report is expected in October 2023.

10.4 Obstetric staffing

Compliance of consultant attendance out of hours in line with RCOG recommendations is monitored and reported on monthly (Table 9).

Table 9. Obstetric staffing

Measure	Aim	July 23	August 23	September 23
Consultant presence on labour ward (hours/week)	≥60 hours	100%	100%	100%
Reported Consultant nonattendance incidents (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	100%	100%	100%	100%

The action plan (appendix 8) to achieve compliance with compensatory rest after a night on call for Consultants in Obstetrics was to revise the work schedule. This has been completed and the revised work schedule does not have planned work after a night on call for Obstetrics. The Department has developed and implemented a standard operating procedure (SOP), which is in line with RCOG guidance on

compensatory rest: Compensatory Rest Following Night On-Call Consultants in Obstetrics & Gynaecology (appendix 8a).

A six months' audit after February 2023 of short-term locum medical staff has shown full compliance in line with RCOG Guidance on the engagement of short-term locums in maternity care and the certificate of eligibility for short-term locums.

A six months' audit of long-term locums after February 2023 has identified 94% compliance with the standards in the RCOG Guidance on engagement of long-term locums. An action plan has been developed to improve the process (appendix 9) and documentation to achieve full compliance.

10.5 Neonatal Nurse Staffing

There is a current risk for non- compliance rate for nurse staffing in Special Care Baby Unit (SCBU) as outlined by the British Association Perinatal Medicine (BAPM), a requirement of MIS safety action 4d. The staffing compliance rate was 86.96%, with the national average for the quarter being 70%. Increase in compliance is largely due to lower than usual occupancy and acuity in July and August. Compliance continues to be managed through escalation in times of increased occupancy and acuity. SCBU have undertaken the annual workforce review and action plan in November, the details can be reviewed in appendix 10.

10.6 Staff survey feedback

Currently undertaking a staff survey and commencing the SCORE survey in October.

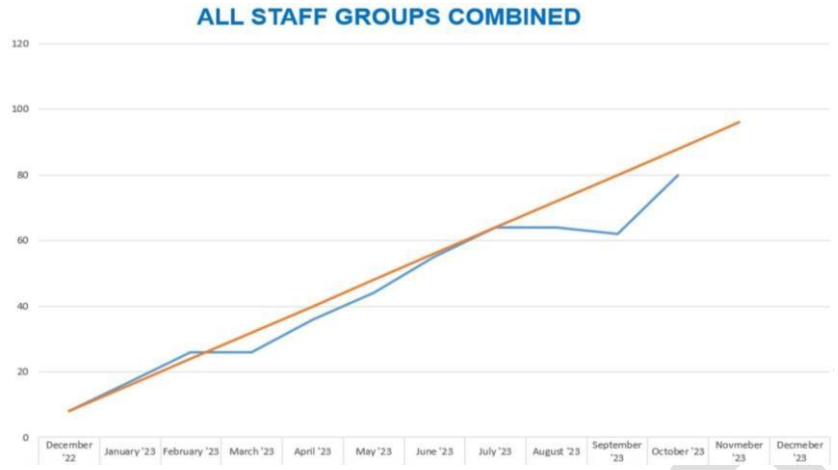
11. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

11.1 Background

On 30 May, the Core Competency Framework version 2 (CCFv2) was published. The CCFv2 is one of the safety actions for MIS year 5: Safety Action 8. The Trust has worked in collaboration with the NENC Local Maternity and Neonatal System (LMNS) to develop a maternity training syllabus to meet the requirements of CCFv2, supporting standardisation of training, servicer user involvement and shared resources. Current compliance against MDT skills training is shown in Graph 3 and the planned training sessions are expected to achieve compliance. Fetal wellbeing training compliance is on track to meet the 90% compliance. To date the following actions are in progress:

- Developed and implanted a new NENC Maternity Training Syllabus.
- Active participant with the NENC LMNS Training development group.
- Development of a robust and accessible training database.
- Develop monthly training trajectories.
- Establish a MDT training group to increase compliance with non-midwifery staff groups.

Graph 3 Progress towards training compliance for MDT Emergency Skills



The obstetric department mandatory training for Q2 (Table 10) demonstrates an overall compliance of 90%. Compliance will continued to be monitored monthly and to support staff to access training.

Table 10. Maternity workforce mandatory training

	Jul-23	Aug-23	Sep-23
Obstetric Department	Overall Compliance %	Overall Compliance %	Overall Compliance %
Monthly Total	90.22%	90.64%	89.06%
Q2 Total 90%			

12. Insights from service users

12.1 Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in Table 11 and 12. Formal complaints within Q2 2023 related to:

- Communication.
- Time of appointment.
- Failure to monitor.
- Lack of compassion.
- Staff attitude.

The above has been communicated to maternity staff through mandatory training where staff undertake exercises in the use of language and behaviours.

Table 11. Complaints

	Jul	Aug	Sep	Total
Concern - Stage one	3	4	4	11
Consent	0	1	0	1
Duty of Candour	0	1	0	1
Informal - Stage two	1	0	0	1
Request for information - Stage 0	1	0	1	2
Total	5	6	5	16

Table 12. Compliments

	Attitude	Care Provided	Communication	Compassion	Staff to Staff	Total
Jul	0	31	1	0	15	47
Aug	2	39	3	0	3	47
Sep	0	3	0	1	2	6
Total	2	73	4	1	19	99

12.2. Service user insights from Maternity and Neonatal Voice Partnership (MNVP)

The MNVP have developed the work plan and approved by Trust, LMNS and ICB. The MNVP meet with the senior leadership monthly where feedback is shared from service users, local and regional forums. Other agenda items include work plans, and engagement opportunities. The MNVP regularly attend meetings within the governance structures. Current projects include:

- Engagement with local communities through baby banks within some of the most deprived communities.
- Development of communication strategies and branding.
- Providing newborn essential skills in resuscitation.
- Developing patient information leaflets.

12.3 Service user insights taken from a recent CQC peer review

No new update since the previous report**.**

13. Continuity of Care

There is no longer a national target for Maternity Continuity of Carer (MCoC). Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. NHS England expects the Trust to continue to review our staffing in the context of Ockenden's final report. The local LMNS, regional and national colleagues are available to support the Trust with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

13.1 Progress to Date

The following Table 13 outlines the current percentage on a continuity pathway i.e. the same team of midwives looking after women throughout their antenatal, intrapartum (labour) and postnatal care.

Table 13. MCoC %

	% of women who are on a CoC pathway at 29 weeks	% of women who are from the BAME community on a CoC pathway at 29 weeks	% of women who live in the 10% most deprived on a CoC pathway at 29 weeks	% of women who were cared for in labour by their continuity team
July	8.80% (18)	12.50%	7.40%	19% (4 in 21)
August	9.9%	0.0%	11.3%	40.0% (4 in 10)
September	9.0%	4.5%	10.8%	10.0% (2 in 20)

Due to a change in risk factors the number of women that receive continuity of care through the intrapartum period is lower than the above figures.

14. Quality improvement and research

14.1 Infant feeding and health in pregnancy specialist services

NTHFT population have some of lowest rates of Breast Feeding at a NENC and national level. In January 2023 NTHFT registered its intent to gain Baby Friendly Initiate (BFI) accreditation. The following outlines key activities and achievements:

- July 2023 – Foundation training re-commenced and staff booked on each month until Feb 2023 when 100% compliance should be met. Audit programme now effectively up and running, to be fed back in Learning Event meeting and also shared on SharePoint under infant feeding tab.
- Aug 2023 – Stage 1 assessment completed. Infant feeding policy, Weight loss management for babies under 2 weeks of age and safe sleep guidelines approved at guideline group. Jaundice in the new-born guideline still under development by NNU. Obstetrician training developed ready for roll out. Infant feeding specialist referral process completed (SOP).
- September 2023: Achieved Stage 1 accreditation.
- April 2024: plan for stage 2 assessment.

Local audit from April –Sept 2023, shows an increase in breastfeeding initiation rates and also an increase in exclusive breastfeeding at discharge from hospital. This correlates with an increase in compliance in training for staff and a noted decrease in supplementation rates.

14.2 Quality Improvement Lead

There are several quality improvement projects active:

- Post-Partum Haemorrhage: the risk assessment integrated in to the EPR is to be implemented in November and optimising haemoglobin at delivery to reduce maternal morbidity. Project has been showcase at the International Federation of Gynaecology and Obstetrics.
- Smoking in Pregnancy: four projects include community and acute wards with initial outcomes sowing a reduction in smoking rates.
- Mechanical induction of labour: on going work to develop processes and training for staff. Collaboration with the MNVP to produce patient information leaflets. Implementation is planned for December.
- Each Baby Counts: a National initiative to encourage MDT working and to create a psychological safe environment. A working group has been established with the first area of focus called Teach or Treat.
- NeoTRIPS: Started a new national project to improve expressed breast milk (EBM) in pre-term infants less than 34weeks gestation.

14.3 Research Midwives

The team have embedded research into maternity services through collaborative working, visibility and motivation and momentum. The team are intrinsic to the maternity service to drive

Improvements for better outcome with 19 active projects. Within the last 18months, the team have recruited 3662 participants in numerous studies and are seeing an increase in staff trained in Good Clinical Practice. One on the research midwives has been named as the top recruiter in NENC.

14.4 Digital Specialist Midwife

The original implementation date for the new EPR system known as Badgernet was deferred from September to 10 October due to industrial action. All eight Trusts within NENC system have either adopted or plan to implement Badgernet and this will create equity of access. The project's key areas of focus are:

- Local configuration & Process mapping.
- Training all staff groups.
- Governance structure in place to support implementation.
- Collaboration across multi-services to maximise interface across systems.

14.5 Bereavement Specialist Midwife

There has been much work on going and the following highlights key activities:

- Planning and success of our charity fundraiser to raise money to help refurbish the Snowdrop Suite.
- Specialist midwife has completed GCP training to assist with health and social research, consent taking, data collection and documentation.
- Development of a new protocol for arranging postnatal, bereavement de-brief appointments specialist midwife is a member of the HTA working group for the Trust and is the HTA Person Designated for Obstetrics.
- Developing a feedback tool called the Maternity Bereavement Experience Measure, which should be active and live within the next two months. This will give insight into families' experience of having regular contact and ongoing support from a bereavement midwife.
- Further progress with improving care standards.

15. Culture and Leadership

15.1 Board level safety champion meetings

Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions. The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies.

The meetings are held with the Executive Board Champion, Non-Executive Director Maternity Champion, the Obstetric, Midwifery and Neonatal Safety Champions, representative from Maternity and Neonatal Voice Partnership, Neonatal Matron, and Clinical Director, Associate Director of Midwifery, perinatal quadrumvirate and the Patient Safety, Risk and Governance. Lead midwife. The meetings are bi-monthly followed by a walkabout of the clinical areas. National, Regional and system developments are discussed along with audits and improvement plans for ATAIN and the optimisation Bundle. The feedback from the perinatal walkabouts are:

- IT resources and equipment – IT contacted to address functionality of equipment
- Pharmacy – improving the process of medications for efficiency. This is being explored by the Senior Clinical Matrons.
- Office space – this will be an on-going project though the new IT equipment will help to resolve this.
- Culture – staff feel supported and they can see improvements to the service and professional development opportunities.

The perinatal quadrumvirate provide regular feedback and inform the members of progress and intelligence shared by peer 'perinatal quads'. An imminent action is to undertake a SCORE survey in late October 2023. The survey is an internationally recognised way of measuring and understanding culture that exists within organisations and teams.

15.2 Advocating for education and quality improvement (A-equip) and professional midwifery advocacy themes

The Professional Midwifery Advocate (PMA) continues to offer restorative support, one to one and in groups, as well as signposting to further sources of support, information and assistance. As a critical part of the advocating for education and quality improvement (AEQUIP) model, the PMA focuses efforts on empowering midwives to confidently handle situations themselves, improve relationships with peers and managers, and to seek ways to increase service quality, safety and excellence. The PMAs met with will meet bi-monthly with the Associate Director of Midwifery and senior midwifery team to with the aim of developing a feedback report to be shared across the maternity services. During the last year, the main themes reported were:

- Staff culture and morale
- Equitable Professional development

15.3 Culture

In November 2022, Aqua were invited as an external agency by the Trust to carry out a discovery and diagnostic piece of work, which focussed on the culture within maternity services. Confidential listening opportunities and surveys were held during December 2022 and January 2023 for all staff groups working in maternity services. A thematic analysis of the responses identified five key themes and in April 2023 Aqua invited all maternity staff to attend feedback sessions over the course of one day. A recording of the feedback session was also made available for those unable to attend in person. The themes identified were:

1. Value and respect
2. Equity and transparency
3. Equipment and resources
4. Shared endeavour
5. Staff being kept informed

Aqua recommended the five themes form five working groups to support improvements within the service and that they are led by all clinicians with support from the senior leadership team. The working groups were formed in May 2023 with a focus on staff engagement.

16. Risk Register

In Q2 Maternity and Neonatal services reported two new approved risks:

- 6661 - Risk of delay in detection and diagnosis due to equipment availability (manufacturing issues) – graded Low.
- 6644 Risk of not training all professional groups of the maternity MDT up to required percentage - links to Maternity Incentive Scheme SA8 - graded Low.

There are 16 open risks, graded as:

- 5 Moderate
- 10 Low
- 1 Very low

In line with the Trust risk management process, risks raised by the service are developed by the service and reviewed in the reviewed in the weekly Care Group SMT. From here they go to the weekly Care Group SMT for review, discussion and progression to the weekly Business Team meeting for discussion and review by the team and then to Risk Management Group. Additionally, risks are raised at the Maternity Quality Assurance Council, through Quality Assurance Committee to Board.

17. Key issues, significant risks and mitigations

Having undertaken a benchmarking assessment the service is concerned about its ability to achieve compliance with two safety actions (as detailed in section 6.2 of this report) of the MIS year 5.

There are on-going staffing challenges and this is likely to continue over the autumn. These will be managed on a daily basis and escalated accordingly.

18. Assurance and Recommendations

The Board of Directors are asked to receive and note the significant on-going work to meet National Maternity recommendations and workforce challenges.

The Board of Directors are to receive and note the culture and leadership developments. The Board of Directors are asked to receive and approve:

- Trust claims scorecard and triangulation of data for shared learning.
- MSDS scorecard.
- ATAIN action plan.
- Neonatal transitional care action plan.
- Midwifery staffing safety measures.
- Action plan and SOP for compensatory rest for consultants following night on-call.
- Long term locum action plan
- Neonatal nurse staffing standards report and action plan.

North Tees and Hartlepool NHS
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Project Highlight Report

Name of Project:	Ockenden IEA's						
Overall Project Status: (RAG)		Legend Major issues require decisions/re-planning Proceeding to plan, issues to be addressed and/or risks to be monitored Proceeding to plan, no major risks/issues					
Forecast trend for next reporting period							
Performance Areas	**Time**	**Cost**	**Scope**	**Quality**	**Risks**	**Issues**	
Highlight Report Completed by	**Name**	Christina Thompson					
	Email Address	cthompson@nhs.net					
Reporting Period	**Month:**	October					
	Year:	2023					

Work continues with the 7 Immediate and Essential Actions (IEA'S) in readiness for the up and coming visit on 19 October 2023. The current position this month is:

1. Compliant

1.1. IEA 1 – All Local Maternity and Neonatal Systems (LMNS) are in place which includes the reporting of all Serious Incidents. Assurance of this is fed into the Maternity Patient Safety Learning Network and Maternity Quality Safety Group. The perinatal quality surveillance model continues to be reported monthly along with HISIB and NHS resolution

1.2. IEA 2 – None Executive Director is in place to support this action. The Perinatal Mortality Review Tool (PMRT) is in place and continues to report. Maternity Voices Partnership (MVP) is now embedded within the service

2. On Track – Progress made since last report

2.1. IEA 3, Q17 & 20, Staff Training Together and Working Together – The training programme has now been updated with a trajectory of 90% compliant with MDT Obstetric and Emergency training

2.2. IEA 4, Managing Complex Pregnancies - audits to monitor complex pregnancy are evident and remain up to date. The Saving Babies Lives Care Bundle assessment tool has now been completed for October which includes 6 elements and covers 70 interventions. Key areas of focus have been identified and this will be presented at MQAC on 10 October 2023. It is to be noted that issues have been raised with the LMNS in regards to formula errors within the tool.

2.3. IEA 5, Risk Assessment throughout Pregnancy – Received Q2 audit and all previous audits reviewed, work is required to improve documentation in the review of risks within care plans

2.4. IEA 6, Monitoring Fetal Wellbeing – A fetal wellbeing Midwife and Consultant is in place to support this. Work around training in line with CCF has now been introduced with an additional training day added to support compliance. Planned trajectory in place to achieve 90% compliance by December 2023

2.5. IEA 7, Informed Consent – a review of the website has now been undertaken. A SOP is in place for decision making. The CQC maternity survey and action plan has now been sent to LMNS. Service user feedback is currently in place via the MNVP feedback and through the use of social media. Links are now in place with MNVP's, Communications and key leads identified across all Maternity services. The aim is to further support the pregnancy app with information to support care plans.

3. Current Position for On-Site Visit Preparation

The service continues to prepare for the onsite visit with evidence requested from the LMNS submitted on 6 October 2023. The agenda and presentation for 19 October has been drafted and circulated

All elements within the Ockenden 7 IEA's will continue to be monitored until embedded, sustainability is evidenced and trust board has assurance of this.

Key Actions for Next Reporting Period:

Description	RAG	Corrective Action
Ensure SBLCB tool errors are addressed		LMNS, Futures MIA contacted
Start to upload evidence to the Futures NHS Platform		
Invite key lead to update IEA Q44 at the next MQAC		

Response from accountable person:

Milestone/GanttChart-ProjectOverview

North Tees and Hartlepool NHS Foundation Trust

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Ockenden Compliance

Project Sponsor:	Lindsey Robertson
Clinical Leads:	Elaine Gouk
Project Lead:	Rachel Scott/Steph Worn

Safety Action	Objective	Last Compliance Visit Met Partially Met Not Me	Self assessment -Sep 2023 On Track to be Met Partially Compliant - ongoing work needed	10/10/2023 comments	Previous comments 2022					
IEA 1 - Enhanced Safety										
Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months	Met	On Track	LMNS Quarterly meetings to discuss dashboard	The triumvirate meet regularly. These meetings are not formally minute but actions are recorded. Clear evidence of development of action plan as a MDT which is then shared widely within the trust at local and board level. Key concerns reported were – workforce, digital, staff well-being					
	Are you able to meet as a triumvirate monthly and minute meetings?	Met	On Track	MIG now in place which is minuted, quarterly board reports. MQUAS minute. Also reports into Ps&Qs						
	Is there evidence of actions taken, and where is this shared	Met	On Track							
	In relation to the Ockenden action plan, where and how often is this tabled for discussion and what are your concerns?	Met	On Track	Badgernet initiated due to be rolled out, training commenced Implantation of Birth-rate+, daily staffing huddles and recorded. Staff wellbeing, physiological safety, wellbeing drop cafe and trust wide health & wellbeing. 1-1 sessions include wellbeing as well appraisals						
	What other concerns are raised on your Ockenden action plan?	N/A	N/A							
Q2	How is triangulation of incidents/complaints and claims achieved?	Met	On Track	LMNS report quarterly which feedback incidents. Presentation for triangulation of incidents, complaints and claims, last presented early July.	Triangulation of incidents, complaints and claims was well narrated and triangulated each quarter. There was a good variety of ways that information was shared with all staff groups. Regional working and shared learning was also evident which was positive to see. The trust should consider how learning is tested and assured to ensure changes are embedded. Staff felt valued and listened to, this was positive to note and indicative of an open safety culture.					
	Is there external clinical specialist opinion from outside the Trust (but from within the region), mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Met	On Track	Carries on as part of LMNS external review. Focus groups commenced related to PSIRF and also regional last held 12 July. LMNS Maternity quality safety group now in place						
Q3	Are all maternity SI reports (and a summary of the key issues) sent to the Trust Board and the LMNS quarterly?	Met	On Track	quartley LMNS report which records all SI's and also the SI's are reported through the trust board report. Flow chart also supports where governance process for the review of incidents is shared	Process clearly articulated and board papers seen					
Q4	Are all PMRT cases reviewed to the required standard	Met	On Track	Audit in place and can be obtained from PMRT. PMRT is also now included within the board report	PMRT review process clearly articulated but no audit evidence seen. The trust should consider how assurance on compliance with the PMRT process is recorded. Board oversight on PMRT process noted.					
Q5	Are you submitting data to the Maternity Services Dataset to the required standard?	Met	On Track	Not all requirements are uploaded due to reporting criteria. Potential to address through Badgernet	The implementation of a new maternity information system to support this was quick and beneficial to the organisation.					

Q6	Have all HSIB cases been reported	Met	On Track	Feedback obtained from HSIB and fed into the triangulation data.	Audit compliance articulated, examples given of using these cases for triangulation					
Q7	implemented June 2021?	Met	On Track	Surveillance Perinatal clinical quality model now reports to monthly P&Qs. Query ICB framework						
Q8	Are all maternity SIs shared with Trust boards at least quarterly and the LMNS	Met	On Track	Board report and LMNS report contain this						
Q9	What other concerns are raised on your Ockenden action plan?	N/A	N/A		See Q1					
IEA 2 - Listening to Women & Families										
Q10										
Q11	Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?	Met	On Track	Non-Executive Director in place	The NED delivers a report to Trust Board on activities and progress of actions. Examples were given of how the NED interacts with staff in the clinical environment and how concerns are directly escalated to board and other safety champions. This was positive to see. Staff were fully aware of the maternity NED and felt able to directly escalate to them. There was evidence of the maternity user voice being heard at board.					
Q12	Is the PMRT tool used to review perinatal deaths to the standard required including women and families involvement?	Met	On Track	PMRT in Place and continues to report	See Q4					
Q13	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Partially Met	On Track	Maternity Voices Partnership (MNVP) is now embedded within the service - updates brought to MIG	At the time of the visit the MVP was not fully established but plans were in place to recruit a chair and further members. Which will likely fulfil this criteria in the near future. There was evidence of previous activity with the MVP					
			On Track		Friends and family tests, CQC maternity survey, Facebook, reflection service, 15 steps.					
			On Track		The service articulated how they hope to develop coproduction when their MVP is in place.					
Q14	Do the Trust safety champions (MW /Obstetrician/Neonatal) meet bimonthly with Board level safety champions and escalate concerns, issues and blockers to improvement work	Met	On Track		There is an alternate month safety champions meeting and the NED attends along with the chief nurse, good examples of sharing learning were seen. The NED and CN are engaged in maternity issues and a good working relationship was evident.					
Q15	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Partially Met	On Track		See Q13					
Q16	Does the non-executive director support the Board level safety Champion who works collaboratively with the maternity safety champions to bring challenge and ensure all voices are heard?	Met	On Track		Patient stories are shared at board. Good reporting to trust board was clearly articulated including feedback to staff in the clinical environment. Attend safety champions meetings, trust board, walk rounds and engagement sessions. Evidence of NED & chief nurse at safety champion meetings					
IEA 3 - Staff Training & Working Together										
Q17	What MDT training does the maternity service provide?	Met	On Track	The training programme has now been updated with a trajectory of 90% compliant with MDT Obstetric and Emergency training	Comprehensive TNA shared that reflects the core competency framework and is responsive to local learning needs. Good compliance with training evidenced with clear trajectory to maintain >90% compliance across all staff groups. Process for DNA follow up clear. Training compliance is discussed at local governance and trust board. Training is audited monthly. Staff articulated involvement in live drills training. The trust should consider how they ensure staff in all areas continue to receive adequate live drills training including baby abduction. Feedback from staff at the visit was that training was valued and of high quality.					
Q18	Have you implemented a day and night Consultant led MDT ward round on the LW?	Met	On Track	Audits in place	Twice daily ward rounds articulated but evidence of compliance with this was not seen. The trust should consider implementation of an audit process to capture this information to gain assurance of this element					
	Do you have a dedicated obstetric governance lead? Do they have protected PA's?	Met	On Track		Evidence of governance lead obstetrician and midwife however time is divided between 5 different services. The trust should consider further investment in the governance team who can focus purely on maternity, ensuring compliance and assurance is robust and that audit is facilitated and results shared					

Q19	Is all external funding allocated for training ring fenced and confirmation from the Finance Director?	Met	On Track		Evidence seen					
Q20	Have 90% of each maternity unit staff group attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Met	Partially Met							
Q21	Is MDT schedule for training in place?	Met	On Track							
IEA 4 - Managing Complex Pregnancy										
Q24	Is there an agreement for the criteria for cases referred to the tertiary level Maternal Medicine Centre	Met	On Track		Pathways in place which are audited. Exemplary pre-conception service noted.					
		Met	Partially Met		Audit programme discussed which was comprehensive and responsive to local need. The trust should ensure they have adequate personnel to deliver the programme effectively.					
Q25	Do women with complex pregnancies have a named Consultant lead?	Met	On Track		Referral pathway clearly articulated, which is audited.					
Q26	Do women with complex pregnancies receive early intervention?	Met	On Track	Audits in place	See Q25					
Q27	Can you demonstrate compliance with all six elements of the Saving Babies' Lives care bundle Version 3?	Met	Partially Met	The Saving Babies Lives Care Bundle assessment tool has now been completed for October which includes 6 elements and covers 70 interventions. Key areas of focus have been identified and this will be presented at MQAC on 10 October 2023	Pathways and audits in place. Example shared of significant improvement in smoking cessation rates, which was positive to see					
Q28	Do all women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place?	Met	On Track	Audits in place	Referral pathway clearly articulated, which is audited					
Q29	Do you have agreed maternal medicine specialist centre?	Met	Partially Met		Plans are in progress within the LMNS to fully implement the maternal medicine service.					
IEA 5 - Risk Assessment Throughout Pregnancy										
Q30	Does the AN RA include the ongoing review of place of birth	Met	On Track	Audits in place	This was articulated well and audit was articulated. The implementation of the new maternity information system has enhanced assurance of this element					
Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Met	On Track	This is covered within the audits required for Q30	See Q30					
Q32	Are you compliant with all 6 elements of SBLCBv3?	Met	Partially Met	Tool completed for October 23 Key areas of focus have been identified						
Q33	Is a RA review and discussion of place of birth recorded at every contact with a Personalised Care Support Plan	Met	On Track	Received Q2 audit and all previous audits reviewed, work is required to improve documentation in the review of risks within care plans	Paper PCSP in place which have been audited. Plans to transfer to a digital PCSP with the newly implement maternity information system was discussed. This will further enhance and provide assurance for this element.					
IEA 6 - Monitoring Fetal Wellbeing										
Q34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	Met	On Track	A fetal wellbeing Midwife and Consultant is in place to support this. Work around training in line with CCF has now been introduced with an additional training day added to support compliance. Planned trajectory in place to achieve 90% compliance by December 2023	Midwife JD seen and was in post. Consultant lead and JD has been shared.					
			On Track		Good variety of training methods articulated with good compliance.					
Q35	Do the leads demonstrate sufficient seniority and expertise?	Met	On Track	See Q34	See Q34					

Q36	Can you demonstrate compliance with all six elements of the Saving Babies' Lives care bundle Version 3?	Met	Partially Met	The Saving Babies Lives Care Bundle assessment tool has now been completed for October which includes 6 elements and covers 70 interventions. Key areas of focus have been identified and this will be presented at MQAC on 10 October 2023	See 27					
Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi professional maternity emergencies training session since the launch of MIS year three in December 2019	Met	Partially Met	See Q17	See Q17					
Q38	Element 4 we are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 3 and national guidelines	Met	On Track	Identified leads for both Midiwfe and Consultant sessions.	See Q34					
IEA 7 - Informed Consent										
Q39	Do you have accessible information to enable informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery?	Partially Met	On Track	A SOP is in place for decision making	Website reviewed on day of visit, relatively easy to navigate with some information available for service users. The service should consider inviting the MVP to review the website and its content and coproduce materials which will fulfil this criteria.					
Q40	Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Partially Met	Partially Met	A review of the website has now been undertaken. A SOP is in place for decision making. The CQC maternity survey and action plan has now been sent to LMNS. Service user feedback is currently in place via the MNVP feedback and through the use of social media. Links are now in place with MNVP's, Communications and key leads identified across all Maternity services. The aim is to further support the pregnancy through the devlopment of Badgernet	See Q39					
Q41	Can women participate equally in all decision-making processes and make informed choices about their care?	Partially Met	On Track	The SOP OBGS17 is in place and audits are covered within the risk assessment audits.	The service articulated a philosophy of supporting women's choices, however audit of this element was not currently in place.					
			On Track		The service were keen to consider and develop methods of gaining feedback around this element that reflected the lived experience perspective.					
			On Track		Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this					
Q42	Are women's choices respected following informed discussion and decision made?	Partially Met	On Track	The CQC maternity survey and action plan is complete and to ready to be sent to LMNS on 15 Sep 2023.	It was clear from discussion that this service is forward thinking in supporting women's choices and use language within guidance which is considered and respectful. Audit of this needs to be strengthened so that the service can continue with this philosophy					
Q43	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Partially Met	On Track	F&F/Relections team Facebook /Maternity Survey / Reflections Team/Compliments /PMRT Patient questions/ Inclusion of patients in investigations / Debriefs	See detail in Q13					
Q44	Are pathways of care clearly described in written information in formats consistent with NHS policy and posted on the trust website.	Partially Met	Partially Met	See Q39	See Q39					

North Tees and Hartlepool NHS
NHS Foundation Trust

Project Highlight Report

Name of Project:	Maternity Incentive Scheme Y5 2023/24						
Overall Project Status: (RAG)		Legend Major issues require decisions/re-planning Proceeding to plan, issues to be addressed and/or risks to be monitored Proceeding to plan, no major risks/issues					
Forecast trend for next reporting period							
Performance Areas	**Time**	**Cost**	**Scope**	**Quality**	**Risks**	**Issues**	
							
Highlight Report Completed by	**Name**	Christina Thompson					
	Email Address	cthompson@nhs.net					
Executive Director Sponsors		Lindsey Robertson					
Reporting Period	**Month:**	October					
	Year:	2023					

Key updates and progress for this reporting period

Work has continued across the service to improve and imbed the requirements for MIS Year 5. The reporting period start dates and submission dates for evidence have been added to the MIS plan along with the frequency of reporting for each Safety Action to allow time for each of the key leads to prepare.

Current position against MIS Safety Actions

1. Currently on track

1.1. **Safety Action 1**, PRMT – Quarterly board report in place and the data analysis from the tool remains on track. The Bereavement Midwife records actions of the PRMT process with families. A new pathway has been produced for a link with CDOP/PMRT and training for this is in place and booked for the patient safety lead. HSIB cases are also concluded

1.2. **Safety Action 2** – Currently meeting 10/11 metrics which meets compliance. The outstanding metric is relating to the 'smoking at delivery' not being recorded with no mandatory field to capture the information. The next update is due on 29 October 2023 and Bagenert has now gone live.

1.3. **Safety Action 3** – Audits are in place within SharePoint. The improvement plan has been in place since 2017 and is currently being reviewed and cleansed and has now been signed off by the ADM and Clinical Director and will be seen by the trust board on 2 November

1.4. **Safety Action 5**, Midwifery Workforce Planning, the element requiring supernumerary status within the department - A full update on recovery was presented at the last MQAC with an agreement that we are compliant with 100% labour ward coordinator supernumerary status. Next steps are to disseminate agreed process to team leaders and monitor closely.

1.5. **Safety Action 6**, Saving Babies Lives Care Bundle - A gap analysis has been undertaken with regards to the new SBLV3 implementation tool (to be fully implemented by March 2024). The Saving Babies Lives Care Bundle assessment tool has now been completed for October which includes 6 elements and covers 70 interventions. Key areas of focus have been identified and this will be presented at MQAC on 10 October 2023. It is to be noted that issues have been raised with the LMNS in regards to formula errors within the tool.

1.6. **Safety Action 7** – Work plan for the MVP is complete and uploaded to the Sharepoint site. The MVP coproduction for the CQC Maternity survey has been drafted and sent to the LMNS.

1.7. **Safety Action 9** – Good progress has been made with this Safety Action and evidence has been uploaded within the SharePoint site. The next score card will be due to be presented at MQAC on 11 October 2023 and Matneo Safety Champions on 18 October 2023, the data to support this is in place

1.8. **Safety Action 10** – This remains on track with evidence in place to support this. No concerns raised

2. Non Compliance/Evidence Required – Recovery Plan

2.1. **Safety Action 4**, Clinical Workforce Planning. Audits for activity are to be undertaken to sit alongside an improvement plan however risks remain within the neonatal workforce. The risk is due to BAPM nurse staffing standards. Currently not BAPM compliant however as required there is an ongoing developing action plan to support this

2.2. **Safety Action 8**, In-house Training. There is development of a training programme for staff to meet the new framework. It is to be noted that the time frame for this Safety Action has changed to 12 month from December 2022 so currently not compliant. Work has progressed with this and presented at MQAC on 14 September 2023. Planned trajectory in place to achieve 90% compliance by December 2023

Key Actions for the Next Month

Description	RAG	Corrective Action
Ensure SBLCB tool errors are addressed		LMNS, Futures MIA contacted
Monitor compliance with training attendance		

Risks this month

- Continuous updates are required to ensure compliance – time do this can impact on compliance
- Additional resource required to support the SBLCB implementation tool – Currently looking at a Midwifery lead to support this

Items for Escalation to Sponsor Executive Directors

- The impact of the SBLV3 implementation tool and that additional resource may be required to support this

Response from Sponsor Executive Directors

Milestone Tracker - Project Overview

Current Status of Task:	Key
Abandoned	A
Completed	C
Initiated	IN
Not Started	NS
Planning	

	Evidence Required
	On Track

M

NHS
North Tees and Hartlepool
NHS Foundation Trust

Project Sponsor: Lindsey Robertson
Clinical Leads: Elaine Gouk
Project Lead: Rachel Scott/Steph Worn

Safety Action	Safety Action Lead	Required Standard	Task Description	Reporting Period Start Date	Evidence to be Submitted Date	Reporting Frequency	Latest Update 10/10/2023	Status (Please Select from drop down)	Evidence Available (YES/NO)	Evidence Location		Jun-23 05/06/2023	12/06/2023	19/06/2023	26/06/2023	Jul-23 03/07/2023	10/07/2023	17/07/2023	24/07/2023	31/07/2023	Aug-23 07/08/2023	14/08/2023	21/08/2023	28/08/2023	Sep-23 04/09/2023	11/09/2023	18/09/2023	25/09/2023
Safety Action 1	Angela Storr	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	30/05/2023	07/12/2023	Quarterly - Board	Quarterly board report in place and the data analysis from the tool remains on track. The Bereavement Midwife records actions of the PRMT process with families. A new pathway has been produced for a link with CDOP/PMRT and training for this is in place and booked for the patient safety lead. HSIB cases are also concluded	On going			Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal).																	
			b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	30/05/2023	07/12/2023			On going			The PMRT must be used to review the care and reports should be generated via the PMRT																	
			c) For deaths of babies who were born and died in your Trustmulti-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	30/05/2023	07/12/2023			On going			The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death.																	
			d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	30/05/2023	07/12/2023			On going			A report has been received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to																	
		Parent Engagement	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review	30/05/2023	07/12/2023			On going																				
			Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information.	30/05/2023	07/12/2023			On going																				
			The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their	30/05/2023	07/12/2023			On going																				
			If parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them.	30/05/2023	07/12/2023			On going																				
		conducting reviews	All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)	30/05/2023	07/12/2023			On going																				
			All stillbirths (from 24+0 weeks' gestation)	30/05/2023	07/12/2023			On going																				
			Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth)While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.	30/05/2023	07/12/2023			On going			If you do not have any babies that have died between 30 May 2023 and 7 December 2023 you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.																	
		Quarterly reports to Trust Boards	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.	30/05/2023	07/12/2023			On going			These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.																	
			Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report	30/05/2023	07/12/2023			On going			Please note that these reports will only show summaries, issues and action plans for reviews that have been published therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months																	
Safety Action 2.	Carolynne Proudlock	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvement	Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	30/05/2023	Final Data: July 2023 (MSDS)	Data published October 2023	Currently meeting 10/11 metrics which meets compliance. The outstanding metric is relating to the 'smoking at delivery' not being recorded with no mandatory field to capture the information. However there is now evidence that this is captured on Badgernet moving forward	On going			The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.																	
			July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional	30/05/2023				On going																				
			Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:	30/05/2023				On going			If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). Trusts are to make an MSDS submission before the Provisional Processing Deadline for July the end of August 2023.Trusts to have at least two people registered to submit																	
		Midwifery Continuity of carer (MCoC)	Over 5% of women who have an Antenatal Care. Plan recorded by 29 weeks and also have the CoC pathway indicator completed.	30/05/2023	July 2023 (COC) August 2023 (If criteria 3 not met)			On going																				
			Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	30/05/2023				On going			Named midwife in place																	

Safety Action 3	Gemma Gordon	Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care	There is evidence of neonatal involvement in care planning			If reviews suspended recommenced from Quarter 4 (Data Beginning January 2023) Quarterly Reviews	Audits are in place within SharePoint. The improvement plan has been in place since 2017 and is currently being reviewed and cleansed to be signed off by the ADM and Clinical Director for preparation of approval by the trust board, LMNS and ICB	On going			
			Admission criteria meets a minimum of at least one element of HRG					On going			
			There is an explicit staffing model					On going			
			The policy is signed by maternity/neonatal clinical leads and should have auditable standards.					On going			
			The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.					On going			
		A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the TrustBoard, LMNS and ICB.	Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks.					On going			
			Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.	.				On going			
			Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving					On going			
			Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan					On going			Need to confirm who sends to the ICB
		Evidence for standard c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care	Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring					On going			
			An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation					On going			
Safety Action 4	Elaine Gouk	Can you demonstrate an effective system of clinical workforce planning to the required standard	NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:	30/05/2023	30/05/2023	6 Month Activity Every 6 Month	Audits for activity are to be undertaken to sit alongside an improvement plan however risks remain within the neonatal workforce. The risk is due to BAPM standards and the ability to meet care level. An escalation plan is in place that supports this based on acuity and the care levels required. It is to be consider how this is managed moving forward to establish whether this standard can be met	On going			
			a) currently work in their unit on the tier 2 or 3 rota	01/03/2023	01/03/2023			On going			Trusts should establish whether any short term (2 weeks or less) tier 2/3 locum have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the
			b) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of	01/03/2023	01/03/2023			On going			
			c) hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	01/03/2023	01/03/2023			On going			
			Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	01/03/2023	01/03/2023			On going			Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
			Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, TrustBoard level safety champions	30/05/2023	07/12/2023	Any 6 Month Period		On going		After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023	2 day rest period in place after shifts Elaine confirm as CD this is compliant SOP from to use qualitative measures
			Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and	30/05/2023	07/12/2023			On going			need to pick this up ASAP
			Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non attendance.	30/05/2023	07/12/2023			On going			
		Anaesthetic medical workforce	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services	30/05/2023	07/12/2023			On going		Trusts to evidence position by 7 December 2023 at 12 noon	
		Neonatal medical workforce	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should besubmitted to the LMNS and Neonatal Operational Delivery Network (ODN)	30/05/2023	07/12/2023			On going		A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023	If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN)
		Neonatal nursing workforce	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board shouldagree an action plan and evidence progress against any action plan previously developed to address deficiencies.A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal	30/05/2023	07/12/2023	At Least Once		On going		Neonatal nursing workforceNursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023	
Safety Action 5	Steph Worn	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A clear breakdown of Birth-rate+ or equivalent calculations to demonstrate how the required establishment has been calculated	30/05/2023	30/05/2023	6 Months	Midwifery Workforce Planning, the element requiring supernumerary status within the department remains a risk as compliance requires every day and this has not been the case despite this being in place over the last few month. A full update on recovery will be presented at MQAC on 14 September 2023	On going			
			In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	30/05/2023	30/05/2023			On going			
			Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls	30/05/2023	30/05/2023			On going			midwifery red flag events could be included in six monthly staffing report Redeployment of staff to other services/sites/wards based on acuity. □ Delayed or cancelled time critical activity. □ Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).
			The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners	30/05/2023	30/05/2023			On going			
			Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.	30/05/2023	30/05/2023			On going			
			The midwife to birth ratio	30/05/2023	30/05/2023			On going			

			The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth-rate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	30/05/2023	30/05/2023			On going			
			Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.	30/05/2023	30/05/2023			On going			The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time.If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
Safety Action 6	Steve Wild	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three	Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available, and share this with the Trust Board and ICB.	30/05/2023	01/03/2024	Quarterly Meetings with ICB Monitor Compliance	A gap analysis is to be undertaken with regards to the new SBLV3 implementation tool (to be fully implemented by March 2024). Further work has progressed with evidence collated within SharePoint which includes completion of the 'fresh eyes' audit. However it would be appropriate for a full overview of all 6 elements to be presented at the next MQAC due to the large amount of evidence required	On going			
			Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024	30/05/2023	01/03/2024			On going		To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual	
			Element one - Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded B. Percentage of women where CO measurement at 36 weeks is recorded..	30/05/2023	01/03/2024			On going			
			Element two - Process indicator: Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan	30/05/2023	01/03/2024			On going			
			Element Three - Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).	30/05/2023	01/03/2024			On going			
			Element four -Process indicators: There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organisation: 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.	30/05/2023	01/03/2024			On going			
			Element five - Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24hours prior birth D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance)	30/05/2023	01/03/2024			On going			Quality improvement plan and measured through lifeQI Dedicated lead for saving babies lives
			Element 6 - Process indicators: Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc).	30/05/2023	01/03/2024			On going		Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.	
Safety Action 7	Rachel Scott	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line withthe Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	30/05/2023	07/12/2023		Work plan for the MVP is complete and uploaded to the Sharepoint site. The MVP coproduction for the CQC Maternity survey has been drafted and this will be ready to send to the LMNS by 15 September 2023	On going			
			Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	30/05/2023	07/12/2023			On going			
			Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions	30/05/2023	07/12/2023			On going			
			Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and	30/05/2023	07/12/2023			On going			
			Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or	30/05/2023	07/12/2023			On going			
			The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it.	30/05/2023	07/12/2023			On going			
			Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.	30/05/2023	07/12/2023			On going			
			Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and	30/05/2023	07/12/2023			On going			
		Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	04/08/2021	01/07/2024			On going		A training plan should be in place to cover all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024.	
			The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.	04/08/2021	01/07/2024			On going			

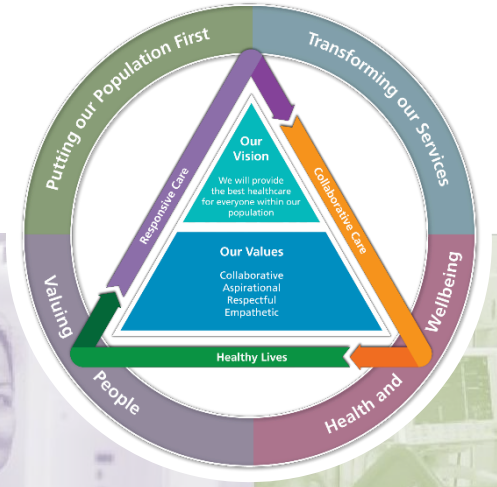
Safety Action 8	Hannah Matthews		The plan is developed based on the "How to" Guide developed by NHS England	04/08/2021	01/07/2024	12 Consecutive Months	In-house Training. There is development of a training programme for staff to meet the new framework. It is to be noted that the time frame for this Safety Action has changed to 12 month from December 2022 so currently not compliant. Work has progressed with this however a full update on recovery will be presented at MQAC on 14 September 2023	On going		12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme	
		Trusts must be able to evidence the four key principles:	1. Service user involvement in developing and delivering training.	04/08/2021	01/07/2024			On going			
			2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well.	04/08/2021	01/07/2024			On going			
			3. Promote learning as a multidisciplinary team.	04/08/2021	01/07/2024			On going			
			4. Promote shared learning across a Local Maternity and Neonatal System.	04/08/2021	01/07/2024			On going			
		Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards:	Obstetric consultants	04/08/2021	01/07/2024			On going			
			All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	04/08/2021	01/07/2024			On going			
			Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.	04/08/2021	01/07/2024			On going		Staff who do not need to attend include: Anaesthetic staff Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) MSWs GP trainees	
		Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards:	Obstetric consultants.	04/08/2021	01/07/2024			On going			
			All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota.	04/08/2021	01/07/2024			On going			
			Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.	04/08/2021	01/07/2024			On going			
			Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)Obstetric anaesthetic consultants.	04/08/2021	01/07/2024			On going			
			All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota.	04/08/2021	01/07/2024			On going			
			Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5	04/08/2021	01/07/2024			On going			
			Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance	04/08/2021	01/07/2024			On going			
			At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff	04/08/2021	01/07/2024			On going			
		Staff in attendance at births should be included for Module 6: Neonatal basic life support.	Neonatal Consultants or Paediatric consultants covering neonatal units	04/08/2021	01/07/2024			On going			
			Neonatal junior doctors (who attend any births)	04/08/2021	01/07/2024			On going			
			Neonatal nurses (Band 5 and above)	04/08/2021	01/07/2024			On going			
			Advanced Neonatal Nurse Practitioner (ANNP)	04/08/2021	01/07/2024			On going			
			Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.	04/08/2021	01/07/2024			On going		The staff groups below are not required to attend neonatal basic life support training: All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). Local policy should determine whether maternity support workers are included in neonatal basic life support training.	
Safety Action 9	Elaine Gouk	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded	30/05/2023	07/12/2023			On going		Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board	
			Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	30/05/2023	07/12/2023			On going		The dashBoard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance.	
			Evidence that the Maternity and Neonatal BoardSafety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.	30/05/2023	07/12/2023			On going			
		Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:	Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues.	30/05/2023	07/12/2023			On going		Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on	
			Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).	30/05/2023	07/12/2023			On going		The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff and	
			To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need	30/05/2023	07/12/2023			On going		The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions.	Good progress has been made with this Safety Action and evidence has been uploaded within the SharePoint site. The next score card will be due to be presented in October 2023, the data to support this is in place

		Evidence for point b)	Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting	30/05/2023	07/12/2023			On going		Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress 60made on identified concerns raised by staff and service users from no later than the 17th July 2023. Evidence that a review of the Trust's claims scorecard is undertaken alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan.																										
		Evidence for point c): Evidence that the Board Safety Champions have been Involved in the NHS England Perinatal Culture and Leadership Programme. This will include:	Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.	30/05/2023	07/12/2023			On going		Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 July 2023.																							
			Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented.	30/05/2023	07/12/2023			On going		Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. This must have been undertaken within 9 months of their teams starting the Perinatal Culture and Leadership 'Quad' Programme.What is thedeadline for reporting to NHS Resolution? By 1 February 2023 at 12 noon																							
Safety Action 10	Angela Storr	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023	Reporting of all qualifying cases to HSIB/CQC//MNSIfrom 30 May 2023 to 7 December 2023.	30/05/2023	07/12/2023			On going																							
			Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023.	30/05/2023	07/12/2023			On going																							
			Trust Board sight of evidence of compliance with the statutory duty of candour.	30/05/2023	07/12/2023			On going																							
			For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the TrustBoard are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	30/05/2023	07/12/2023			On going			This remains on track with evidence in place to support this. No concerns raised																			
			Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution.	30/05/2023	07/12/2023			On going																							
			Trust Board sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme	30/05/2023	07/12/2023			On going																							
			Trust Board sight of evidence of compliance with the statutory duty of c	30/05/2023	07/12/2023			On going																							

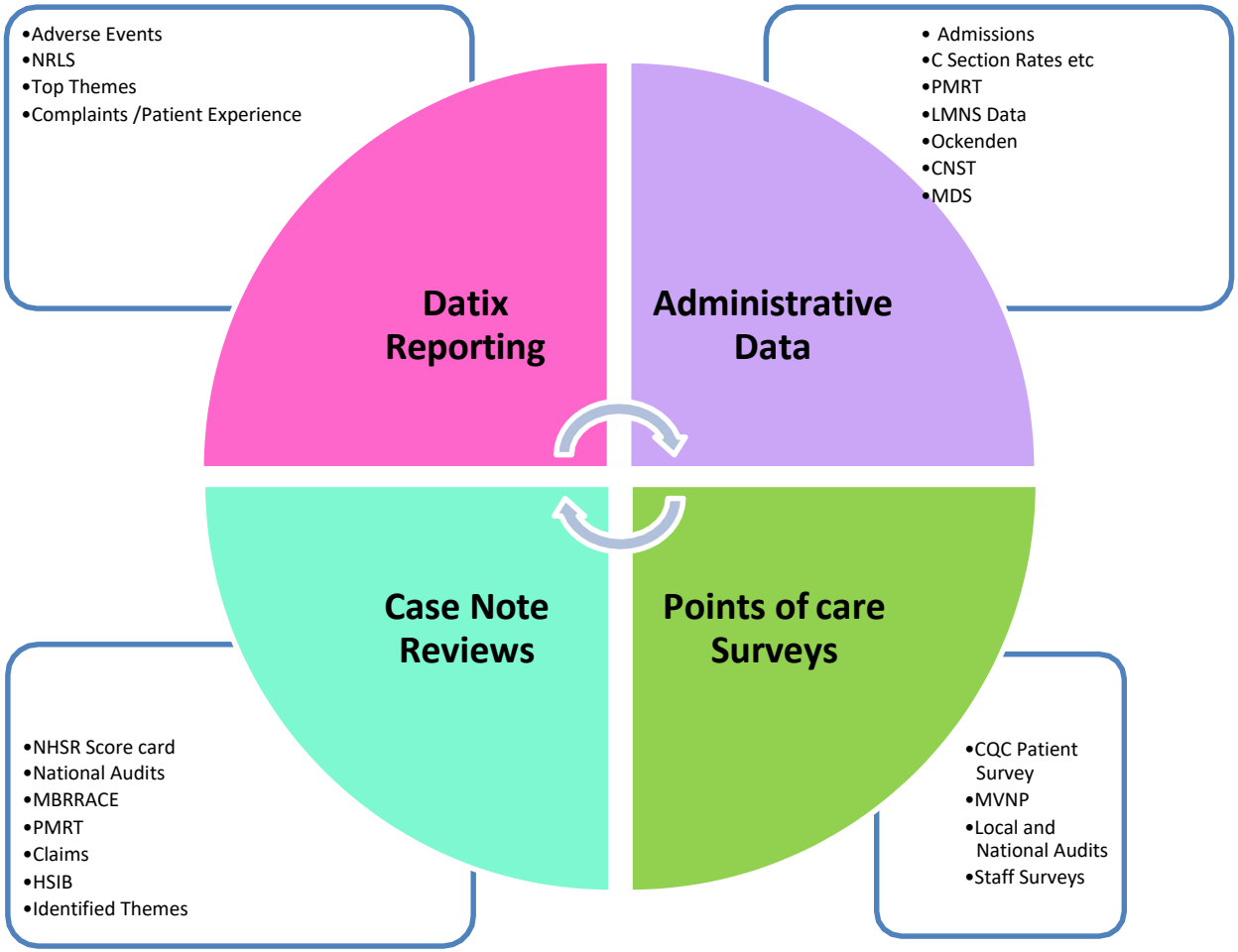
North Tees and Hartlepool
NHS Foundation Trust

NHSR Claims scorecard obstetrics Quarter 2. 2023/2024

Triangulation of Data



Understanding different sources of evidence data



Data Collection

- Top 5 themes from incidents reported
- Themes from SI's /PMRT/external reviews
- Review of litigation claims/NHSR Score card
- Themes from complaints / Debriefs /Compliments/reflections team
- National reviews of themes and lessons learned /HSIB/MBRRACE/National Reports/CDOP

Evidence (Data)

Incidents

Labour other delivery

Other please specify (related to administrative issues)

Post Partum Haemorrhage over 1500mls

Access admission /Transfer /Discharge

Unsafe working environment

Simple complication of treatment

Administrative Data

Documentation

Plans of care /Discussed with patient

Evidence of information regards procedures/care

Appropriate triage

Risk assessments/VTE

Body mapping of babies

DOC documentation

Follow up results

Staffing levels

PMRT report (ethnic minorities)

Survey/Audit

Post partum haemorrhage treatment

PMRT (smoking) completion of electronic system /SGA

Readmission (tissue viability)

Lack of follow up postnatal care

VTE Risk assessment and treatment

CTG interpretation of

Lack of communication /Consent

Litigation/NHSR Score card

Delay in admission to hospital **(Red)**

Delay in Treatment

Inapp use of equipment /Ventouse

Failure to respond to FH

Maternal Death Post Partum Hamorraghe

Failure act on test results /Pre eclampsia **(Blue New settlement)**

Complaints

Staff attitude communication regards consent. (Documentation does not include all options available .)

Written communication

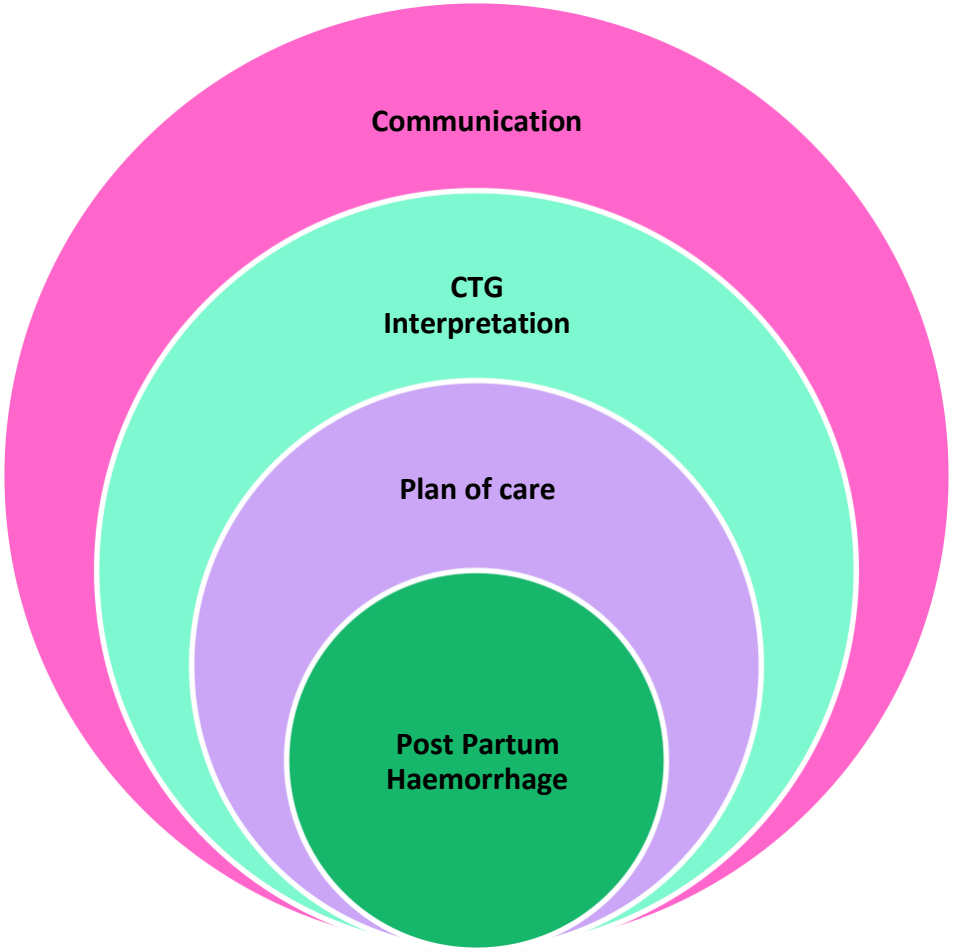
Lack of pain relief

Lack of care following pregnancy loss

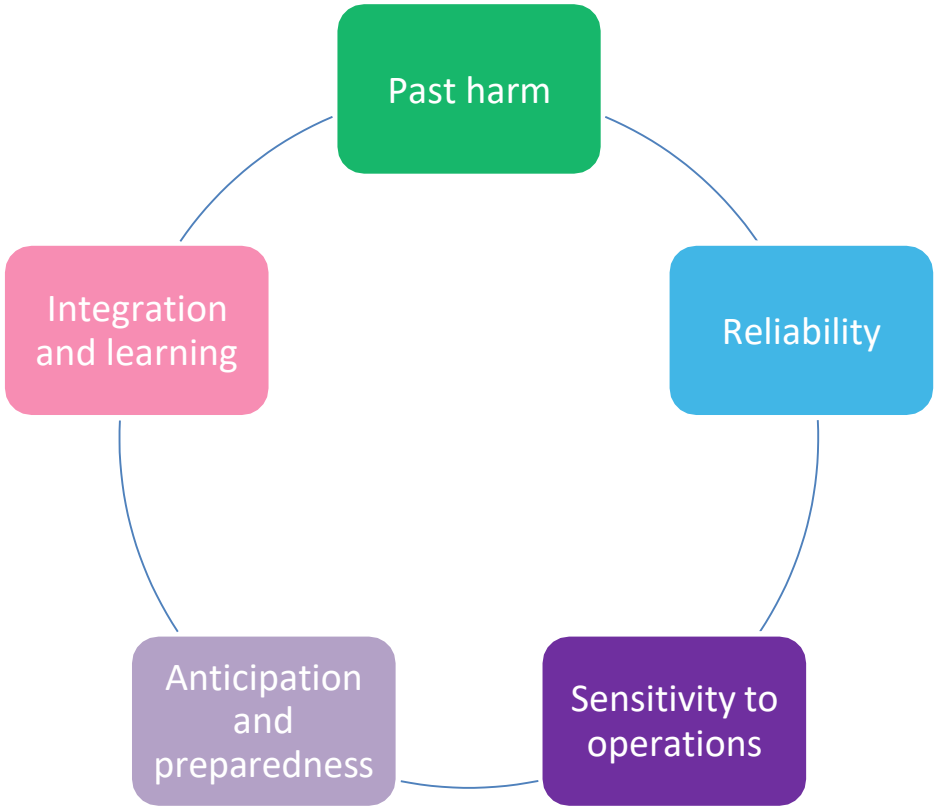
Lack of information regards test results

Reflections (communication /dismissive staff not listened to)

Themes


Communication
CTG
Interpretation
Plan of care
Post Partum
Haemorrhage

Safety measurement and monitoring



Actions implemented

QI Measurement of blood loss Recruitment of retention midwife /Increase in recruitment

Review in the LMNS management of PPH

Daily monitoring of staffing levels

Development of LMNS escalation plan

Review of babies unexpected to special care

Review of information provided to patients regards postnatal care (MNVP)

- Implementation SBLV3 Tool
- Triage process
- Right place of birth Audit
- Co production with MNVP
- Staff training
- Review of results
- Review of VTE guideline
- DOC Audit

Triage of patients to include monitoring of reduced fetal movements (Audit)

Review of website to include information to make an informed consent MNVP

Monitoring of maternal blood loss

Training –re body mapping

Recruitment of bereavement midwife

Monitoring of daily staffing levels

QI PPH project

Post partum blood loss

CTG training (increased due to CCF v.2

Review of smoking guideline Readmission Audit undertaken

Support for patients by the introductions of FLO's

Ensure patients included in debriefs

Introduction of Badgernet

Improvements

- Daily review and assessment of staffing levels through and Birth Rate + appointment of retention midwife to support newly qualified midwives , this has also helped to see a return of staff who previously left the organisation.
- PPH monitoring continues . (This has been included as part of the PSIRF review and has identified for major PPH there maybe still additional learning therefore may require a PSII- ICB)
- PMRT appointment of bereavement midwife to support patients through the process (As part of PSIRF it is acknowledged certain incidents will require a review out with the framework due to National reporting requirements this would include PMRT . It is estimated potentially 2-4 incidents will be reviewed per year)
- CTG machines have been replaced with new ones which provide an electronic assessment of fetal well being. A further day has been introduction to support CTG training .(Previously cases which would have been referred to HSIB which were often as a result of mis -interpretation of CTG . They will continue to investigate incidents but can support Trusts with investigations . They have provided a vast amount of tools to support with the implementation of PSIRF)
- Development of the Maternity website which will help patients make an informed choice about patient care.
- Introduction of Badgernet will help support the collation of data .

Organisation Name	March 2023	April 2023	May 2023	June 2023	July 2023
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	4	4	5	5	5

Organisation Name: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	200			Passed
CQIMDQ14	220	215	102.3		Passed
CQIMDQ15	215	215	100.0		Passed
CQIMDQ16	205	215	95.3		Passed
CQIMDQ24	200	205	97.6		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	110	220	50.0	Passed
CQIMDQ08	220	220	100.0	Passed
CQIMDQ09	220	215	102.3	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	220	215	102.3		Passed
CQIMDQ11	65	220	29.5		Passed
CQIMDQ12	10	220	4.5		Passed
CQIMPPH	10	220		41	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	220	215	102.3		Passed
CQIMDQ22	215	215	100.0		Passed
CQIMDQ23	205	215	95.3		Passed
CQIMPreterm	10	215		47	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	220	215	102.3		Passed
CQIMDQ15	215	215	100.0		Passed
CQIMDQ16	205	215	95.3		Passed
CQIMDQ18	140	215	65.1		Passed
CQIMDQ20	5	135	3.7		Passed
CQIMTears	5	135			Passed

Note: The most recent available reporting period is based on provisional data. All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	220	215	102.3	Passed
CQIMDQ15	215	215	100.0	Passed
CQIMDQ16	205	215	95.3	Passed
CQIMDQ18	140	215	65.1	Passed
CQIMDQ26	215	215	100.0	Passed
CQIMDQ27	320	320	100.0	Passed
CQIMDQ28	140	320	43.8	Passed
CQIMVBAC	0	10	0.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	220	215	102.3	Passed
CQIMDQ31	220	220	100.0	Passed
CQIMDQ32	205	220	93.2	Passed
CQIMDQ33	220	220	100.0	Passed
CQIMDQ34	140	220	63.6	Passed
CQIMDQ36	220	220	100.0	Passed
CQIMDQ37	105	220	47.7	Passed
CQIMDQ38	220	220	100.0	Passed
CQIMDQ39	220	220	100.0	Passed
CQIMRobson01	0	25	0.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	25	65	38.5	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	15	15	100.0	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	320	215	148.8	Passed
CQIMDQ04	320	320	100.0	Passed
CQIMDQ05	35	320	10.9	Passed
CQIMSmokingBooking	35	320	10.9	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	5	220	2.3	Failed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	320	320	100.0	Passed

3.

MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	245	245	100.0	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	0	0	0.0	Passed

4.

Provisonal Window Submission

Indicator	Result
Provisional Submission	Passed

5.

Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

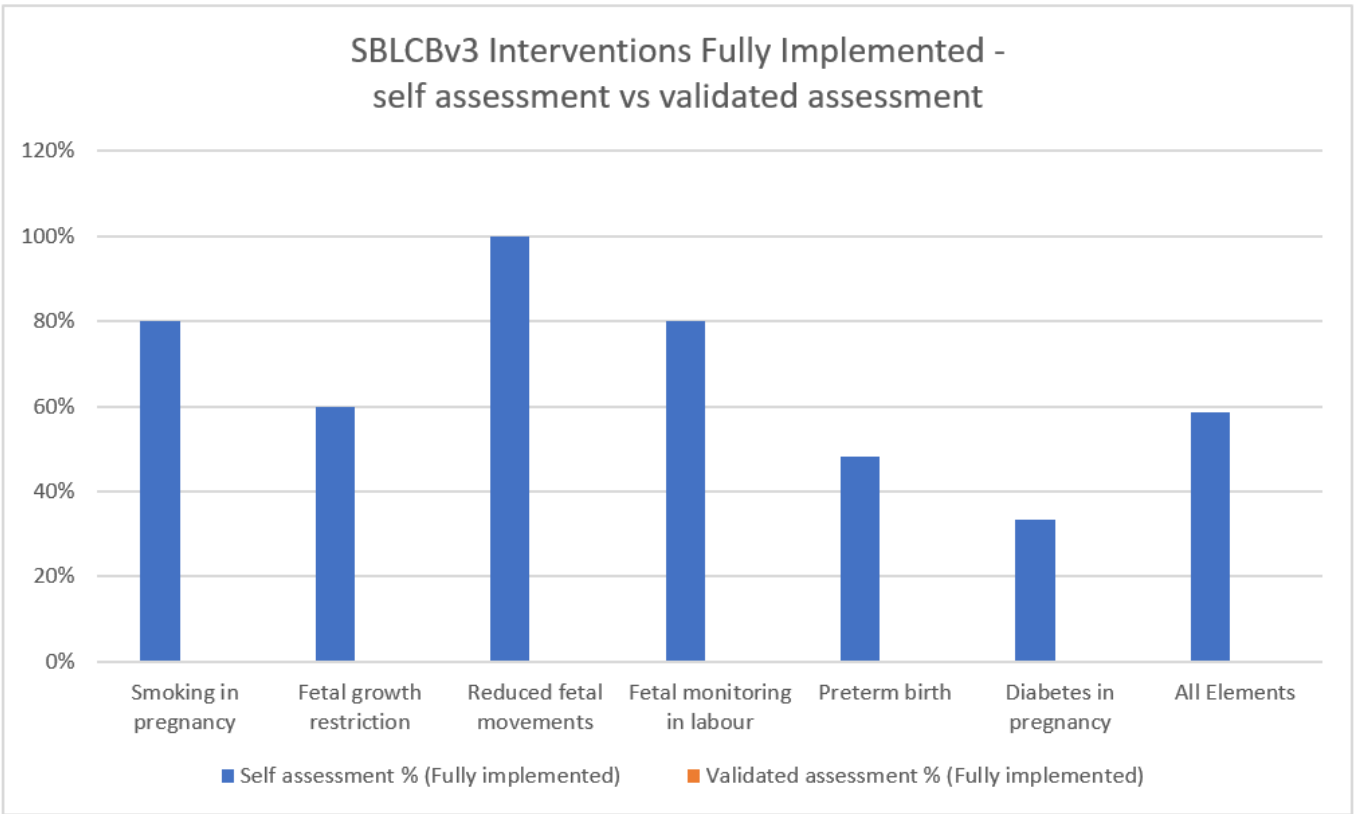
North Tees and Hartlepool NHS
NHS Foundation Trust

Project Highlight Report

Name of Project:	SBLCBV						
Overall Project Status: (RAG)		Legend Major issues require decisions/re-planning Proceeding to plan, issues to be addressed and/or risks to be monitored Proceeding to plan, no major risks/issues					
Forecast trend for next reporting period							
Performance Areas	**Time**	**Cost**	**Scope**	**Quality**	**Risks**	**Issues**	
Highlight Report Completed by	**Name**	Steve Wild, Abbie Wren, Kathryn Hardy					
	Email Address	Kathryn.hardy@nhs.net					
Executive Director Sponsors		Lindsey Robertson					
Reporting Period	**Month:**	26/10/23					
	Year:	2023					

Current Position

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	80%		0%
Element 2	Fetal growth restriction	Partially implemented	60%		0%
Element 3	Reduced fetal movements	Fully implemented	100%		0%
Element 4	Fetal monitoring in labour	Partially implemented	80%		0%
Element 5	Preterm birth	Partially implemented	48%		0%
Element 6	Diabetes	Partially implemented	33%		0%
All Elements	TOTAL	Partially implemented	59%		0%



Partial and non compliant elements – progress plan

Partial compliance (work on going) Work yet to commence

Element	Evidence required	Progress	Lead
Element 1 – Smoking in pregnancy			
1.6	2 Audits underway to obtain data regarding smoking; 1. women referred into the service who set a quit date. 2. Women who set a quit date deemed non-smokers 4 weeks later	Both audits on track to be completed by 30/11/23	Julie Bardsley
1.7	Audit to demonstrate that women referred to smoking cessation services feedback of progress and treatment plan is shared with maternity services	Audit on track to be completed before 30/11/23	Julie Bardsley
Element 2- Risk perception, surveillance and management of pregnancies considered at risk of fetal growth restriction			
2.1	Initial audit of 50 sets of notes determined only 40% had a risk assessment for Aspirin documented.	Repeat audit required Badgernet audit to be undertaken January 2024	Kathryn Hardy
2.2	Recommend Vitamin D supplementation to all women	Audit underway to review track that Vitamin D is recommended at booking	Carol Proudlock
2.4	Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway.	Audit required to ensure that all booked women have a customised growth scan generated following dating scan	G.Gordon J.Verity
2.6	As part of risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in pregnant women	BP machine log has been obtained through medical devices. All matrons are checking areas to ensure monitors are on the approved pathway.	All SCMs
2.7	Women who are deemed as high risk for FGR should undergo UAD assessment 18+0 to 23+6 gestation	Awaiting Q2 SGA audit to reflect improvement of UAD being undertaken as previous audit determined 0%. Review of pre term data required to demonstrate increase in performance of UAD in eligible women. QI project outcome required	G.Gordon J.Verity
2.10	Women low risk of FGR should have fundal Height measurement before 28+6 weeks. Measurements should be plotted on a customised growth chart	Audit underway to reflect care pathway	Anita Scott
2.17	Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that must	Clarification required that Multiple Births pathway complies accordingly. Twin audit to be reviewed to ensure evidence captured	Kathryn Hardy Dr. Wild

	be agreed by both the local ICS and the regional team.		
2.19	In fetuses with EFW between 3rd <10th, delivery should be considered at 39 weeks.	Audit required; Number of babies >3rd centile born <39 weeks where growth restriction was suspected. Denominator Total babies > 3rd centile	Carol Proudlock providing data
Element 4 – Effective Fetal monitoring during labour			
4.1	All staff who care for women are expected to under go annual mandatory training and competency assessment.	On track to achieve 90% trained by December 2023. Ensuring all staff attend training as organised. Mop up sessions on going	Abbie Wren
Element 5 – Reducing Preterm birth			
5.1	Each provider should have Obstetric Consultantlead for preterm birth, delivering care through a specific pre term birth clinic. A preterm birth optimisation midwife, a neonatal Consultant lead and identified Neonatal nursing lead.	Require evidence in the form of job description or job planning to support the roles in practice. Require; Obstetric Consultant lead and Neonatal consultant lead.	R.Scott V.Whitfield
5.2	Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high.	Further discussion regarding pre term risk assessment required and Badger audit moving forward. Review required that referral process and assessment is clear	G.Gordon J.Verity
5.3	In the assessment or women presenting in suspected pre term labour, evaluated digital tools are now available (QUIDS,QUiPP) to improve predictive accuracy.	Review required of pre term clinic data to provide assurance and evidence that this process is embedded in practice	G.Gordon J.Verity
5.6	Risk assessment and management of multiple pregnancy should complywith NICE guidance.	Review of twins trusts data to ensure practice reflects NICE guidance and repeat audit plan. Update of Implementation plan required following Twin audit February 2023	Terri Oliver Dr Fincham
5.9	Symptomatic women require assessment using quantative fetal fibronectin measurements and use of decision assisted tools.	Review of clinic data required and examination of evidence for this element required to ensure robust processes are in place.	Dr.Baphir G.Gordon J.Verity
5.11	Test for asymptomatic bacteriurea by sending off an MSU for C&S at booking.	Audit underway	Kathryn Hardy
5.14	Local Implementation plans for CoC models should ensure prioritisation of women from the most deprived groups are targeted.	CoC strategy/model required. Should current position be detailed and improvement plan included as evidence	Anita Scott AM Collighan
5.16	Ensure Neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth.	Audit commenced reviewing babies <30 weeks who were admitted to SCBU. Clarification require regarding what is recognised as pre term cut off when neonatal team should attend	Janice Atkinson Kathryn Hardy

5.20	Antenatal corticosteroids should be offered to women22+0 and 33+6 weeks optimally prior to 48 hours of birth.	Audit scores are low as there are very few infants delivered at NT&H so 1 missed case impacts upon compliance. QI programme developed to improve compliance. Update required and on-going audit information through Mat Neo SiP	Janice Atkinson Danielle Stephens Kathryn Hardy
5.21	Magnesium Sulphate to be offered to women 22+0 and 29+6 weeks gestation and considered between 30+0 and 33+6 weeks who are established in labour within 24 hours.	Audit scores are low as there are very few infants delivered at NT&H so 1 missed case impacts upon compliance. QI programme developed to improve compliance. Update required and on-going audit information through Mat Neo SiP	Janice Atkinson Danielle Stephens Kathryn Hardy
5.23	Babies born< 37 weeks should have their cord clamping delayed for 1 minute after birth. This can have benefits for all babies.perinatal MDT shold work together to ensure this is delivered.	On-going audit and implementation via QI programme will be monitored to include in evidence	Danielle Stephens Kathryn Hardy
5.24	Babies born < 37 weeks should have their first temp between 36.5-37.5 within one hour of birth.	On-going audit and implementation via QI programme will be monitored to include in evidence	Danielle Stephens
5.25	Early maternal milk should be given ideally 6 hours following admission aiming for within 24 hours.	Audit was poor regarding this element and QI programme initiated NeoTripps QI programme. Breastfeeding guideline updated and BFI stage 1 accomplished. On-going monitoring and re audit required including evidence of improvement	Danielle Stephens Laura Charlton Kathryn Hardy Janice Atkinson
5.26	For babies born < 34 weeks gestation who need invasive ventilation, use volume targeted ventilation in combination with synchronised ventilation as primary mode of respiratory support.	Trainee ANNP has been allocated to review cases and implement target volume ventilation. This will include guideline review and update and training plan and implementation plan.	Trainee ANNP Janice Atkinson
5.27	For babies born<30 weeks gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours.	This element does not apply to NTH as any infant born<30 weeks should be stabilised and transferred to NICU. Caffeine administration is not part of stabilisation process. Evidence to be submitted describing SCBU provision in NTH	Janice Atkinson
Element 6 – Management of Diabetes in pregnancy			
6.1	Women with pre existing diabetes should be offered care in a one stop clinic, providing care to pre existing diabetes only, offering MDT review having resource and skill set to address all antenetal care requirements.	Gap analysis complete. One stop clinic to be organised as dedicated time slots within the clinics at both Hartlepool and NT. SOP required to outline the dedicated time slots allocated. Administration to review clinic time slots to ensure compliance. Diabetic specific dietician required specifically to be part of the MDT	Dr.Fincham Dr.Wild T.Oliver Dr. Ijaz Julie Sinclair Rachel Scott
6.2	Women with type 1 diabetes should be offered continuous	Audit undertaken requires minor amends and on going audit plan provided as	Terri Oliver Julie Sinclair

	glucose monitoring. Provided with education and support to use this.	evidence. Evidence required regarding what information and teaching is given to women re CGM. When	
6.4	Women with diabetes should have HbA1C measured at the start of third trimester and measurements above 48mmol/mmol should have increased surveillance.	Audit undertaken requires review and future audit plan outlined as evidence	Terri Oliver Julie Sinclair
6.6	Recognising the very high risk of fetal death associated with DKA, all pregnant women presenting to secondary care with DKA should have on going MDT consultant input and be cared for in line with jointly agreed guidance.	Draft DKA guideline has been developed. Trust wide ratification and assurance all disciplines have had an opportunity to comment. Then guideline will be available for all and shared across the trust	Dr.Ijaz

Key Actions for the Next 4 Weeks:

- Continue to evaluate evidence
- Complete audits and submit to portal as evidence
- Submit and update evidence hub and spreadsheet
- Weekly meetings with core team members to agree on going risks and developments
- Representation on quality assurance meetings sharing progress and risks
- 06/11/23 LMNS NENC meeting to review evidence and information.
- Link with other trusts sharing insights and updates
- Discuss evidence submission with Simon Mehigan

Risks this Month

- LMNS assessment of evidence strength does not align with trust self-assessment and compliance level lowers.
- Progress stalls, audits remain incomplete or further audits identified.

North Tees and Hartlepool NHS Foundation Trust

Action Plan 2023 – Avoiding Term Admissions in Neonates (ATAIN)

Directorate(s): Women and Children's – Care Group 1 Healthy Lives

Ward/Department: SCBU and Obstetrics

Date (including revisions): Transferred from previous action plan 14/9/23 Updates 4/10/23.

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
1	Improve the safety of care and keep mothers and babies together whenever it is safe to do so.	All unplanned term admissions to the neonatal unit to have a thorough and joint clinical review by maternity and neonatal staff to identify learning and improve care provision	Transferred 14/9/23 (April 21)	Obstetric and Neonatal Teams	Ongoing	**14/9/23** Leads established – JA/ AM. Joint review of all term admissions identified on badger JA **4/10/23** Meet quarterly (to allow time for return notes) until live with badger then monthly meeting. JA	
		Quarterly reporting of Audit to joint obs/neonatal meeting, Maternity Improvement Group and Maternity/Neonatal safety champions	20/9/23	SCBU/ward matron/Neonatal Safety Champion	Ongoing quarterly		
		Continue to Implement the BFI standards and maintain UNICEF Baby Friendly accreditation	Transferred 14/9/23 (31/8/2019)	SCBU matron, Paediatric SCM, Infant feeding Lead, Maternity SCMs	1/10/2025	**14/9/23** Maternity and Neonatal unit both achieved stage 1 BFI accreditation. Wok ongoing for stage 2 within a year. JA	
		Implement Audit NEWTT tool on postnatal ward to ensure fully embedded as part of TC audits	14/9/23	SCBU Matron Maternity SCM	1/10/23	**14/9/23** discussion re how to audit- GG to link with deteriorating patient lead. JA	

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
2	ATAIN audit to continue with joint participation from obstetric and Neonatal teams using national data collection tool	Joint monthly review of previous months term admissions Feedback findings in monthly joint obstetrics and Neonates meeting alongside term admission review Feedback into bi monthly maternity and neonatal safety champions meeting	Transferred 14/9/23 (25/11/22) Transferred 14/9/23 (25/11/22) Transferred 14/9/23 (25/11/22)	SCBU matron Neonatal safety champion/ SCBU matron/ Fetal wellbeing midwife. Neonatal Safety Champion	Ongoing 30/10/23	**14/9/23** difficulty in completing audit monthly due to availability of maternity noes- escalated to VW, SW. JA **14/9/23** To review joint obs/neo meeting and TOR. Meeting not well attended in last quarter and stood down. JA **14/9/23** To have q1 ready for presentation in next mat neo safety champs meet 18/10/23 and update on progression of Q2 JA	
3	Transitional Care Audit of service provision	Audit of compliance of classification of babies as TC against agreed guideline	Transferred 14/9/23 (25/11/22)	Post-natal ward manager SCBU Matron	Ongoing	**14/9/23** TC audit to be taken to mat neo champions 18/10/23. New audit criteria for Q3 with launch of updated TC guideline JA	
4	Avoidable admission for Q3 and 4 audit – social admissions and maternal escalation	Discuss with safeguarding re ensuring adequate supervision, nominated supervisors in place on birth response plan Explore with maternity SCMs alternatives to admission to SCBU for babies with maternal health escalation	Transferred 14/9/23 (30/7/23) 30/7/23	SCBU Matron Children's Safeguarding Senior Nurse	30/10/23	**14/9/23** Discussed with CF in safeguarding managers meet 1/9/23 JA will chase update. JA **21/9/23** CF emailed awaiting response. JA	
5	Difficulty in obtaining notes in a timely manner to review maternal care	Identify pathway for return of community notes Escalate to EDM department	Transferred 14/9/23 (10/9/23)	SCBU Matron Admin lead	30/10/23	**14/9/23** Delay in completing Q1 audit due to notes availability- escalated. To chase 15/9/23 with ward 22 clerk and EDM team. JA	

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
		notes required for audit				21/9/23 Notes available audit to be completed today. JA	

North Tees and Hartlepool NHS
NHS Foundation Trust

Action plan – Late Preterm Neonatal Transitional Care

Directorate: Health Lives – Maternity and Neonates **Ward/Department:** 22 **Developed by:** Transitional Care Group **Date:** 21/09/2023

Item	Problem/Issue	Actions	Responsibility	By When	Evaluation Status /%Completed Progress Update Including any further agreed actions
1	Terms of Reference required for regular Neonatal Transitional Care Meeting	Develop Terms of Reference and bring to group for review and sign off	JA	07/09/23 (next NTC meeting)	Completed
2	Review of Agenda for Neonatal Transitional Care Meeting	Review and amend agenda items for Neonatal Transitional Care Meeting	JA	07/09/23 (next NTC meeting)	Completed
3	Review of audit criteria	Review and amend if relevant current audit criteria	all	07/09/23 at NTC meeting	Completed
4	Finalise and approval of audit criteria to commence for Q3.	Agree questions for audit Send to BI team for audit template	GG/JA	07/09/23 at NTC meeting	Completed Completed – awaiting template
5	Involvement of the wider antenatal postnatal team in the Neonatal Transitional Care Meeting needed	Invite to be sent out to all core staff members including Maternity Support Workers, Midwives and Nurses working on the Postnatal Ward	LC – send list of all staff to JA JA – to send out invite	05/10/23	LC to allocate MSW to group LB to allocate RM to group and lead
6	New transitional care guideline now available on trust intranet – new criteria to BAPM standard but not part of routine practice	'Launch' event for new criteria – posters and display board Training and awareness of differences in new policy	JJ	09/10/2023	Launch event next week
7	Women and their babies are still being separated for the	Development of training and competency booklet required for all	JJ	07/10/2023	Booklet completed and training pack GG to email JJ to commence training 20/11/2023

Item	Problem/Issue	Actions	Responsibility	By When	Evaluation Status /%Completed Progress Update Including any further agreed actions
	administration of IV Antibiotics (transfer to SCBU for a short period of time).	midwives on IV drug administration for the neonates			
8	Women and their babies are still being separated for the administration of IV Antibiotics (transfer to SCBU for a short period of time).	Complete IV drug administration training for all registered midwives working on the postnatal.	JJ	31/12/2023	GG to email JJ to commence training 20/11/2023
9	Women and their babies are still being separated for the administration of IV Antibiotics (transfer to SCBU for a short period of time).	Ensure equipment, secure drug and clean utility area (separate from maternal drugs) set up and ready. Agree start date for change implementation.	LB all	30/11/20233 Nov 23 NTC meeting	NIPE table Room to be emptied and consider stock Drugs and drugs cupboard will be needed LB to link up with ANNP with TC and arrange equipment needed.
10	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Review data regularly of any babies that may have met the BAPM criteria but remain on SCBU due to trust guidance to be presented alongside NTC audit at PIG	JA	30/10/2023	Data continually collated but to be placed on PIG agenda from November to be presented and will inform decision making. JA emailed MB for regular item on agenda to include NTC, 34 week babies and ATTAIN audit – confirmed item on agenda going forward Complete – data collection ongoing
11	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Development of training and competency booklet required for all midwives and maternity support workers for nasogastric tube feeding of the neonate	JJ	30/11/2023	
12.	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust	Complete NGT for the neonate training for all registered midwives and Maternity Support Workers working on	JJ	TBC once action 11 complete	

Item	Problem/Issue	Actions	Responsibility	By When	Evaluation Status /%Completed Progress Update Including any further agreed actions
	guidance currently from 35 weeks for NTC.	the postnatal ward.			
13.	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Ensure equipment available and part of regular stock order for NGT feeding equipment. Agree start date for change implementation.		TBC once action 11 complete	
14.	NEWT2 guidance released BAPM 2023 for review and consideration of trust guidance/SOP	Share guideline and review by next NTC meeting Discuss with LS digital midwife regarding parameters set in Badgernet Decision at next NTC meeting re next steps	JA LB all	30/11/2023	

Appendix 8

Action Plan: RCOG Compensatory Rest Action Plan

Item	Issue	**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 AND Rag Rate**	**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	Consultant work schedule has Wednesday morning at work after night on call. (No activity after other nights on call)	Change the emergency work template to remove the Wednesday morning session after Tuesday night on call	13/09/2023	CD WACS Operational Manager	October 2023 Complete	Consultant schedule has no planned work after on call for Obstetrics Complete Implemented October 2023
2	No standard process for compensatory rest	Develop a Standard Operating Procedure for compensatory rest in the department	13/09/23	CD WACS	October 2023 Complete	Complete Implemented October 2023

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard Operating Procedure

SOP number

SOP Title **Compensatory Rest Following Night On-Call Consultants in Obstetrics & Gynaecology**

	Name	Title	Signature	Date
Authors	Elaine Gouk	Clinical Director		12/09/2023
Reviewer	Nicola Wilding	Service Manager, Administration Team Healthy Lives	NWilding	13/09/2023
Authoriser				

Effective Date:	01/10/23
Published date:	14/09/23
Review Date:	13/09/24

SOP Change / Review Control

SOP and version no.	Effective date	Significant changes	Previous SOP and version no.

Standard Operating Procedure

1. PURPOSE AND BACKGROUND

To clarify the departmental process being implemented to enable appropriate compensatory rest following a night on call for consultant medical staff in Obstetrics & Gynaecology

2. SCOPE

Consultant medical staff involved in overnight on-call work
Obstetrics and Gynaecology rota administrative team

3. PROCESS

From the 1st October, there will be no planned clinical sessions following a night on call for obstetrics & gynaecology.

If the consultant is scheduled as a back-up consultant on-call for Gynaecology and required for emergency work during the on-call night and therefore unable to fulfil the clinical session the following day, the consultant should contact the rota administration team by telephone at 0800h on 01429 522634 to inform of activity affected.

If in exceptional circumstances a second consultant, not scheduled to be on-call, is asked to attend for emergency care reasons overnight, the compensatory rest process will also apply.

The rota administrative team will review the timetable to assess if cover is required and contact any other relevant staff for that activity. The rota team can contact the Clinical Lead for advice if required. If there is no cover available, the clinical session will be cancelled.

8. EDUCATION AND TRAINING REQUIREMENTS

None

11. IMPLEMENTATION REQUIREMENTS

Process shared with consultant, rota administrative and senior teams.

12. AUDIT AND MONITORING

A record will be maintained by the rota administrative

13. INDIVIDUAL RESPONSIBILITIES

The rota administrative will maintain a record of all sessions affected

13. REFERENCES

RCOG: Guidance on appropriate standards for compensatory rest for consultants and senior SAS doctors following non-resident on-call activity

14. CONTACTS

Name	Position	Phone	Email
Elaine Gouk	Clinical Director	07747 006858	Elaine.gouk@nhs.net

Appendix 9

Action Plan: RCOG guidance on engagement of long-term locums

Item	Area for Improvement	**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 AND Rag Rate**	**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	Documentation of the detail in the local induction	Implement a new long-term locum starter checklist/pack to aid recording of the detail to achieve the required RCOG standards. To be implemented by December 2023.	11/10/2023	Operational Manager, O&G	24/11/2023	
2	Establish a standard process for MDT feedback prior to Out of Hours work	Named Supervising Consultant to gain MDT feedback and record details in the Trust's Probationary Period documentation prior to OOH work	11/10/2023	Clinical Lead O&G	24/11/2023	
3	Improve recording of performance and feedback to locum	Trust Probationary Period documentation to be used to record performance and feedback	11/10/2023	Clinical Lead O&G	24/11/2023	

Nurse staffing standards Action Plan

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

Date (including revisions): January 2020, June 2020, April 2021, June 2021, January 2022, August 2022, September 2022, January 2023, June 23, 31/8/23

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/CD	6 monthly	**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 **Date 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 **Date 14/4/21** Next workforce review due June 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. **Date 11/6/21** Workforce review with deputy chief nurse and head of workforce. Raised re BAPM compliance and varying compliance depending on occupancy and acuity. Raised with CGM and clinical director to determine forward plans. **Date 19/1/22** Secured funding via NCCR £91.042 recurrent for additional Nurse staffing. . **Date 22/8/22** Workforce review date 6/9/22 3.4WTE still required to be fully BAPM compliant **ongoing** **Date 6/9/22** Workforce review completed with associate director of workforce

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.***
						Date 16/1/23 Ongoing **Date 31/8/23** Meeting arranged with AD ER for workforce to complete a further workforce review. 7/11/23 Dining tool completed and attached  Copy of Neonatal Workforce calculator **Ongoing**
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/ Neonatal lead	Jan 2020	**Date-Jan 2020** part of ODN. Fully integrated and represented at all meetings by the SCM. Neonatal lead 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	Jan 2020	SCM/ Matron	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 **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

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.***
		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: 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%**				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 **Date 14/4/21** Next workforce review due June 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. **Date 11/6/21** Continue to utilise safecare live. Monthly audits in place and monitored through the Trusts workforce steering group. Professional judgement and challenge implemented with all members of the nursing team. Raised within annual workforce meeting and for further discussed with CGM and clinical director **Date 4/11/21** Workforce review data sent to Neonatal Network Manager **Date 19/1/22** Secured funding via NCCR £91.042 recurrent for additional Nurse staffing **Date 8/7/22** Q4 Network reports BAPM compliance 74.4% **Date 1/8/22** 1 additional RN in post, 1 awaited. **Date 6/9/22** Workforce review with associate director of workforce

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.***
						Date 26/11/2022 Q1 Network report BAPM compliance 94.5% **Date 16/1/23** Consideration and exploration of Band 4 Nursing workforce in SCBU . **13/6/23** BAPM compliance monitored through Neonatal network quarterly reports. Q4 94% compliance. Risk remains active within Trusts risk register. Risk ID Network Staffing Report 22-23_Q4.pdf **Ongoing for 6 monthly review** **31/8/23** Workforce review with AD ER 7/11/23
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/ Matron	June 2020	**Date-Jan 2020** safecare live integrated within the unit. Training re professional judgement delivered **Date June 2020** compliance varies-number of errors within system identified and resolved. Cot capacity captured also on Badger. **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 accuracy and compliance **Date 9/4/22** Safecare continues to be submitted, compliance for Q4 SCBU 94.4% **Date 1/7/22** Q1 Safecare compliance 93.3 %

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.***
						Date 26/11/2022 Q2 Safecare compliance 89% - access difficulties in this quarter throughout trust **Date 16/1/23** Safecare compliance continually good. Safecare embedded in SCBU. **Date 5/10/23 Q2** Current safecare compliance 95% **Ongoing**
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/ Matron	June 2020	**Date-Jan 2020** Dinning calculated. **Date-June 2020**- re done for June and integration of HCA. **Date 1/9/22** Dining tool to be recalculated following increase in WTE. Meeting arranged with matron to complete **Date 9/9/22** Dining tool calculation 1.8 WTE requirement for full compliance with BAPM standards shared with the ODN.. **Date 16/1/23** Dining tool shared with ODN, regular reviews as part of workforce planning **Date 31/8/23** Meeting arranged with AD ER for workforce to complete a further workforce review. 7/11/23 Dining tool completed and attached  Copy of Neonatal Workforce calculator
6	Training and development must be linked to annual individual appraisals and	• TNA report • Monthly Rag report • Monthly SCM report	Jan 2020	SCM/ Matron	June 2020	**Date- Jan 2020**-great compliance evidenced within RAG report. QIS compliance 93%

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.***
	development plans, and must be provided within the resources available to the team.	70% of the nursing establishment mist be qualified in speciality (QIS) Established formal learning opportunities including e-learning, seminars, simulation, rotation and shadowing				**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. **Date-15/6/21**-Excellent compliance with training. Overall compliance 98% and appraisal 97% (one staff member on long-term leave). Monitored monthly with RAG and ESR systems and overview by senior clinical matron. Discussed with matrons in monthly managers meetings and action plans to be implemented if needed. **Date 1/9/22** Training continuous to show evidence of sustained improvement 97% **Date 26/11/2022** Training compliance 94.48%- 2 new modules added to training this month **Date 16/01/23** Training compliance consistently above trust standard **Date 31/8/23** Ongoing compliance above 95% for the SCBU **Ongoing**
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	Jan 2020	SCM Matron	June 2020	**Date-Jan 2020** daily staffing huddles and OPEL meetings in place. Jointly attended with maternity matrons. **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. **Date 14/7/21** Q4 neonatal report-BAPM compliance 90% overall within this quarter

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.***
		• Fair rostering policy • Flexible working • Minimising agency staffing				**Completed**
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 collaboration	Jan 2020	SCM	June 2020	**Date Jan 2020** fully integrated level 1 unit following reconfiguration **Date June 2020**-specialist commissioning and uncertainly re community neonates commissioning-raised with contracting manager and also within the Network board meetings **Date 15/6/21** All pathways adhered to and as part of MCN/ICP community neonatal project underway to facilitate early discharge with community neonatal nursing involvement **Date 1/7/22** Attendance at Board meetings continue. Represented at meetings to discuss care pathway changes for under 27 weeks within network. No further MCN work undertaken at present, data re NG feeding at NT shared. **Date 16/1/23** Ongoing any non compliance will be datixed and investigated **Completed**
9	All neonatal units should input data into BadgerNet to enable national benchmarking.	• Badger data inputted and network compliance monitored	Jan 2020	SCM/ Matron	June 2020	**Date-Jan 2020** fully evidenced through quarterly reports **Date June 2020**-Quartlerly reporting on-going **Completed and Ongoing**

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.***
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, MBBRACE, 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 **Date June 2020** journey to platinum continues and a number of QI projects initiated by the team. Use of datix to report incidents and robust patient safety process in place including individual feedback to staff. Active and fluid risk register also in place. **Date 14/5/21** Accreditation for platinum in July depending on QRG outcome. Deep dives of the unit completed and high standards and quality of care evidenced. Local parental feedback survey completed and excellent feedback obtained. Weekly matron drop in for parents/Guardians and staff re-established. **Date October 21** Awarded Platinum accreditation. **Date 03/5/22** CQC inspection **Date 8/7/22** NNAP data presented in ACE committee for 2019/202 data. FFT and quarterly Network satisfaction reports continue. All transfers and term admissions datixed and reviewed. Matron drop in sessions continue. Continued work on joint QI projects with obstetric team. **Date 26/11/22** NNAP 2021 report released- areas for improvement ROP, DCC, parents presence on ward round. QI work with MatNeo team launch due 1/12/22 Complaints, medication incidence, FFT and compliments monitored through yellow fin dashboard **Date 5/10/**23 Presenting NNAP 2021 at ACE

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.***
						Date 13/10/23 2022 report released- for highlight summary. Continue to review data quarterly
	Medical workforce in the special care baby unit is compliant with BAPM recommendations as per Optimal arrangements for Local Neonatal Units and Special Care Units in the UK 2018 in all tiers of medical staffing. Medical staffing should be regularly reviewed to ensure appropriate cover for SCBU.	• Monitoring of Rota information • Escalation plans for unplanned leave • Review of daily staffing • Workforce planning • Weekly safe staffing meetings	5/10/23	Neonatal clinical lead Clinical Director	April 2024	**Date 5/10/23** Rota compliant with BAPM framework. ANNP workforce to 7WTE- unable to cover maternity leave. JA
	Tier 3 Medical workforce are required to evidence 8 hours CPD annually in neonatology	• Proforma for evidencing CPD • CPD added to ESR for compliance monitoring • All consultants to evidence in annual appraisal	5/10/23	Clinical Director	April 2024	**Date 5/10/23** ESR compliance monitored by clinical lead and paediatric lead nurse within CYP operational meetings.

Agenda Item 15

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Winter Resilience Plan										
Date:	9 November 2023										
Prepared by:	Rachel Blackmore Care Group Director Responsive Care Matt Wynne Care Group Director Healthy Lives Lindsey Wallace Care Group Director Collaborative Care										
Executive sponsor:	Rowena Dean, Acting Chief Operating Officer										
Purpose of the report	The purpose of this report is to provide the Board of Directors with assurance that the Trust is prepared with its approach to managing the escalation in demand across all operational areas and the system over the winter months.										
Action required:	Approve		Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring		Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The report details the Trusts approach to managing escalations in demand whilst striving to achieve the key NHS England and Regional Delivery Requirements, namely;

- 80% 4-hour performance
- 90% of category 2 ambulance
- Ambulance handovers within 30 minutes.
- Achievement of High Level Impact Interventions;
    - Improve Same Day Emergency Care (SDEC)
    - Frailty.
    - Maintain patient flow:
    - Community bed productivity and flow:
    - Virtual Wards:
    - Urgent Community Response:
    - Care Transfer Hubs

- Protect elective capacity over the winter period to ensure the following by March 2024
    - Elimination of 65-week waits,
    - Reduction the 62-day backlog
    - Meet the Faster Diagnosis Standard

At the beginning of the financial year, the Trust agreed investment in clinical services on a recurring basis in recognition that to deliver the agreed planning and priorities framework for 2023/24 there was a need to develop our services on a sustainable basis. Through this approach, the number of interventions for winter escalation only has been reduced as the Trust has implemented a stepped increase in infrastructure to support achievement of its core quality, safety and service delivery standards throughout the year.

The delivery plan includes

- Community Infrastructure
- Patient Process Facilitators
- Frailty Model
- Additional community beds workforce
- Discharge lounge
- Safer Nursing Care workforce (EAU, ACU, Ward 24,26,36,40,41,42,33)
- Discharge Ambulance (ERS)
- Emergency Department workforce to support Acuity and Resuscitation area
- 24/7 Surgical Decision Unit SDEC
- Additional Emergency / Trauma / urgent planned Operating Theatres
- Maximisation of the University of Hartlepool elective hub.

In addition the following w inter schemes have been funded recurrently through the delivery plan

- Resilience ward – 7 months – Opened 1st October 2023 (5 months decant to support backlog estate maintenance.)
- Additional portering
- Additional Domestic Staff
- Critical Care Outreach enhanced

The Trust has established a 4-hour standard continuous improvement project to support improvements in the 4-hour standard with a focus on our type one performance. Through this approach the introduction of operational delivery managers 7 days a week to support multi-speciality pathway improvement have been recruited and the introduction of an additional senior decision maker within Accident & Emergency overnight to support the services, especially the non-admitted patient pathways has also been implemented.

EAU assessment areas have had remedial work to enhance the assessment / treatment rooms in the short term whilst a capital business case is being developed for long-term expansion of the assessment areas.

Theatre lists are moved to UHH in January with a change in appropriate case mix for the site to ensure only emergency, urgent and cancer patients are prioritised for the inpatient beds on the UHNT site during this period of heighted emergency pressures.

Clear Manager On Call and Director on Call roles with escalation for clinical decisions group to be available to support collective clinical decision making at times of escalation.

The proactive approach to the recruitment of our nursing and AHP staff vacancies has put the Trust in a positive position going into the winter months.

The report details the potential issues and risks for the Trust and associated mitigations.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
BAF 1C compliance and performance BAF 1A Patient Safety and Outcomes BAF 2A Workforce BAF 3C Financial stability and sustainability

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion	x	Reputational	x

Workforce	x	Environmental	
Financial/value for money	x	Estates and Facilities	x
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
N/A		N/A	
Recommendation	The Board to recognise the planning and investment within the organisation to prepare for winter.		

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Winter Resilience Report

Report of the Acting Chief Operating Officer

1. Introduction/Background

The purpose of this report is to provide an overview of the Trusts approach to managing the escalation in demand across all operational areas and the system over the winter months. At the beginning of the financial year, the Trust agreed investment in clinical services on a recurring basis in recognition that to deliver the agreed planning and priorities framework for 2023/24 there was a need to develop our services on a sustainable basis and that this would incorporate surge plans. Through this approach, the number of interventions for winter escalation only has been reduced as the Trust has implemented a stepped increase in infrastructure to support achievement of its core quality, safety and service delivery standards throughout the year.

2. Main content of report

2.1 The National and Regional delivery requirements for winter;

NHS England operational resilience delivery through winter:

- 80% 4-hour performance
- 90% of category 2 ambulance handovers within 30 minutes.
- Achievement of High Impact interventions;
    - Improve Same Day Emergency Care (SDEC): by operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
    - Frailty: Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission and to support discharge.
    - Maintain patient flow: Ambulance handovers & reduced length of stay with a particular focus on bringing forward the discharge processes for pathway 0 patients
    - Community bed productivity and flow: System approach to managing patient flow through pathways inclusive of in hospital and community bed provision.
    - Virtual Wards: Improve the level of care and utilization of virtual wards to prevent avoidable admission to hospital and to support hospital discharge.
    - Urgent Community Response: Increase volume and consistency of referrals to improve patient care, support people safely at home, ease pressure on ambulance services, and reduce avoidable admissions to hospital.
    - Care Transfer Hubs: Continue to build on the local integrated coordination centre model with system partners to reduce variation and maximise access to community rehabilitation and prevent avoidable re-admissions to hospital.

ICB System Resilience Framework:

- Ambulance turnaround within 30 minutes of arrival.

- Improve flow through Emergency Departments to improve patient experience and maintain safety.
- Length of Stay for patients referred to Same Day Emergency Care or Assessment Units being as low as possible.
- Patients that no longer meet the Criteria to Reside (CTR) are supported to move onto the next steps of their journey.
- Community services provide a 2 Hour Urgent Care Response to support patients in their own home and who may otherwise have been admitted to hospital.

Tees Valley LAEDB (Local Area Emergency Delivery Board) winter priorities:

- Getting people to the right place first time and improving discharges and transfers of care (CAS assessment for category 3&4 with ISPA, frailty push/pull and urgent community response)
- Keeping the system flowing well (reduced ambulance handover delays and streaming at the front door)

In addition to the above, the national OPEL (Operational Pressure Escalation Levels) framework has been revised. The OPEL approach lends itself to the timely and consistent identification of operational pressures both internally and externally. Subsequent actions advised include at OPEL 2:

- For patients in ED requiring a specialty review this should happen within 30 minute
- Transfer of patients from the Emergency Department after initial treatment to the requested specialty, if required.
- Director led patient flow meetings four times a day
- Four hourly OPEL review

At ICB level there has been the development of the following policies;

- Mutual aid policy, which is planned to be put in place when all core capacity, has been used and no further option for further capacity can be created.

- Repatriation policy with an aim to ensure patients are repatriated as close to home as soon as possible following specialist care intervention with appropriate escalation to Chief Operating Officers if delays following a request for repatriation is experienced.

- Ambulance handover policy with a zero tolerance to over 59 minute delays, deflections and diversions.

In addition, there is also an expectation that the Trust protects its elective capacity over the winter period. In May 2023, the Trust received direction from NHS England seeking assurance that plans were in place to eliminate 65-week waits, reduce the 62-day backlog and meet the Cancer Faster Diagnosis Standard, by March 2024. A further letter was received on 27 July 2023 in relation to delivering operational resilience across the NHS during winter, with the possibility of ring-fencing elective and cancer capacity throughout the winter period. More recently, on 4 August 2023 the Trust received further correspondence from NHS England, highlighting the need for focused attention on outpatients with a request to provide Board level assurance against a set of activities that they feel will drive outpatient recovery at pace.

Based upon the above expectations, the Trust recognises that there is a need to ensure that there is a balancing of priorities to be achieved through working together as a system, maintaining an agile approach to managing flow across pathways whilst continuing to support the wellbeing of our workforce.

2.2 Implementation of the Delivery Plan

The teams commenced recruiting and developing services in April 2023 to support our demand across the patient pathways throughout the year. Detailed below is an overview of the developments that are being implemented to support achievement of our standards;

- Enhancing the community services infrastructure inclusive of support to Care Homes and work towards supporting alternative offers to patients in the community as opposed to attendance or admission in hospital
- Patient Process Facilitators to assist with in hospital patient flow and coordination
- Frailty Model to ensure that people with the right knowledge, skills and experience are in place to support patients presenting with frailty 12 hours a day, 7 days a week.
- Workforce to support additional community beds to deliver improved patient outcomes and maintain flow.
- Enhancements to out discharge/transport lounge model and the associated workforce required
- Validated Safer Nursing Care Tool data utilised to support in hospital areas and the workforce required to manage acuity/dependency, with an increase of workforce to EAU, ACU, Ward 24, 26, 36, 40, 41, 42, 33
- Discharge Ambulance (ERS) contract to enhance the availability of staffed vehicles to support timely discharge from hospital/ED
- Emergency Department workforce enhancements to support increased resuscitation activity and demand at peak times
- 24/7 Surgical Decision Unit SDEC
- Additional emergency / trauma / urgent planned operating lists
- Maximisation of the University of Hartlepool elective hub
- In line with national programmes, Urgent Community Response and Virtual Ward developments have been progressed with system partners

2.3 Winter Schemes funded recurrently through the delivery plan

- Resilience ward will open for 7 months from 1st October 2023 supporting an additional 29 beds. Historically this was for 5 months but there has been a recognition of the demand on services through the autumn months. From 1st April until end of September, this area supports as a decant area to ensure that critical work can be undertaken inclusive of estate maintenance
- Additional portering support to assist with patient flow at peak times
- Additional Domestic Staff to maintain standards and ensure turnaround times for bed areas are maintained
- Critical Care Outreach support enhanced

2.4 Staffing

It is recognised that our staff are our greatest asset and the commitment and dedication to service delivery, especially in times of escalation is key. Through the delivery plan, there has been a significant investment in substantive workforce this financial year and a key aim was to reduce the need for bank and agency staff. The RN vacancy position for August 2023 is 91.53wte (6.22%) which is a reduction from 96.11wte (6.54%) in July 2023. However, forecasting to the end November

2023 sees the RN vacancy position reduce further to approximately 46wte (3.13%) which sees both the September 2023 newly qualified nurses and cohort 4 of our Internationally Educated Nurses (IEN) move into the establishments. This does not include any additional domestic RN recruitment, which continues monthly. The registered AHP vacancy in August 2023 is 38.99wte (9.23%) which is a reduction from 46.28wte (10.95%) in July 2023. This is a positive position for the Trust going into the winter months.

There is also focussed work on staff wellbeing through our vaccination programme and the suite of well-being offers available to staff to maintain a healthy workforce.

2.5 Other initiatives to support winter

The Trust has established a 4-hour standard continuous improvement project with a focus on our type one performance. Through this approach the introduction of operational delivery managers 7 days a week to support multi-speciality pathway improvement have been recruited. The introduction of an additional senior decision maker within the Emergency Department overnight to support the service through winter, especially the non-admitted patient pathways has also been implemented following a positive impact demonstrated in a pilot during September.

The Trust is currently developing a capital business case to expand the EAU assessment areas and is a key potential development for 2024/25 capital programme; However, to support this area over this winter, remedial work has taken place to enhance the assessment / treatment rooms in the short term.

As part of the winter planning arrangements, theatre lists are moved to the University Hospital of Hartlepool (UHH) in January with a change in appropriate case mix for the site to ensure only emergency, urgent and cancer patients are prioritised for the inpatient beds on the UHNT site during this period of heighted emergency pressures.

Robust manager on call and director on call roles are in place with coordinated internal escalation meetings occurring 7 days a week at 8am, 1pm, 4pm and 8pm that ensure risks and issues are understood and that appropriate actions are progressed to effectively manage and escalate the situation. Arrangements are being developed to support escalation for clinical decisions group to be put in place to support collective clinical decision making at times of escalation.

3. Key issues, risks and mitigations

3.1 Emergency pressures escalation is greater than planned additional capacity. Mitigations include agreed escalation processes through the OPEL framework, Full Capacity Protocol agreed and implemented. Escalation at system level supporting appropriate mutual aid, diverts and deflections.

3.2 Impact on protecting elective recovery in times of increased emergency escalation at both Trust and system level. Clinical priority planning will take place at times of pressures and maximum use of University Hospital of Hartlepool Elective Hub to maintain appropriate elective procedures.

3.3 Increased short-term sickness of staff over the winter period could affect delivery of both emergency and planned capacity. The reduced vacancy factor provides the Trust with improved resilience over the winter months, use of bank and agency at times of escalation.

3.4 Wider stakeholder pressures across the local authority and voluntary sector affecting ability to maintain effective Home First approach, Urgent Emergency Response and Criteria to Reside compliance. The Trust has good relationships with system partners at place and develops plans collaboratively to ensure they work effectively with a clear understanding of interdependencies.

4. Conclusion/Summary/Next steps

4.1 It is recognised that there is an expectation that this winter there will be an increase in emergency / urgent demand across the health and social care system. The Trust has put in place both recurrent and non-recurrent service provision to support management of service delivery over this period with the ability to escalate accordingly to continue providing agile, safe and effective care for our patients.

5. Recommendation

5.1 The Board of Directors is requested to note the content of the report.

Care Group Directors

Agenda Item 16

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	NHS Core Standards for EPRR 2023/24								
Date:	9 November 2023								
Prepared by:	Stewart Ellison – Emergency Planning Officer								
Executive sponsor:	Rowena Dean – Acting Chief Operating Officer								
Purpose of the report	The NHS Core Standards for EPRR set out the minimum requirements expected of NHS organisations to ensure they are able to meet the legislative requirements in respect of the Civil Contingencies Act (2004). This report aims to provide a preliminary update to the Board with regards to the Trusts current position at this stage of the core standards assessment process, with a focus on the following areas: • Overview of the new regional assessment process, timeframe for completion and anticipated organisational impacts. • Preliminary self-assessed compliance rating.								
Action required:	Approve		Assurance	x	Discuss		Information	x	
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services		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:

In June 2023, it was confirmed that all providers across North East and Yorkshire were required to transition to a new core standards assessment process for the 2023/24 core standards period. The Trust was initially notified of this change on 19th June 2023, at which time an overview of the new process, change in evidential threshold and associated guidance documentation was released.

The new process aims to provide a more robust independent assessment of EPRR arrangements to help ensure that a more consistent measure of assurance can be achieved across each provider. As part of the process documentary evidence has been submitted against each standard for independent assessment and verification by regional NHS England colleagues.

It should is acknowledged that the changes to the core standards process provides a mechanism for achieving a greater depth of internal and external assurance. However, there has been joint recognition across the region that, because of the short notice rollout of the new process and changes to the evidential threshold within the EPRR core standards process, there will be a reduction in the Trusts compliance against the EPRR Core Standards for the upcoming year.

As a result of the regional timeline for the assessment process this report provides a preliminary status of the Trusts compliance against the core standards following completion of our our initial self-assessment. A further report will be produced to reflect any recommendations and changes to the

assessed level of compliance following completion of the regional check and challenge of supporting evidence.

Following completion of our self-assessment during the first stage of the 2023 Core Standards process there is a provisional indication that the Trust is **fully compliant** against 77% of the standards applicable to NHS Acute Trusts. This provides a preliminary organisational assurance rating of **Partial Compliance**, demonstrating that the Trust has assessed itself as being fully compliant against 77-88% of applicable NHS EPRR Core Standards. The preliminary compliance rating contained within this report is subject to change

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
EPRR Board Assurance Framework 1D			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Trust Resilience Forum – 6 November 2023			

Recommendation	It is requested that the Board of Directors support the following recommendations: 1. Note the content of this report, the areas of improvement identified and the ongoing work taking place to address gaps in EPRR arrangements. 2. Acknowledge that due to the changing nature of risks and expectations with regards to emergency preparedness, the development and implementation of EPRR arrangements is a dynamic process, where adaptation, improvements and reflective learning is required on an ongoing basis to help meet changing national best practice. 3. Accept this report as a preliminary summary of our compliance against the 2023/24 EPRR Core Standards assessment period and acknowledge that a further report will be submitted to the Board of Directors in February to detail the Trusts final level of compliance, a summary of work completed over the past 12 months and a forward EPRR work programme for the upcoming year.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

NHS Core Standards for EPRR 2023/24

1. Introduction/Background

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

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

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

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

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

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

1.6. Although the annual assurance process is still underway, this report aims to provide a preliminary update to the Board with regards to the Trusts current position at this stage of the process, with a focus on the following areas:

- Overview of the new regional assessment process, timeframe for completion and anticipated organisational impacts.
- Preliminary self-assessed compliance rating.

2. Main content of report

Changes to the Annual Assurance Process

2.1. In June 2023, it was confirmed that a new format for the EPRR core standards assessment, which was piloted in the Midlands during the 2022/23 assessment period, would be implemented across other NHS regions as part of a phased rollout. As part of this programme of work all providers across North East and Yorkshire have been required to transition to the

new assessment process for the 2023/24 core standards period. The Trust was initially notified of this change on 19th June 2023, at which time an overview of the new process, change in evidential threshold and associated guidance documentation was released.

2.2. The new process aims to provide a more robust independent assessment of EPRR arrangements to help ensure that a more consistent measure of assurance across each provider can be achieved. To support the new process, a more detailed, structured overview of expectations with regards to full compliance was issued to help remove subjective interpretation of standards and better highlight where improvements can be made. As part of the process documentary evidence was also required to be submitted against each standard for independent assessment and verification by regional NHS England colleagues in support of the self-assessed position of providers.

2.3. It is acknowledged that the changes to the core standards process provides a mechanism for achieving a greater depth of internal and external assurance. However, there has been joint recognition across the region that, because of the short notice rollout of the new process, there is likely to be a corresponding reduction in organisational compliance across the region whilst providers work to adapt EPRR arrangements to better reflect the evidential expectations set out within the new process. The potential for reduction in organisational compliance is evidenced through the results of the 2022/23 pilot where 66% of Trusts saw a significant reduction in their level of compliance, with over 30% of Trusts moving to a status of non-compliance. The potential for a reduction in organisational compliance as a result of the new process was acknowledged in a letter from the North East and North Cumbria Integrated Care Board in September 2023 where it was highlighted that 'due to significant changes in the assurance process this year, there may be an impact on the reported level of compliance across providers'. It was further acknowledged that although organisational compliance may be affected in the short term that the 'process should support more reliable assurance and point up areas for further work to strengthen future arrangements going forward'.

2023/24 EPRR Core Standards Timeline:

2.4. The following table highlights the separate stages and agreed timeline for the 2023 EPRR Core Standards Assurance Process for the North East and Yorkshire NHS region.

Time Period (No Later Than)	**Assessment Stage**	**Process**
29 September 2023	• Self-Assessment and Submission of Evidence	Organisations to submit initial self-assessment, together with associated evidence, signed off by Accountable Emergency Officer.
27 October 2023	• Primary Evidence Review (NHSE/ICB)	Review of organisational evidence by regional teams.
24 November 2023	• Supplementary Evidence Submission and Review • Cross Organisational Confirm and Challenge • Final Submission of Compliance	Organisations to submit supplementary evidence (where required) in support of their stated position prior to submission of final compliance statements.
31 December 2023	1. Assurance	Organisations to provide assurance report to the Board of Directors and National Team, together with an updated action plan for improving compliance.

2.5. The first stage of the core standards assessment process was completed on 29th September 2023, where a self-assessment of the Trust's organisational compliance together with accompanying evidence was submitted to the Regional NHS England team for review.

2.6. Following completion of our initial self-assessment, it has been recognised that there will be a reduction in compliance between the 2022/23 and 2023/24 assessment period. However, the final position of the Trusts compliance level for this period will not be fully understood until the full regional check and challenge process has been completed. Initial feedback on the Trusts self-assessed position was received on 27th October and is currently under review.

2.7. In order to meet the expectations set out within the core standards process it is necessary to provide an update to the Board on the Trusts status of compliance by 31st December. However, in light of the regional timeline for completion of the assurance process, it should be noted the content of this report is only able to reflect the result of our position as of the 31st October 2023, recognising that this does not include the outcome of feedback received from NHS England and our final, agreed status of compliance for the 2023/24 assessment period, and may be subject to change. A further report will be submitted to Board in February 2024 to provide our final status of compliance together with:

- A reflection of associated risks and mitigations.
- Updated status of the EPRR work programme over the previous core standards period.
- A reflection of incidents and disruptions within the Trust over the past 12 months
- A preliminary EPRR improvement plan for the upcoming year.

Preliminary Status of Core Standards Assessment (as at 31st October 2023)

2.8. Following completion of our self-assessment during the first stage of the 2023 Core Standards process it felt that the Trust was **fully compliant** against 77% of the standards applicable to NHS Acute Trusts. The following table shows the self-assessed status of compliance against each of the specified domains:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to Risk Assess	2	2	0	0	0
Duty to Maintain Plans	11	7	4	0	0
Command and Control	2	1	1	0	0
Training and Exercising	4	2	2	0	0
Response	7	4	3	0	0
Warning and Informing	4	4	0	0	0
Cooperation	4	3	0	1	3
Business Continuity	10	10	0	0	1
Hazmat/CBRN	12	9	0	0	7
Total	**62**	**48**	**10**	**1**	**11**

2.9. It should be noted that the scoring mechanism for the core standards only recognises those standards which have been highlighted as fully compliant, within the final percentage scoring. All standards that are highlighted as either partially compliant or non-compliant reduces the final

rating equally, regardless of the associated level of risk or reason for reduced level of compliance.

2.10. The results of the Trust's initial self-assessment indicates that we have a preliminary organisational assurance rating of **Partial Compliance**, demonstrating that the Trust has assessed itself as being fully compliant against 77-88% of applicable NHS EPRR Core Standards.

3. Key issues, significant risks, controls and mitigations

3.1. The initial phase of our self-assessment for the 2023/24 core standards assessment period demonstrates that there will be a reduction in compliance between the 2022/23 and 2023/24 core standards periods with a provisional indication that the Trust will move from a rating of substantial compliance to one of partial compliance. Whilst recognition should be given to the reduction in compliance level it should be noted that the drop in compliance is a reflection of current EPRR arrangements against the higher evidential threshold set out in the new process, resulting in a greater number of areas of partial compliance, and does not necessarily reflect a higher level of risk in the ability of the Trust to respond to emergencies and maintain the safety of patients.

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

3.3. Once the final core standards status has been agreed for the upcoming year any gaps in compliance and identified areas for improvement will be appropriately assessed and will help support the development of a risk rated EPRR work programme across the upcoming year.

Provisionally Identified Areas of Partial and/or Non-Compliance

3.4. As part of the Trust's self-assessment the following standards have provisionally been assessed as areas of partial and/or non-compliance. A summary of the reasons for the assessed level of compliance has been provided against each standard listed. It should be noted that the areas highlighted below are subject to change, following completion of the regional check and challenge process, and an updated position will be reported to Board when available.

Domain	Standard Ref	Standard	Self-Assessed Compliance Level	Summary for Level of Compliance / Identified Areas for Improvement
D3	CS15	Mass Casualty Plan	Partial Compliance	2. Current plan in a period of transition. A new standalone mass casualty plan to be developed following development and full implementation of new incident response and coordination processes.

	CS16	Evacuation and Shelter Plan	Partial Compliance	3. Plan due for review.
	CS17	Lockdown Plan	Partial Compliance	4. New Lockdown plan under development.
	CS18	Protected Individuals Plan	Partial Compliance	5. Plan due for review.
D4	CS21	Trained on Call Staff	Partial Compliance	6. Awaiting finalisation of regional health commander portfolio process. Once finalised this will be implemented within the Trust. 7. Command staff working towards completion of national principles of health command training launched in September 2022. 88% of command staff have currently completed training.
D5	CS22	EPRR Training	Partial Compliance	8. Command staff working towards completion of national principles of health command training launched in September 2022. 88% of command staff have currently completed training. 9. Formal EPRR training needs analysis covering all necessary staff roles to be produced. 10. Awaiting finalisation of regional health commander portfolio process. Once finalised this will be implemented within the Trust. Continue to build a full forward programme of EPRR training.
	CS24	Responder Training	Partial Compliance	11. Awaiting finalisation of regional health commander portfolio process. Once finalised this will be implemented within the Trust. 12. New process for recording all EPRR training through use of ESR to be completed. Work underway but retrospective upload of EPRR training to system still to be undertaken.
D6	CS29	Decision Logging	Partial Compliance	13. Process for incident log keeping to be reviewed to ensure full alignment with National requirements.

D8	CS37	LHRP Engagement	Non-Compliant	14. No attendance over the past 12 months. Forward programme of dates has now been received into the Trust and attendance will be maintained in line with national requirements going forward.
D10	CS55	Hazmat/CBRN Governance	Partial Compliance	15. Clarity with regards to direct responsibility for CBRN/Hazmat to be added to the EPRR policy.
	CS58	Hazmat/CBRN Plan	Partial Compliance	16. CBRN plan due for review.
	CS61	Equipment Preventative Programme of Maintenance	Partial Compliance	17. Further work to be undertaken to ensure a structured annual programme of planned maintenance across all CBRN equipment can be evidenced.

4. Conclusion/Summary/Next steps

4.1. As reflected in this report it should be recognised that, although there has been some key improvements made to EPRR processes over the past 12 months, the changes to the evidential threshold within the EPRR core standards process will result in a reduction in the Trusts compliance against the EPRR Core Standards for the upcoming year.

4.2. Although this report reflects the status following the initial self-assessment of standards by the Trust a further report will be produced to reflect any recommendations and changes to the assessed level of compliance following completion of the regional check and challenge of supporting evidence as detailed within the agreed regional timeline.

4.3. Further information pertaining to the key improvements to EPRR processes, incidents and disruptions that have impacted the Trust over the past 12 months and risk reduction plans relating to the current assessment period will be reported to the Board in February 2024

5. Recommendation

5.1. It is requested that the Board of Directors support the following recommendations:

4. Note the content of this report, the areas of improvement identified and the ongoing work taking place to address gaps in EPRR arrangements.

5. Acknowledge that due to the changing nature of risks and expectations with regards to emergency preparedness, the development and implementation of EPRR arrangements is a dynamic process, where adaptation, improvements and reflective learning is required on an ongoing basis to help meet changing national best practice.

6. Accept this report as a preliminary summary of our compliance against the 2023/24 EPRR Core Standards assessment period and acknowledge that a further report will be submitted to the Board of Directors in February to detail the Trusts final level of compliance, a summary

of work completed over the past 12 months and a forward EPRR work programme for the upcoming year.

Stewart Ellison
Emergency Planning Officer

Appendix 1 – NHS Core Standards for EPRR Domain Overview

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

Agenda Item 17

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Assurance Report of the Quality Committee										
Date:	28 October 2023										
Prepared by:	Fay Scullion, Non-Executive Director – Chair of QAC										
Executive sponsor:	Lindsey Robertson, Chief Nurse and Director of Patient Safety and Quality										
Purpose of the report	The purpose of this report is to provide the Board with an update in relate to Patient Quality and Safety: - Identifying key emerging themes and trends that may have an impact on Quality and Safety - Risks for the Board to note - Provide reassurance to the Board										
Action required:	Approve		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				
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:

Summary Context

Each meeting commences with the patient story, as this has strengthened the connect between the strategy and delivery and demonstrates the impact on the local population.

The Board Assurance Framework is the primary agenda item and a focus of the Quality Assurance Committee, which generates scrutiny and discussion. In addition, there are standing reports aligned to the annual work plan, that are provided as an annual update, or a quarterly update as well as Executive Summary Reports. The new summary sheets are providing a good focus for discussion highlighting the key issues.

Key Issues

Agreed the merged BAF (1a & 1b) to one Quality BAF

- The high risk in regard to Neonatal and Children and Young People's acute service delivery and associated pathways, primarily Consultant Paediatric workforce, has now reduced to moderate following work undertaken within the Healthy Lives Care Group. All risks continue to be monitored through the appropriate governance structures.
- Although infection rates continue to increase across the system, the Trust continues to be a positive outlier in relation to C.Diff.
- The Outpatient Transformation work continues with the Health Inequalities project where patients or carers from low deprivation areas are contacted prior to their appointment. If the patient is unable to attend, they are re-booked for an appointment that is convenient to them.
- Gastroenterology has now gone live with PEP - allowing patients to effectively manage their appointments. This will be rolled out to other services as part of a phased plan.
- The Trust is achieving three out of ten cancer standards, and there will be a change to the metrics

to be reported from October following a national consultation, reducing from the current ten standards down to three. Key breach themes across the cancer standards this month were reported as a result of delay to diagnostic procedures, reporting and multiple investigations required.

- The Trust's local population reside in one of the most deprived areas in the country, with the rates of smoking one of the highest in the North East and is reflected in the maternity population. The Trust continues to support patients in reducing smoking to help optimise the health of the newborn and mother. Significant achievement noted at time of birth for mothers stopping smoking due to the QI projects in place.
- The Trust continues to reduce Postpartum Haemorrhage (PPH) rates, which can be attributed to the recent introduction of the Quality Improvement (QI) project.
- Breast feeding rates within the Trust fall below the North East & North Cumbria average and one of the lowest in the region. To improve the take up rate throughout 2023, the Trust has employed an infant feeding specialist midwife with a key focus on gaining the breast feeding initiative. The Trust has achieved BFI level 1.
- There have been positive developments around organ donation with an increase in donations
- A question was raised with regards to the need to ensure that Lying and Standing BP was undertaken when needed and Stephen Green was asked to review the risk.
- The harrowing patient story of a child who has died, not in this Trust, has demonstrated that the Trust has made a positive improvement following recommendations on food to be made available to parents or carers of a child when in hospital.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
The Committee reflects on the BAF objectives and the September position was presented at the October meeting. The BAF objectives are: 1a Patient Safety 1b Patient Experience (now merged) 1d EPRR 3a Transforming Our Services

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	x
Workforce	x	Environmental	
Financial/value for money	x	Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
Some agenda items are discussed at Quality Assurance Council and escalated to Quality Assurance Committee by exception.	

Recommendation	The Board are asked to approved the report and be assured that the work continues in line with the Trust portfolio.

Agenda Item 18

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Assurance Report of the Resource Committee								
Date:	9 November 2023								
Prepared by:	Chris Macklin, Non-Executive Director (Chair)								
Executive sponsor:	Kate Hudson-Halliday, Director of Finance								
Purpose of the report	To provide assurance to the Trust Board regarding the efficiency and effectiveness of the Resource Committee meeting on 24 October 2023.								
Action required:	Approve		Assurance	x	Discuss		Information	x	
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People		Transforming our Services	x	Health and Wellbeing		
Which CQC Standards apply to this report	Safe		Caring		Effective	x	Responsive	x	Well Led	x

Executive Summary and the key issues for consideration/ decision:

The meeting was confirmed as quorate, in accordance with the Terms of Reference.

Agenda Items were discussed in detail with key issues noted and actions agreed.

Matters for Escalation

There were no matters for escalation.

Key Issues Discussed

Minutes of the meeting held on 26th September 2023 were recorded and approved.

A wide range of issues were discussed including:

- Terms of Reference for the Committee
- Integrated Performance Report (reporting to 30th September 2023)
- Protecting and Expanding Elective Capacity Gap Analysis Operations Report (Presented to Board 5th October 2023)
- Elective Hub Update
- Governance Structure
- Planning & Performance Board Assurance Framework & Risk Update Report – Performance (reporting to 30th September 2023)
- Financial Position and Performance – Month 6 (reporting to 30th September 2023)
- CIP Update (reporting to 30th September 2023)
- Finance Board Assurance Framework & Risk Update Report – Finance (reporting to 30th September 2023)
- I&TS Update & Assurance Report September 2023
- Digital Board Assurance Framework & Risk Update Report – Digital (reporting to 30th September 2023)

- Transformation Update Report (reporting to 30th September 2023)
- Transformation Board Assurance Framework & Risk Update Report – Transformation Internal and External (reporting to 30th September 2023)

Decisions Made

- Terms of Reference approved and agreed by the committee.
- Integrated Performance Report noted by the committee.
- The Integrated Commissioning Board (ICB) assurance template with regard to protecting and expanding elective capacity was noted by the committee.
- The extension of two planned risk reduction action noted in the Finance Board Assurance Framework & Risk Update Report for Finance was agreed by the committee, subject to Audit Committee approval.
- Confirmed continued support for I&TS function in the delivery of Digital Strategy reported in the I&TS Update & Assurance Report covering September 2023
- Approved the realignment of strategic risks associated with the previous transformation BAFs 3b and 3e.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
This report links to the Finance, Performance and Digital BAF domains.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money	x	Estates and Facilities	x
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Resource Committee – 24 October 2023			
Recommendation	The Board of Directors is requested to note this summary report of the minutes of the Audit Committee meeting held on 26 September 2023.		

Agenda Item 19

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report	Assurance Report of the Risk Management Group										
Date	9 November 2023										
Prepared by	Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary										
Executive sponsor	Neil Atkinson, Managing Director										
Purpose of the report	To provide assurance to the Board of Directors regarding the Risk Management Group meeting on 27 October 2023.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
CQC Domain(s) supported by this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Matters for Escalation

There were no new risks that require escalating to the Board of Directors. All risks have been reported via the Business Team, monthly Directors Performance Team Meeting and strategic risks have been reported to the assurance Committees that met in September 2023, via the BAF domains.

The Trust continues to report two red risks relating to the Trust's ageing estate (current risk score of 20) and the delivery of savings (current risk score of 16).

Key Issues Discussed

The meeting of the Board of Directors on 29 September 2023 was held virtually (via e-mail) and there were no minutes required to be approved.

The content of the papers for the meeting on 27 October 2023, included the following key areas;

- Risk Register Report (to 30th September 2023)
- Committee BAF and risk update
- Risk management enabling – governance structures and corporate plans on a page
- AuditOne overdue recommendations
- Committee Forward Plan

Actions

- It was agreed that outstanding governance structures and corporate plans on a page will be presented and approved at assurance committees during November 2023.

- A report on the completed HFMA governance training will be provided at the Risk Management Group meeting in November 2023.
- Using new software, a demonstration will be made at the next Risk Management Group meeting in November on bite-size content that will increase the awareness of the Trust's risk management process.
- A summary of operational risks assigned to the existing 12 BAF domains will be presented at the next meeting based on the revised 7 BAF domains.

Decisions Made

It was agreed that the monthly report on open and overdue recommendations will be presented to the Risk Management Group and this will be a standing agenda item.

Strategic Risk linked to the Board Assurance Framework this report relates to:
This report links to all domains in the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and Facilities	X
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	x

Board committees where this item has been considered	Management Group meetings where this item has been considered
N/A	Risk Management Group (27th October 2023)

Recommendation	The Board of Directors is requested to; - Note the assurance report from the Risk Management Group meeting on 27th October 2023; and - The monthly open and overdue recommendations report will be a standing agenda item of the Risk Management Group.

Agenda Item 20

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Data Protection SIRO Report - DSPT Year End 2022/23										
Date:	9 November 2023										
Prepared by:	Neil Dobinson, Interim Deputy Chief Information Technology Officer										
Executive sponsor:	Ken Anderson, Chief Information Technology Officer / SIRO										
Purpose of the report	The purpose of this report is to provide an update and level of assurance to the Trust Board of Directors relating to the range of Information Governance (IG) and cyber security activities within the Trust.										
Action required:	Approve		Assurance	x	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe	x	Caring		Effective	x	Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

1. Information Governance (IG) Framework

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

2. Information Governance (IG) - Key Performance Indicators 2022/23

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

KPI Indicator	2022/23 Trust Target	2022/23 Actual	Previous Year
Data Security Training Completed By Staff In Period	95%	95.4%	<2%
Subject Access Requests - Complaince with response period of one calendar month (cumlatitve % for the period)	98% > 100%	98%	=
DSPT Toolkit Compliance @ year end for mandatory compliance requirements	100%	100%	=

3. Information Governance Risks

Operational Risk Position (including Cross Cutting Risks)			
Number of Risks/only BAF 3d	⬆30 /10 ⬆	Number overdue review	⬆ 5
Number of Tolerated Risk	⬆ 22	Number of Issues	⟺3
Number of Actions agreed	⬆ 26	Number of risk within appetite	⬆17 (11 below⬇)

4. Data Protection by Design

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

5. Data Security Protection Toolkit (DSPT) 2022/23

The Trust submitted its DSPT submission on the 29 June 2023. The Trust has self-assessed compliance with all 10 standards and all 113 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the 2022/23 DSPT.

The 2022/23 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during March & April 2023 prior to the DSPT submission.

The Trusts independent risk assessment scored the Trust as 'Substantial' for eight and 'Moderate' for two of the ten National Data Guardian Standards (see table1 in main report). All recommended actions for the two moderate areas were completed and verified by the auditor prior to the DSPT submission date providing the Trust with substantial assurance for all 10 standards.

The overall confidence level of the independent assessor in the veracity of the self-assessment was rated as '***Substantial'.***

6. Incident reporting

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

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

The Trust actively encourages staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy. During the 2022/23 DSPT reporting period the Trust reported three potential high-risk incidents to the ICO, down from four in the previous reporting period. All incidents reported to the ICO have since been closed by the ICO with no further actions pending.

7. Cyber Security

The Trust has focused activity on ensuring that the following required mitigations are in place:

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

8. Reporting and Assurance

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
This impacts on the Digital BAF domain.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	x
Workforce	x	Environmental	
Financial/value for money	x	Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
• I&TS Governance Group • Digital Strategy Committee (now disbanded and replaced by Resources Committee in September 2023)			
Recommendation	The Board of Directors are asked to note progress to date and confirm their approval of the approach, governance and assurance methods outlined in this report.		

North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Data Protection SIRO Report - DSPT Year End 2022/23

1. Background

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

2. Purpose

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

3. Organisational Context

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

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

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

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

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

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

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

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

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

4. Information risk, roles and responsibilities

4.1. Senior Information Risk Owner (SIRO)

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

4.2. Data Protection Officer (DPO)

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

4.3. Information Asset Owners (IAO's)

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

4.4. Information Asset Administrators (IAA's)

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

4.5. Caldicott Guardian & Deputy Caldicott Guardian

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

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

5. Information Governance (Data Protection)

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

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

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

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

5.1. Policy and Strategy

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

Policies & Strategies	Standard Operating Procedures	Privacy Notices
IG40 – Clear desk and screen policy	ICT-SPAP1 Systems Privileged Access Protocol	NT&H Employee Privacy Notice
IG45 – National Patient Opt Out Policy	HCR-SAR01 Right of Access, Rectification, Restriction and Erasure	NT&H Patient Privacy Notice
	IG-PBD01 Data Protection by Design and Default – DPIA Procedure	NT&H Patient Privacy Notice (Children's)

5.2. Strategic & Operational Risks

Operational I&TS risks continue to be populated into the Datix risk reporting system and are reviewed in accordance with the Risk Management Policy and are presented to the I&TS Governance Group meeting on a monthly basis. These risks are referenced in the startegic Board Assurance Framework(BAF) where operational risks link to strategic risks.

Operational I&TS risk themes inculde:

- Storage of corporate & healthcare paper records
- Correspondence errors
- Access to data via Trust systems and networks

- Staff non-compliance with policy and procedure
- The use of email
- Cyber security
- Connected medical devices
- Departmental resources

Operational Risk Position (including Cross Cutting Risks)			
Number of Risks/only BAF 3d	⇧30 /10 ⇧	Number overdue review	⇧ 5
Number of Tolerated Risk	⇧ 22	Number of Issues	⇔3
Number of Actions agreed	⇧ 26	Number of risk within appetite	⇧17 (11 below⇩)

The Chief Information & Technology Officer (CITO) and Deputy CITO, in liaison with the I&TS senior team, continue to review the strategic risk via Board Assurance Framework on a monthly basis to ensure it reflects the known and anticipated challenges of 2023/24 and potential impact of the delivery of strategic objectives. The current approved risk appetite of the I&TS (Digital) section of the BAF is 'OPEN' which translates to being willing to consider all potential options and select those with the highest probability of productive outcomes.

The inherent, current and target risk scores for the six strategic risks are provided in the table below, including the date that risk scores were last amended and reviewed.

Strategic Risk Theme	Inherent	Current	Target	Movement	Last amended	Last reviewed
New System Implementation	5 x 3 - 15	3 x3 = 9	2 x 3 = 6	⇔	Jan 2023	Sept 2023
Data breaches	5 x 4 = 20	3 x 4 = 12	2 x 4=8	⇔	Jan 2023	Sept 2023
Cyber-attack	5 x 4 = 20	3 x 4 = 12	2 x 4=8	⇔	Jan 2023	Sept 2023
Insider threat	4 x 4 = 16	2 x 4 = 8	1 x 4 = 4	⇔	Jan 2023	Sept 2023
People & Process	4 x 4 =16	3 x 4 = 12	1 x 4 = 4	⇔	Jan 2023	Sept 2023

Key Risk Considerations:

- ***BAF Review*** - The BAF and its strategic and operational risks and its risk appetite are currently under review as part of a deep dive review into the Digital BAF. An updated BAF will be presented back via the I&TS Governance Group and then into the Resource Committee for consideration and approval at the November 2023 meeting.

- ***Cyber Threats/ GCHQ/ NCSC*** - Changing cyber security landscape with new emerging threats constantly change the landscape in which we operate to maintain safe and secure services. The Trust maintains and active monitoring stance to review new and emerging threats to consider the impact on strategic and operational risk.

- ***Digital Strategy*** - Digital and Cyber Strategy alignment with South Tees to form a Group digital and cyber strategy may impact both the strategic and operational risks in this area and the BAF and Datix risks will be reviewed as part of this process.

- ***Data Protection and Digital Information Bill (No2/2023)*** – the bill has been introduced to parliament and it is anticipated it could become legislation circa March 2024. We should monitor the Bill's progress and consider what, if any, changes we wish to make when it becomes law to ensure that it does not impact on our strategic and operational risk.

5.3. IG Key Performance Indicators (KPI)

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

KPI Indicator	2022/23 Trust Target	2022/23 Actual	Previous Year
Data Security Training Completed By Staff In Period	95%	95%	<2%
Subject Access Requests - Complaince with response period of one calendar month (cumlativte % for the period)	98% > 100%	98%	=
DSPT Toolkit Compliance @ year end for mandatory compliance requirements	100%	100%	=

5.4. Data Security and Protection Toolkit (DSPT) – June 2023 Submission

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

Personal Confidential Data
Staff Responsibilities
Training
Managing Data Access
Process Reviews
Responding to Incidents
Continuity Planning
Unsupported Systems
IT Protection
Accountable Suppliers

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. The DSPT for 2022 set out 113 mandatory evidence items which cover these 10 standards, the Trust must evidence compliance against all ten in order to gain full compliance.

The Trust submitted its DSPT submission on the 29 June 2023. The Trust has self-assessed compliance with all 10 standards and all 113 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the 2023 DSPT.

The 2023 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during March /April 2023 prior to the DSPT submission.

The Trusts independent risk assessment scored the Trust as 'Substantial' for eight and 'Moderate' for two of the ten National Data Guardian Standards (see table1). All recommended actions for the two moderate areas were completed and verified by the auditor prior to the DSPT submission date providing the Trust with substantial assurance for all 10 standards.

The overall confidence level of the independent assessor in the veracity of the self-assessment was rated as '***Substantial'.***

Table 1: Overall risk rating:

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

5.5. Incident reporting 2022/23

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

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

The Trust actively encourages staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy. During the 2022/23 DSPT reporting period the Trust reported three potential high-risk incidents to the ICO, down from four in the previous reporting period. All incidents reported to the ICO have since been closed by the ICO with no further actions pending.

The following incidents were reported to the Information Commissioners Office (ICO) in the DSPT 2022/23 reporting period (July 2022 to June 2023):

Incident ID	Reported Date	Brief Description	Outcome
31558	09/03/2023	Disclosure of personal data in error caused by non-compliance with Trust policy – Impact on one data subject	• Incident closed by ICO • Additional staff training given / procedures reviewed • Low risk of harm
31203	09/02/2023	Physical theft of personal data (paper) from secure Trust premises with potential for disclosure of limited personal data - Impact on up to 18 data subjects	• Incident Closed by ICO • Security procedures reviewed • Data subjects informed • Low risk of harm
29111	17/08/2022	Unauthorised sharing of data by staff member. Non-compliance with Trust policy – Impact on one data subject	• Incident Closed by ICO • HR disciplinary actions as per policy • Additional staff training given • Low risk of harm

As in previous years, in order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred during 2022/23 the following key actions were undertaken or are planned:

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

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

5.6. Data Protection by Design

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

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

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

The Trust continues to see a strong compliance and buy in from services with 'Data protection by design' principles and this is reflected in the number of new DPIA's which have been submitted in 2022/23 for projects which meet the mandatory criteria.

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

5.7. Data Protection and Security Audits 2022/23

Throughout 2022/23 the Information Governance team have undertaken data protection and security audits in 33 different randomly chosen locations with a split between clinical and non-clinical departments with 23 at North Tees, 7 at Hartlepool and 3 in community settings. The purpose of these audits is to ensure that the departments within the Trust are complying with Trust data protection and security policies and procedures and where they are not being followed actions have been assigned and mitigated.

As a result of the audits a number of actions were assigned (not detailed in this report for security reasons) and successful mitigation put in place to ensure compliance to policy and procedure. No major actions were identified during the 2022/23 audit.

The full audit report has been submitted to the I&TS Governance Group for assurance.

6. Cyber Security

The Trust has implemented a Cyber Security Strategy and is actively engaging with NHSE and partners to further underpin the Trust cyber readiness. As part of this, the Trust is undertaking rigorous testing in the form of independent cyber assessments using the Cyber Essentials Plus assessment, DSPT and the National Cyber Security Centre health check assessment and exercises.

In line with National Cyber Security Centre advice central NHS Operational Instructions & Advice on improving cyber security resilience. The Trust has focused its mitigation activity in the following areas:

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

The Trust's SIRO, IT and security team are reviewing the suggested improvement actions and request board support for any required technical and or process measures required to ensure compliance. The SIRO will provide a further update to board including actions and requirements derived from this exercise.

6.1. Cyber Security Risks

The Trust has identified various risks linked to the Trust's cyber security challenges, which were identified following an ICT Security Audit. There are currently twelve cyber security risks on the corporate risk register, all rated as 'Medium Risk'.

Summary of the current Cyber risks*:

ID	Risk Title	Description
6166	Connected Medical Devices and Equipment	Medical devices running outdated and unpatched computer operating systems that also do not have Anti-Virus on them or may be unsupported.
6165	Cyber Threat Exploit Kits	Exploit kits include a collection of ready-made exploits usually planted in compromised websites or used in advertising campaigns. Exploit kits have the ability to identify exploitable vulnerabilities in a user's browser or web application and automatically exploit them.

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

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

7. Reporting and Assurance

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

8. Recommendations

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

Neil Dobinson
Interim Deputy Chief Information and Technology Officer

Agenda Item 21

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation Report										
Date:	9 November 2023										
Prepared by:	Emma Roberts, Associate Director of Nursing and Professional Workforce										
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality										
Purpose of the report	The report presents the Board of Directors with the current revalidation process in place for registered nursing, maternity, Nursing Associate and Allied Health Professional staff.										
Action required:	Approve		Assurance	x	Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing				
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

This report outlines the expectations of the registrants from the Nursing and Midwifery Council (NMC) and the Heath and Care professions council (HCPC) and the Trust level monitoring in place to ensure all staff are compliant with revalidation requirements and standards.

In the M1 – M6 FY23/24 there were 109 registrants due to revalidate. 96 completed revalidation, and it is determined that no staff are working in patient-facing roles without a valid registration. Rationale for the remaining 13 staff that were due to revalidate but have not done so in the period.

It is evident that through regular reporting and escalation, staff and managers are aware of upcoming revalidation requirements, allowing sufficient time for the revalidation to be completed

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

2a - Workforce

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
People Committee – virtual 30 October 2023	People Group

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

9 November 2023

Nursing, Midwifery, Nursing Associate and Allied Health Professional Revalidation

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

1 Introduction

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

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

2 Preparation and support for registrants

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

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

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

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

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

3 Monitoring compliance

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

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

If a registrant fails to renew their registration or to revalidate, an alert is flagged centrally and to a member of the Workforce Team and the Head of Employee Relations. The HR Employment Checks Policy is currently being refreshed and is in the Policy Group process to update the section on registration. This is to ensure a consistent approach on all issues connected with lapse registrations (whatever the reason). All registration lapses will go through an MDT panel who will determine an appropriate interim resolution, including restrictions to non-patent facing duties until full registration is restored. All MDT meetings involving nursing issues have a Senior Nurse of the Day on the panel to provide professional advice.

4 Revalidation data

Data extracted from ESR from 1 April 2023 to 30 September 2023 showed that 109 registered nurses were due to revalidate (table 1). Of the 109, 96 staff (88%) completed their revalidation leaving 13 staff (12%) un-validated within the ESR system. Following review of these 13 members of staff, it was found that 6 of them are currently in non-nursing roles, 2 have left the Trust, 2 have their revalidation due by the end of October 2023, 1 has an extension till the end November 2023 following maternity leave and 2 are employed on zero hour contracts (covid) and are not currently working within the Trust.

Table 1

Month	Total to Revalidate	Revalidated
Apr-23	8	7
May-23	5	4
Jun-23	4	1
Jul-23	29	27
Aug-23	52	48
Sep-23	11	9
Total	**109**	**96**

5 Recommendation

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

Lindsey Robertson
Chief Nurse / Director of Patient Safety and Quality