Group Board Meeting

Thursday, 3 July 2025 at 13:00

Cameron Suite, Health and Social Care Academy, 2nd Floor, University Hospital Hartlepool

University Hospitals Tees

MEETING OF THE GROUP BOARD TO BE HELD IN PUBLIC
ON THURSDAY 3 July 2025 AT 1:00pm
CAMERON SUITE, HEALTH AND SOCIAL CARE ACADEMY,
2ND FLOOR, UNIVERSITY HOSPITAL HARTLEPOOL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
CHAIR'S BUSINESS					
1.	Patient/Staff Story	Information	Group Chair	Verbal	13:00
2.	Welcome and Introductions	Information	Group Chair	Verbal	13:20
3.	Apologies for Absence	Information	Group Chair	Verbal	
4.	Quorum and Declarations of Interest	Information	Group Chair	ENC	
5.	Minutes of the last meeting of the held on 8 May 2025	Approval	Group Chair	ENC	13:25
6.	Matters Arising and Action Log	Information	Group Chair	ENC	13:30
7.	Group Chairman's Report	Information	Group Chair	ENC	13:35
8.	Group Chief Executive's Report	Information	Group Chief Executive	ENC	13:45
9.	Group Management Team Chairs Log: 22 May 2025	Information	Group Chief Executive	ENC	14:00
10.	University Hospital Tees (UHT) Strategy Update	Assurance	Group Chief Strategy Officer	ENC	14:05
11.	Board Assurance Framework – 30 April 2025	Assurance	Director of Risk, Assurance & Compliance	ENC	14:15
QUALITY AND SAFETY					
12.	Quality Committee Chairs Log: 27 May and 23 June 2025	Assurance	Chair of Committee	ENC	14:25

Group Board – the Group Board is the Board of Directors for North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

	ITEM	PURPOSE	LEAD	FORMAT	TIME
13.	STHFT Patient Experience Annual Report	Assurance	Group Chief Nurse	ENC	14:35
14.	Infection Prevention Control: - Improvement Plan & Strategy - NTHFT & STHFT Annual Report	Assurance	Group Chief Nurse	ENC	14:40
PEOPLE					
15.	People Committee Chairs Log: 27 May & 25 June 2025	Assurance	Chair of Committee	ENC	14:50
16.	Guardian of Safeworking Report	Assurance	Group Chief Medical Officer	ENC	15:00
17.	Nurse Safer Staffing Report – April 2025	Assurance	Group Chief Nurse	ENC	15:10
FINANCE & PERFORMANCE					
18.	Resources Committee Chairs Log: 28 May and 25 June 2025	Assurance	Chair of Committee	ENC	15:20
19.	Finance Report - Month 2: 2025/26	Assurance	Deputy Director of Finance	ENC	15:30
20.	Integrated Performance Report - 30 April 2025	Assurance	Group Managing Director	ENC	15:40
21.	Green Plan 2025 to 2028 – NTHFT & STHFT	Approval	Group Director of Estates	ENC	15:50
WELL LED					
22.	Fit and Proper Person Test Annual Submission 2024/25	Assurance	Head of Governance/ Company Secretary	ENC	16:00
SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
23.	Audit & Risk Committee Chairs Log: 20 May 2025 23 June 2025 EO CiC (verbal)	Assurance	Chair of Committee	ENC	16:10

	ITEM	PURPOSE	LEAD	FORMAT	TIME
NORTH TEES & HARTLEPOOL NHS TRUST UNITARY BOARD					
24.	Audit Committee Chairs Log: 21 May 2025 23 June 2025 EO CiC (verbal)	Assurance	Chair of Committee	ENC	16:15
25.	Good Governance Institute (GGI) Update	Assurance	Director of Risk, Assurance & Compliance	ENC	16:20
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Group Board of Directors will take place on Thursday 4 September 2025 in the Board Room, Murray Building, James Cook University Hospital				

University Hospitals Tees

Register of members interests

Meeting date: 3 July 2025

Reporting to: *Group Board*

Agenda item No: 4

Report author: *Jackie White, Head of Governance/Company Secretary*

Executive director sponsor: *Jackie White, Head of Governance/Company Secretary*

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *n/a*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF risks

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The report sets out membership of the Group Board interests registered by members. Conflicts should be managed in accordance to the Constitution - If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trusts or Group, the Director must declare the nature and extent of that interest to other Directors.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Careful consideration has been given to the risk that directors may have conflicts of interest due to being jointly appointed directors of both Trusts. Under Group arrangements and by delegating jointly exercised functions, there are a number of reference points permitting this to occur;

- Overall NHS legal and policy framework for collaboration
- Specific statutory provisions for managing conflicts
- NHS best practice
- Authorisation of joint director roles

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Robust processes are in place to provide all relevant information to support informed and robust decision making in the best interest of patients and the population the Group serves.

Recommendations:

The Board of Directors are asked to note the register of interest.

Group Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2022	Ongoing	Role – Governor and Chair of the Board of Governors, Teesside University
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Fellows	Non-Executive Director		Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		December 2023	Ongoing	Governor of the Board and member of the Audit Committee Northumbria University
		December 2023	Ongoing	Independent Member of the Audit Committee Newcastle City Council
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Wilson	Non-Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Ann Baxter	Non-Executive Director		Ongoing	Independent Scrutineer of Safeguarding / Chair of Statutory Safeguarding Partnership – Darlington Borough Council
				School Governor at Thirsk High School and Sixth Form College
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Chris Hand	Group Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
			Ongoing	Client Representative ELFS Shared Services Management Board
		June 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
David Redpath	Non-Executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	Deputy Chairman – Seaton Delaval Football Club

Board Member	Position	Relevant Dates From	to	Declaration Details
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Emma Nunez	Group Chief Nurse	April 2025	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Fay Scullion	Non-Executive Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
		March 2023	Ongoing	Company Secretary of South Tees Healthcare Management Limited - Company number 10166808
			Ongoing	Daughter and Daughter in law employees of South Tees Hospitals NHS Foundation Trust
Ken Anderson	Group Chief Information Officer	May 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Kenneth Readshaw	Non-Executive Director	2016	Ongoing	Treasurer – Leyburn Community Leisure Club
		2018	Ongoing	Chair – Health Accommodation Trust
		2000	Ongoing	Chair – Horsehouse School Charity - Charity number: 513060
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Matt Neligan	Group Chief Strategy Officer	October 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
Mark Dias		20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		21 June 2023	Ongoing	Chair – Workforce Committee, Seacole Group
		September 2023	Ongoing	Permanent Deacon in Training (Voluntary Position). Roman Catholic Diocese of Middlesbrough
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		March 2025	Ongoing	Director of Nicholas Postgate Catholic Academy Trust

Board Member	Position	Relevant Dates From	to	Declaration Details
Michael Stewart	Group Chief Medical Officer			Wife is employed at South Tees NHS FT
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Miriam Davidson	Non-Executive Director		Ongoing	Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Neil Atkinson	Group Managing Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		June 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
Derek Bell	Group Chair	April 2020	Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration
		April 2018	Ongoing	Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration
		April 2021	Ongoing	Centre for Quality in Governance
		July 2022	Ongoing	NHS South East London Chair of SEL SEEC
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Rachael Metcalf	Group Chief People Officer	December 2020	Ongoing	Role of School Governor at High Tunstall College of Science
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Rowena Dean	Chief Operating Officer North Tees & Hartlepool NHS Trust			No declared interest
Ruth Dalton	Group Director of Communications	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Samuel Peate	Chief Operating Officer South Tees Hospitals NHS Foundation Trust	1 April 2021	Ongoing	None
Stacey Hunter	Group Chief Executive	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		March 2024	Ongoing	Director, Health Innovation North East North Cumbria Limited

Board Member	Position	Relevant Dates From	to	Declaration Details
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work within organisations of the NHS
		April 2025	Ongoing	Chair of NHS Confederation Productivity Group
		May 2025	Ongoing	Member of NHS Confederation Acute Advisory Panel
		April 2025	Ongoing	Member of UHA Executive Steering Committee (hosted by NHS Providers)
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
Steven Taylor	Group Director of Estates			Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board Son employed by NTH Solutions LLP – ICT Project Officer/Digital Performance Coordinator Wife employed by NTH Solutions LLP – Catering Assistant
Stuart Irvine	Director of Risk, Assurance and Compliance	2023	Ongoing	Chair – Hartlepool College of Further Education Trustee of Hospitals Trust of the Hartlepool Sons (x2) are employees at Hartlepool College of Further Education Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

NHS
University Hospitals Tees

DRAFT Minutes of a meeting of the University Hospitals Tees Group Board held in Public at 12.30pm on Thursday, 8 May 2025 in the Boardroom, 2nd floor, Murray Building, James Cook University Hospital

Present:
Ann Baxter, Group Vice Chair/Non-Executive Director & Maternity Champion (Chair)
Ali Wilson, Group Vice Chair/Non-Executive Director
Liz Barnes, Group Non-Executive Director
Alison Fellows, Group Non-Executive Director
Fay Scullion, Group Non-Executive Director
Miriam Davidson, Group Non-Executive Director & Maternity Champion
David Redpath, Group Non-Executive Director
Mark Dias, Group Non-Executive Director
Stacey Hunter, Group Chief Executive
Neil Atkinson, Group Managing Director
Chris Hand, Group Chief Finance Officer
Rachael Metcalf, Group Chief People Officer
Mike Stewart, Group Chief Medical Officer
Emma Nunez, Group Chief Nurse & Maternity Champion
Matt Neligan, Group Chief Strategy Officer

Directors – non-voting:
Ken Anderson, Group Chief Information Officer
Steve Taylor, Group Estates Director
Ruth Dalton, Group Director of Communications
Stuart Irvine, Director of Risk, Assurance & Compliance
Sam Peate, Site Chief Operating Officer, South Tees Hospitals NHS Foundation Trust
Rowena Dean, Site Chief Operating Officer, North Tees and Hartlepool NHS Foundation Trust
Jackie White, Head of Governance/Company Secretary

In Attendance:
Mary Sweeting, Heart Failure Nurse Consultant (for item 1 only)
Mel Cambage, Group Deputy Director of Patient Experience and Involvement (for item 1 only)
Steph Worn, Group Director of Midwifery (for item 20 only)
Sarah Hutt, Assistant Company Secretary (note taker)

Members of staff and union representatives:
Sharon Bailey, Unite FTO
Kat Evans
Jack Fletcher, BMA Rep
Lindsey Ford
Jane Harker, RCM FTO
Les Holmes
Sarah Hughes, RCN FTO
Andrew McDonald, BMA Rep
Tracy McKeone
Roaqah Shaher

GB25/015 Welcome and Introductions

The Chair welcomed everyone to the meeting including the members of staff and union representatives in attendance. The Chair advised there was not a specific item on the agenda in relation to car parking,

however, staff were welcome to submit questions in writing, which would be responded to in writing and not verbally during the meeting. Introductions were provided for the benefit of those in attendance.

The Chair highlighted it was a special day, VE Day, noting the strong links between the organisation, armed forces and veterans. Stuart Irvine, Director of Risk Assurance, Assurance and Compliance, as organisational lead for Veterans and Armed Forces provided a small address, marking the significance of Victory in Europe 80, the 80th anniversary commemorating those involved in the conflict. A two-minute silence had been observed at 12 noon across the organisation.

GB25/016 Apologies for Absence

Apologies for absence were reported from Derek Bell, Group Chair, Ada Burns, Group Non-Executive Director/Senior Independent Director and Ken Readshaw, Group Non-Executive Director.

GB25/017 Patient Story

The Chair welcomed Mary Sweeting, Heart Failure Nurse Consultant supported by Mel Cambage, Group Deputy Director of Patient Experience and Involvement to share a poignant story about a patient called Fred. A video was played regarding the care he had received at James Cook University Hospital and the extra mile the staff had gone to meet the patient's dying wishes and to support the family. There were positive and negative aspects to the care provided, although overall the family were very happy with how Fred was cared for, including allowing his little dog Ted to stay with him during his final days before he passed away. The video, which had been made by Mary Sweeting, had been shared in a variety to forums to support future learning, which was commended by the Board.

GB25/018 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

<u>No perceived conflicts of interest</u>

There was no perceived conflicts of interest from the agreed agenda. Should a conflict arise during the course of the meeting, affected individuals should raise the conflict and a decision would be made to ensure appropriate action was taken.

GB25/019 Minutes of the last meeting held on, 4 March 2025

The minutes of the last meeting held on, 4 March 2025 were accepted as a true and accurate record.

Resolved: that, the minutes of the meeting held on, 4 March 2025 be confirmed as a true and accurate record.

GB25/020 Matters Arising and Action Log

There were no matters arising from the minutes of the previous meeting and an update was provided against the action log.

Resolved: that, the verbal update be noted.

GB25/021 Group Chair's Report

The Chair highlighted the key points of the Group Chair's Report that included national, regional and local matters. The Report was taken as read.

- Attended the North East and North Cumbria (NENC) Integrated Care Board (ICB) Chairs meeting on 13 March 2025. Key topics included annual planning process for 2025/26 and the NHS 10 Year Plan;
- Visited the new robotic and emergency maternity surgical state of the art theatre on the

University of North Tees Hospital site providing cutting edge robotic surgical and training facilities and dedicated emergency maternity theatre;

- Attended the unveiling of the COVID-19 Memorial artwork and memorial services on World Health Day, 7 April 2025 at both the University Hospitals of Hartlepool and North Tees;
- Quarterly Armed Forces and Veteran Coffee mornings are held across the Group, as part of the continued commitment to the Armed Forces Covenant, with the most recent event taking place on 8 April 2025;
- Chris Macklin, Group Non-Executive Director stood down from his role on 30 April 2025, having served 50 years across the NHS. The Board wished Chris well in his retirement. In addition, Liz Barnes, Group Non-Executive Director would be leaving the organisation on 30 June 2025, the Board formally thanked Liz for her contribution and involvement in the development of a new Academic Board Committee. The Chair reported that Professor Chris Day had been appointed by Newcastle University as a Group Non-Executive Director who would join the organisation shortly and continue the academic work.

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

GB25/022 Group Chief Executive's Report

Stacey Hunter, Group Chief Executive highlighted the key points of the Group Chief Executive's Report:

- The planning process for 2025/26 was complete and the focus now was on delivering against the plan and meeting statutory responsibilities through driving activity to deliver results. The achievement in delivering the organisation's plan in 2024/25 was acknowledged;
- Significant changes in the NHS were taking place following the announcement to abolish NHS England and plan to create a single aligned centre with the Department of Health and Social Care (DHSC);
- A new 10 Year Health Plan for the NHS was in development, with a focus on illness prevention, improved access to care, improved patient outcomes and ensuring the NHS remained fit for the future;
- Following the UK Supreme Court ruling regarding the legal definition of gender based upon biological sex, the organisation was taking advice in order to adhere to the ruling whilst supporting staff, patients and relatives.

Ali Wilson, Vice Chair/Group Non-Executive Director reported on the recent Get It Right First Time (GIRFT) accreditation at the Friarage Hospital, which was a great achievement.

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

Chair's Log – Group Management Team Meeting

The Group Chief Executive presented the Chair's Log for meetings of the Group Management Team (GMT) held on 20 March 2025 and 17 April 2025. It was noted that the GMT had met three times to date providing useful oversight of the activity across the UHT Group.

Resolved: that, the content of the Chair's Logs be noted.

GB25/023 University Hospital Tees (UHT) Group Strategy

Matt Neligan, Group Chief Strategy Officer presented the UHT Group Strategy and strategic objectives for approval. The Strategy had been developing since the inception of the Group structure in April 2024 with board development sessions and through significant engagement with wider groups. The Strategy provided a coherent five to ten year plan to redesign care and services to meet the needs of the population, operating at scale across the UHT Group. The five Clinical Boards comprising clinical and operational representation, had been working on clinical services proposals to develop a Group Clinical Services Strategy since May 2024, which was at the core of the Group Strategy.

Six new strategic objectives had been developed to support the ambition and vision of the UHT Group and would replace the previous objectives for the two trusts. To support delivery of the objectives, three key pillars of reform had been developed, Patients and population, People, Partnerships and places. Continued engagement would take place internally and externally with key stakeholders including the ICB, local authorities, Healthwatch and other partnerships. It was noted that the Strategy would continue to evolve incorporating any required changes should they arise as part of the NHS 10 Year Health Plan.

Following a positive discussion the Board approved the UHT Strategy and six new strategic objectives.

Resolved: that, the UHT Group Strategy and six new strategic objectives be approved.

UHT People Plan

Rachael Metcalf, Group Chief People Officer presented the UHT Group People Plan, which set out the Group's approach to creating an outstanding experience for staff by leading well and being an employer of choice.

The Plan included four strategic enablers, Developing for the future, Culture and Inclusion, Embedding Wellbeing and Collaborative Ways of Working, which had been developed through staff feedback and responses from the annual staff survey. In addition, a new set of values had been developed with input from over 6,000 members of staff under three headings, Respect, Support and Collaborate.

Key measures of success were outlined, which would be monitored through the Group People Committee. Mark Dias, Group Non-Executive Director and Chair of Group People Committee commended the Chief People Officer and team for the Plan. The Plan was positively received by the Board with a number of questions and points of clarity provided.

A brief discussion ensued questioning the value of participating in the annual NHS Staff Survey, as the response rate had remained low for a number of years. It was proposed that more pulse surveys would be undertaken during the year to capture the views of staff.

Resolved: that, the UHT Group People Plan and strategic enablers be acknowledged and supported.

GB25/024 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) Update to the period February 2025 and highlighted the key points. Standardised and consistent reporting arrangements were now embedded at Committee and Board level and were aligned to the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

For NTHFT:

- 37 strategic risks
- 11 strategic risks outside the approved risk appetite, with 6 red/high risks
- 90 planned mitigating actions, with 3 actions reported as complete and 7 timescale extension requests

For STHFT:

- 31 strategic risks
- 12 strategic risks outside the approved risk appetite, with 7 red/high risks
- 79 planned mitigating actions, with 3 actions reported as complete and 7 timescale extension requests.

The BAF continued to be developed and a visit was planned to Walsall Healthcare NHS Trust to review their processes as part of a benchmarking exercise.

Following a query by Liz Barnes, Group Non-Executive Director regarding increasing the threat of cyber-attacks to a red risk, following recent attacks on a number of high profile retail organisations, Ken Anderson, Group Chief Information Officer advised that despite the attacks, there was no evidence to suggest there was an increased risk to NHS organisations and the national NHS cyber risk level remained unchanged. However, there was no room for complacency, the organisation continued to ensure it had robust systems and processes in place and would be rolling out a number of cyber awareness campaigns to increase staff vigilance. A brief discussion ensued regarding the importance of staff completing mandatory training in this area and ways in which compliance could be improved. The Group Chief Information Officer reported that a Group Cyber Security Manager had recently been appointed and would be managing this function across the organisation. A report would be taken to the next Group Resources Committee.

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

GB25/025 Quality Assurance Committee Chairs Log

Fay Scullion, Group Non-Executive Director presented the Group Quality Assurance Committee Chairs Log for the meeting held on 28 April 2025, noting there had been some additions to the Log since the time of writing.

Key topics included the continued focus on infection rates and the challenge of maintaining good infection prevention control due to admission rates and movement. At North Tees, deep dives were being undertaken in areas of concern and a change in the cleaning policy had been implemented to ensure the gold standard was being met. MRSA screening continued to be monitored closely with support from the IPC team visiting key areas. It was reported that there had been a case of MRSA reported in a neonate, which was being reviewed, an outbreak had also been reported in the Neonatal Suite at Newcastle Hospitals NHS Foundation Trust (Newcastle FT) with learning being shared between teams. Emma Nunez, Group Chief Nurse advised that the type of infection had been different at Newcastle FT, however the same environment had been used as the source of learning. Mike Stewart, Group Chief Medical Officer highlighted that the neonatal outbreak was ongoing as there had been other cases, which was a cause for concern. The link to Newcastle FT was around the estate so if a closure were required that could create a service pressure across the system.

Performance against the cancer targets across both trusts remained a concern, in particular the 62-day referral to treatment target, site level and individual pathway action plans were being reviewed, noting a focus on Urology. The Quality Assurance Committee escalated a concern to the Group Resources Committee regarding performance.

It was positively reported that a resolution for Healthcall with Northumbria Healthcare NHS Foundation Trust had been reached and the organisation would continue to have representation at key meetings. Escalated items had included the outstanding Human Tissue Authority issue regarding stored samples. The issue had now concluded and formal feedback was awaited from the Coroner, which was positive.

The maternity triage system was now in place at North Tees and was anticipated to be fully functional 24/7 by June 2025. It was noted there had been some staff issues due to sickness / staff absence, which had necessitated the suspension of the Intrapartum Service, women had been offered the use of the Rowan Birthing Unit at the University Hospital of Hartlepool in the interim.

The never event in Ophthalmology was discussed and the Committee was assured by the action plan and audit plan. The Draft Quality Account and Quality Priorities were discussed and it was agreed that 8 out of the 9 priorities would be carried forward for more work. The draft documents would be shared with external stakeholders for comment.

Stacey Hunter, Group Chief Executive reported that 62-day performance recovery had been discussed at the Group Management Team Meeting and would be happy for the report to be shared with the Committee to review in conjunction with the commitment to improve performance. In addition, the Executive Team had an update regarding the Ophthalmology never event and received good assurance regarding the processes that underpinned the events, with good resolution. However,

concern had been raised regarding culture and behaviours, so requested some work be undertaken in this area and would keep the Board informed.

Sam Peate, Site Chief Operating Officer for STHFT reported that in relation to 62-day performance, there had been improvement in the Urology pathway with a reduction in the waiting time from GP referral to the biopsy report and further improvement was anticipated. Rowena Dean, Site Chief Operating Officer for NTHFT reported that the target for NTHFT was 75%, with some areas challenged to achieve this and to be aware there was added pressure with an increase in referrals from County Durham and Darlington NHS Foundation Trust.

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

GB25/026 Care Quality Commission Compliance Update Report

Emma Nunez, Group Chief Nurse presented the Care Quality Commission (CQC) Compliance Report and highlighted progress against the 'must do' and 'should do' actions.

Funding of £1.2m had been secured to support the required estates work in maternity services at STHFT, it was requested to reduce the action from alert to advise for future reports due to the progress being made. All other actions on the STHFT Action Plan were on track to deliver and were monitored through the CQC Compliance Group.

A Safeguarding Joint Targeted Area Inspection (JTAI) had recently been undertaken with Redcar and Cleveland Local Authority involving other partners and the CQC. The inspection was in relation to domestic abuse in children under the age of 7 and was similar in theme to the recent JTAI completed for North Yorkshire. The CQC carried out a site visit on 8 April 2025 to a number of services and the initial high level verbal feedback was positive. The final report was awaited.

As the required estates work to improve the maternity services would involve a major rebuild, which was anticipated to take c.5 years, it was suggested to review the plan and identify smaller schemes that could be addressed in the short term, for example, the removal of ensuite facilities.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Group Director of Estates and Group Chief Nurse review the maternity services estates scheme to identify some short-term improvements that could be implemented.

GB25/027 People Committee Chairs Log

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Log for the meetings held on 26 March and 29 April 2025.

Escalated items included Medical Job Planning to Board and Resources Committee, seeking intervention to achieve 100% job planning and the system issues at NTHFT to be resolved. Education and Training Compliance was also escalated to Board and Resources, specifically around mandatory training compliance for medical staff, emergency and urgent care services, safeguarding and resuscitation training. Compliance against information governance training was also flagged, in light of recent national cyber security attacks and the importance of staff being informed and vigilant. Nurse safer staffing was highlighted, following concerns raised to the CQC regarding Ward 9 due to staff shortages and absence management, although it was noted that no further CQC enquiries were made in April. The Integrated Performance Report, particularly appraisal rates and number of employees who had not had an appraisal for 2 years or more were escalated to Board.

Issues regarding Industrial and Employee Relations to be included on the People BAF to seek assurance regarding risks to delivery and leadership capability.

The Supreme Ruling in relation to Women Scotland Ltd v The Scottish Ministers [2025] UKSC 16 and interim guidance by the Equality & Human Rights Commission were discussed and the Committee

were assured regarding the interim measures and support for individuals affected by the judgement, and sought acknowledgement from the Board regarding those individuals who were suffering a process of change.

David Redpath, Group Non-Executive Director and Chair of Resources Committee highlighted whether there was any correlation between the escalated items of appraisal rates, sickness absence rates and mandatory training compliance, noting data had been requested for the next Committee meeting, which prompted a productive discussion.

It was agreed that whilst recognising it can be challenging at times for staff to complete mandatory training and engage with the appraisal process, it was important that staff took responsibility and managers were held to account for low compliance rates, as appraisals were an important part of an employee's development. Directors were asked to review appraisal rates and training compliance within respective teams escalating as appropriate and to consider possible consequences for non-compliance.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the importance of appraisals and mandatory training was noted, Executive Directors to review compliance levels within respective teams and consider consequences for non-compliance; and
(iii) that, compliance levels regarding medical staffing job planning be improved to achieve 100% and system issues at NTHFT to be resolved.

GB25/028 NHS Staff Survey

Rachael Metcalf, Group Chief People Officer presented the NHS Staff Survey 2024 results, noting that the data had been disseminated and each care group/collaborative were reviewing the data to agree three core goals per areas to identify learning.

The Survey was based around the seven themes of the People Promise and two additional themes, staff engagement and morale. The return rate for the Survey for STHFT was 29% (3,043 completed surveys) and 45% (2,337) for NTHFT, which was a reduction of 428 returns for STHFT and 107 for NTHFT. A breakdown of scores for each theme was provided, noting there had been a reduction in scores for the majority, although there were examples of positive improvements across both trusts. A number of sessions had been arranged to share the results with staff, including an all staff listening event.

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

GB25/029 Freedom to Speak up Report

Jules Huggan and Philippa Imrie, Freedom to Speak Up (FTSU) Guardians, presented the FTSU Annual Report: 2024/25, the first Group Annual Report and highlighted the key points.

There were a total of 217 concerns received across the Group during 2024/25, with 152 at STHFT and 65 at NTHFT. This was an increase from 125 concerns at STHFT reported in 2023/24 and a decrease at NTHFT from 97 concerns reported. The number of anonymously reported concerns at STHFT increased in 2024/25 to 65 and was above the national average, work was ongoing regarding the FTSU IT system, which would hopefully reduce the number of anonymous cases going forward. Anonymous reporting at NTHFT remained low.

In respect of FTSU training levels, 62.5% compliance was reported at STHFT and at NTHFT workshops had been delivered to 118 staff, it was planned to use the results of the NHS Staff Survey to target areas that may benefit from a workshop. Referrals had been received following an MDT and from the Education team.

The main themes of cases mirrored the national data and for both trusts, the most reported theme was inappropriate attitude/behaviours. At both trusts, 100% of respondents would use the FTSU service again. It was noted that currently Equality, Diversity and Inclusion (EDI) data was not captured at NTHFT, as it was not a national requirement, however, it was planned to begin collecting the data from Quarter 1: 2024/25. At STHFT, the FTSUG regularly met with the EDI lead to triangulate any issues and themes.

Awareness raising continued across the Group with a number of initiatives in place, supported by a Group Improvement Plan for FTSU to create a business as usual culture of speaking up.

The level of anonymous concerns being reported and number of concerns raised by staff reported to have a disability were acknowledged.

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

GB25/030 Resources Committee Chairs Log

David Redpath, Group Non-Executive Director presented the Resources Committee Chairs Logs for the meeting held on 30 April 2025 and acknowledged the amount of work by the Finance teams to complete year end.

Items for escalation included the increase in whole time equivalent (WTE), which at Month 12: 2024/25 was 2,767 (21%) higher than the average deployed during 2019/20 requiring a Board discussion to manage grip and control.

The Committee received the first joint Procurement Report and the improvement in the standard of reporting was noted. There was a requirement for both trusts to confirm they were working on the same definition of procurement savings (cost avoidance v cost savings).

Stacey Hunter, Group Chief Executive acknowledged the importance of reducing the Group's WTE and highlighted that the Group's 2025/26 plan was only deliverable if WTE spend was reduced by 500 through a variety of mechanisms, noting this was a position reflective of trusts across the NHS. Internal controls had been strengthened with very clear expectations being articulated across the organisation. Neil Atkinson, Group Managing Director reiterated the work being undertaken including the tightening of site vacancy control processes to understand and mitigate risks and recognised the difficulties in achieving the planned reduction of WTE, especially without the option of redundancy and voluntary severance. A discussion ensued regarding actions that could be taken to ensure achievement of the required WTE reduction, as part of the ongoing grip and control work. It was queried how long tighter internal controls would continue before more stringent measures were implemented. A discussion ensued with a number of suggestions by Non-Executive Directors raised and responded to. It was agreed to consider further actions to achieve WTE reduction as part of deep dive and grip and control exercises being undertaken.

The Committee's Terms of Reference and Cycle of Business had been reviewed, highlighting the requirement to clarify where Subsidiary reporting resided, urgent action was required to appoint a temporary vice chair and the scope of procurement oversight to be reflected. Jackie White, Head of Governance/Company Secretary reported that discussion had taken place at the recent Board Development session regarding Committee arrangements. In addition, feedback from the recent advisory audit on group governance arrangements had been received, which would be incorporated into terms of reference for the Committees.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Group Chief Finance Officer and Group Managing Director consider further actions to achieve WTE reduction as part of the grip and control exercises being undertaken.

GB25/031 Finance Reports Month 12, 2024/25

Chris Hand, Group Chief Finance Officer presented the Finance Reports for Month 12, 2024/25 and highlighted the key issues. The Group had delivered against the overall deficit control total of £7.8m, which was a favourable variance of £0.08m against the year to date plan.

Clinical income was ahead for both trusts offset by pay pressures, the pay award and high cost drugs /devices. Agency expenditure totalled £8.9m, which was a reduction of £4.3m compared to 2023/24. Less positive was the net overall increase of 603 WTE in Month 12, compared to the average in 2023/24 and compared to the previous month was an increase of 80. The Group's capital expenditure to the end of Month 12 totalled £121.5m, which included the Community Diagnostic Centre (CDC). The cash balance at the end of Month 12 stood at £110.5m and the continued strong cash position supported good compliance with the Better Payment Practice Code.

The Chair thanked all those involved in achieving the financial plan for 2024/25.

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

GB25/032 Going Concern 2024/25

Chris Hand, Group Chief Finance Officer reported that in line with accounting standard IAS1 as part of the accounts preparation process, it was a requirement for organisations to make an assessment of the ability to continue as a going concern. Information regarding both NTHFT and STHFT was presented and it was confirmed that both organisations met all of the requirements, it was therefore recommended that the 2024/25 annual accounts for both trusts be prepared on a going concern basis.

Resolved: that, agreement be given for the 2024/25 annual accounts for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust be prepared on a going concern basis.

GB25/033 Integrated Performance Report

Neil Atkinson, Group Managing Director Group presented the Integrated Performance Report (IPR) for the reporting period February 2025 and highlighted the key points, noting a detailed review of the IPR was undertaken through the Board Committees.

The alert, advise and assure framework formed the basis of the report, with 9 alert metrics for NTHFT and 11 for STHFT. It was noted that from the reporting period April 2025 onwards, any alert metrics over three consecutive months would prompt a deep dive to understand the issues. Included for the first time were supplementary metrics relating to health inequalities and population health, which would be overseen by the newly formed UHT Health Inequalities Strategy Group, noting one key concern was the continued funding streams for this work, which was being addressed with the ICB.

On 18 March 2025, the first site performance reviews had taken place using the Group IPR as the basis for the reviews, which provided the opportunity for Executive colleagues to understand the granular detail.

Stacey Hunter, Group Chief Executive requested a mechanism for the Board to be sighted on the work being undertaken around health inequalities and population health with partners across the wider system, it was proposed that a board development session be arranged.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, a board development session be arranged in respect of the work being undertaken in respect of health inequalities and population health with system partners.

GB25/034 Maternity Reports

Steph Worn, Group Director of Midwifery presented the maternity reports and highlighted the key points taking the reports as read.

Reports provided:
NTHFT and STHFT Perinatal Quality and Safety Reports Quarter 4: 2024/25
NTHFT and STHFT Perinatal Staffing Reports Quarter 4: 2024/25

For NTHFT, the stillbirth 12 month rolling rate was 3.9% per 1,000 births, it was noted that on average the Trust had 200 births per month. In addition to the perinatal mortality review tool, thematic review was in development to provide further due diligence.

For STHFT, escalations through the board level safety champion meetings in Quarter 4 were in relation to the impact of the loss of estate on Ward 19, which was affecting the number of antenatal beds and the relocation of the neonatal resuscitaire.

From a workforce perspective, both sites were at full establishment for the midwifery and obstetric workforce, noting both sites were compliant with BirthRate+ recommendations and the 3-year review was expected in October 2025. At NTHFT, whilst at full establishment for the obstetric workforce, there were gaps in the rotas that was being reviewed. The 24/7 emergency rota was always prioritised to ensure 100% compliance. The neonatal medical workforce was BAPM compliant, noting the neonatal nursing workforce does not meet BAPM compliance. An action plan would be developed for Quarter1 reporting. At STHFT, both the neonatal medical and nursing workforce do not meet the BAPM standards; an action plan would be developed for Quarter 1 reporting.

The perinatal leadership team and board safety champions at each site, continued to meet a minimum of bi-monthly as per national guidance, including a review of the claims score cards. Culture plans continued with progress at each site to undertake a review and revision for 2025.26. There had been an increased demand and expectation in respect of the Maternity and Neonatal Voices Partnership (MNVP) as part of the wider safer maternity care requirements, which was challenging and it was noted that the representatives for the MNVP were voluntary lay individuals. The matter had been escalated for the Board's attention, prompting a brief discussion. It was agreed for the Board Maternity Champions to write a letter to the National Chief Midwifery Officer regarding the issue. At NTHFT, the Chair of the MNVP Group had stood down due to other commitments and the Board were asked to note her valuable contribution. Currently a replacement had not been identified, however the role would be advertised, which had been raised with the ICB and Local Maternity and Neonatal System (LMNS).

At STHFT, a full review into midwifery community services, including caseload, pathways and estates priorities was planned. At NTHFT, phase 1 of the Maternity Triage 24/7 Service was due to go live at the end of May, a staff consultation paper was in progress due to a change in working hours to support the new service requirements.

Both sites had received confirmation of compliance for all ten safety actions of the MIS year 6 submission.

The improved overall position regarding staffing was noted. Mike Stewart, Group Chief Medical Officer suggested clarity be provided in future reports regarding the different specialist midwife roles across the Group highlighting any alignment of roles between the Trusts.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Board Maternity Champions write to the National Chief Midwifery Officer regarding the increased expectations in respect of safer maternity care and the role of the Maternity Voices Partnership; and
(iii) that, clarity be provided in future reports regarding specialist midwife roles across the Group.

South Tees Hospitals NHS Foundation Trust Unitary Board items only:

GB25/035 Audit and Risk Committee Chairs Log

David Redpath, Group Non-Executive Director presented the STHFT Audit and Risk Committee Chairs Log and the STHFT Audit and Risk Committee and NTHFT Audit Committee Meeting in Common Chairs log for the meetings held on 28 March 2025.

There were no escalated items from the Audit and Risk Committee meeting. The meeting in common received Committee Effectiveness Reviews for the Quality Assurance Committee, People Committee and Resources Committee and provided good assurance that the Committees were effectively discharging their duties.

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

GB25/036 South Tees Charitable Funds Committee Chairs Log

Ali Wilson, Group Vice Chair/Non-Executive Director presented the STHFT Charitable Funds Committee Chairs Log and the STHFT Charitable Funds Committee and NTHFT Charitable Funds Committee Meeting in Common Chairs log for the meetings held on 12 March 2025.

It was escalated that a draw down from investments would be made as the accounts balance overall was positive.

A new member of staff had been appointed to support fund raising and to improve applications for funding. An update was provided regarding Maggie's Centre, which was due to go live on the James Cook University Hospital site on 1 October 2025.

At the meeting in common, an aligned cycle of business was shared, to support greater work on a joint basis and opportunities for programmes of work were shared.

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

GB25/037 Modern Slavery and Human Trafficking Statement

Jackie White, Head of Governance/Company Secretary presented the STHFT Modern Slavery and Human Trafficking Statement for 2025/26.

The statement was prepared in line with the requirements of section 54 (1) of the Modern Slavery Act 2015 and the new Procurement Act 2024, which came into force on 1 February 2025. It set out steps taken by the Trust and its subsidiary South Tees Healthcare Management Limited to ensure modern slavery nor human trafficking was not taking place in any part of the business or supply chain.

The statement for 2025/26 would be signed by the Group Chair and Group Chief Executive and would be placed on a prominent place on the website.

Resolved: (i) that, the STHFT Modern Slavery and Human Trafficking Statement 2025/26 be approved and signed off by the Group Chair and Group Chief Executive; and
(ii) that, the signed STHFT Modern Slavery and Human Trafficking Statement 2025/26 be placed on the Trust website.

GB25/038 Use of Seal

Jackie White, Head of Governance/Company Secretary presented the Use of Seal Report to seek retrospective approval for the items executed under seal.

Alison Fellows, Group Non-Executive Director sought clarity regarding item 2025/006 that listed the

parties as the Sellers and Warrantors and did not identify the specific names. It was agreed to review the register.

Resolved: (i) that, retrospective approval be granted for the items executed under seal; and
(ii) that, clarity of the individual parties for item 2025 /006 be confirmed.

North Tees and Hartlepool NHS Foundation Trust Unitary Board items only:

GB25/039 Audit Committee Chairs Log

Alison Fellows, Group Non-Executive Director presented the NTHFT Audit Committee Chairs Log for the meeting in common with STHFT Audit and Risk Committee held on 28 March 2025.

The Committees received the Committee Effectiveness Reviews for the Quality Assurance Committee, People Committee and Resources Committee and provided good assurance that the Committees were effectively discharging their duties.

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

GB25/040 North Tees Charitable Funds Committee Chairs Log

Neil Atkinson, Group Managing Director presented the NTHFT Charitable Funds Committee Chairs Log and the NTHFT Charitable Funds Committee and STHFT Charitable Funds Committee Meeting in Common Chairs log for the meetings held on 12 March 2025.

There were no escalated items from the NTHFT Charitable Funds Committee meeting. The meeting in common held with STHFT Charitable Funds Committee received an aligned cycle of business to support greater joint working.

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

GB25/041 Modern Slavery and Human Trafficking Statement 2025/26

Jackie White, Head of Governance/Company Secretary presented the NTHFT Modern Slavery and Human Trafficking Statement for 2025/26.

The statement was prepared in line with the requirements of section 54 (1) of the Modern Slavery Act 2015 and the new Procurement Act 2024, which came into force on 1 February 2025. It set out steps taken by the Trust and its subsidiaries Optimus Health Limited and North Tees and Hartlepool Solutions Limited Liability Partnership to ensure modern slavery nor human trafficking was taking place in any part of the business or supply chain.

The statement for 2025/26 would be signed by the Group Chair and Group Chief Executive and would be placed on a prominent place on the website.

Resolved: (i) that, the NTHFT Modern Slavery and Human Trafficking Statement 2025/26 be approved and signed off by the Group Chair and Group Chief Executive; and
(ii) that, the signed NTHFT Modern Slavery and Human Trafficking Statement 2025/26 be placed on the Trust website.

GB25/042 Use of Seal

Jackie White, Head of Governance/Company Secretary presented the Use of Seal Report seeking retrospective approval for the items executed under seal.

Alison Fellows highlighted the items where the individual parties were referred to as the Sellers and

Warrantors and it was agreed to review the register.

Resolved: (i) that, retrospective approval be granted for the items executed under seal; and
(ii) that, clarity regarding the individual parties be obtained where not specified.

GB25/043 Any Other Business

There was no other business reported. Jackie White, Head of Governance/Company Secretary outlined the new actions noted during the meeting, prompting further discussion on a number of the items.

GB25/044 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 3 July 2025 in the Boardroom, 2nd floor, Murray Building, James Cook University Hospital.

The meeting closed at 4.00pm

Signed: Date:

Group Board Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes	Action delegated to Committee
04 March 2025	GB/251	***Quality Assurance Committee Chairs Log*** *Board Development session involving Public Health Consultants to share work regarding population health and health inequalities.*	Jackie White Mike Stewart	03 July 2025	Open	It was agreed it would be helpful to invite the Public Health Consultants to a future Board Development session to share with the Board current projects and progress to date regarding population health and health inequalities. MS and JW to agree arrangements.	
04 March 2025	GB/251	***Quality Assurance Committee Chairs Log*** *The high level IPC plan to be shared with Board*	Emma Nunez	03 July 2025	Open	It was agreed to share with the Board the high level plan in respect of IPC. The high level plan was going to Committee in June and would come to Board in July 25.	
04 March 2025	GB/254	***Safer Staffing Report*** *A review of the criteria used to measure turnover data across both trusts to be undertaken to support more aligned reporting going forward.*	Emma Nunez	03 July 2025	Open	There were stark differences in the reported turnover figures between the Trusts and a review was being undertaken to ensure the same criteria were being measure against.	
04 March 2025	GB/254	***Safer Staffing Report*** *Undertake a Board Seminar in June 2025 linked to the Clinical Strategy around nursing establishment.*	Emma Nunez/ Jackie White	05 June 2025	Open	It was agreed to hold a Board Seminar to share with the Board the work being undertaken across both trusts in respect of nursing establishment.	
08 May 2025	GB25/026	***Care Quality Commission Compliance Update Report*** Maternity Services Estates Recommendations Action Plan to be reviewed to identify items that could be implemented in the short term.	Steve Taylor/ Emma Nunez	03 July 2025	Open	It was agreed to review the maternity estates plan to identify short term improvements that could be made in the interim, as the overall plan involved major rebuilding work which would take c.5 years to complete.	
08 May 2025	GB25/027	***People Committee Chair's Log*** Escalated item from People Committee to improve compliance levels regarding medical staffing job planning.	Mike Stewart	03 July 2025	Open	Medical Job Planning rates had remained below the 95% target. The issue was escalated from People Committee to achieve 100% compliance and to resolve reported system issues at NTHFT.	
08 May 2025	GB25/027	***People Committee Chair's Log*** Escalated item from People Committee regarding low appraisals rate and training compliance for staff.	All	03 July 2025	Open	Staff appraisal rates and mandatory training compliance remained low. The issue was escalated from People Committee for Executive Directors to review compliance levels within respective teams and consider consequences for non-compliance.	
08 May 2025	GB25/030	***Resources Committee Chairs Log*** Escalated item from Resources Committee to consider actions to achieve WTE reduction as part of deep dive and grip and control exercise being undertaken.	Chris Hand/ Neil Atkinson	03 July 2025	Open	Following escalation from Resources Committee a discussion ensued regarding actions that could be taken to ensure achievement of the required WTE reduction, as part of the ongoing grip and control work. It was queried how long tighter internal controls would continue before more stringent measures were implemented.	
08 May 2025	GB25/034	***Maternity Reports*** Maternity Board Champions to write to National Chief Midwifery Officer regarding increased expectations around safer maternity care.	Ann Baxter Miriam Davidson	03 July 2025	Open	It was agreed for the Maternity Champions to escalate to the National Chief Midwifery Officer the increased expectations on organisations in respect of safer maternity care and Maternity Voices Partnerships.	
08 May 2025	GB25/034	***Maternity Reports*** Clarity to be provided in future maternity report regarding range of specialist midwife roles across the Group.	Steph Worn	03 July 2025	Open	Following a query regarding specialist midwifery roles across the Group, it was agreed to provide clarity in future reports as to the current roles.	

University Hospitals Tees

Group Chairman's Report

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: *7*

Report author: *Jackie White, Head of Governance/Company Secretary*

Executive director sponsor: *Jackie White, Head of Governance/Company Secretary*

Action required:
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *n/a*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The report provides an overview of the health and wider related issues.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

n/a

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

n/a

Recommendations:

The Group Board of Directors are asked to note the report.

Group Board
3 July 2025
Group Chairman's Update

1. Introduction

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

1.1 NHS England

Large volume of information now coming from NHS England in particular the 3-year Spending Review which was published on 11 June and the 10 Year Health Plan which is working its way across government and likely to be published in the Autumn.

A new Urgent and Emergency Care Plan has been launched linked to elective recovery which is aimed at improving urgent and emergency care services in England. It focuses on reducing waiting times in A&E, improving ambulance response times, and shifting care closer to people's homes. The plan includes investments in new same-day emergency care and urgent treatment centres, as well as enhanced support for mental health needs within emergency settings,

A review of quality programmes across NHS England, the Department of Health and Social Care (DHSC), and the Care Quality Commission (CQC) is underway to agree on a core set of indicators around safety, effectiveness, and patient experience. This will ensure a more joined-up, focused approach to improving care in ways which are more clearly linked to making a difference to patients.

1.2 ICB and Trust Chairs meeting

I attended a meeting on 13 March in London for ICB Chairs and Trust Chairs. The meeting focussed on the key issues for the health service and the important role that Chairs and Non-Executive Directors can and will play in navigating them. This also included an update on the financial and operational planning process for 2025/26, as well as the 10 Year Health Plan. Reinforced the need to work as a system both regionally and across the population University Hospitals Tees serve to achieve patient benefit

1.3 NHS Confederation

I attended the NHS ConfedExpo last week which is the UK's leading health and care conference, dedicated to improving care for patients and the public. As the largest event of its kind, NHS ConfedExpo brings together over 5,000 leaders, professionals and partners from across the health and care sector to collaborate, share insights and develop innovative solutions to deliver high quality care for all. Key speakers including Sir Jim Mackey from NHS England and Wes Streeting, Secretary of State for Health and Social Care. Emphasis on the need for collaboration optimal use of resources and collaboration.

1.4 Group Board walkrounds and development sessions

The Group Board is currently undertaking unitary board training as part of its ongoing development programme. Two sessions have been held to date with a further session due later this summer. This training is in addition to the board seminar programme in which [illegible] months the board have had updates on Strategy, risk appetite, [illegible]ivity and unwarranted variation.

The Board continue to undertake walkrounds when on site and most recently visited clinical support services areas in James Cook along with visiting the Melisa Bus to support and celebrate PRIDE month.

1.5 Non Executive Director updates

Since our last meeting there have been a number of changes to the Non Executive Directors. Chris Macklin who was originally a non executive director for North Tees & Hartlepool Trust and Senior Intendent Director for the Trust has retired following a service to the NHS of 50 years in a variety of roles and organisations. This month Professor Chris Day, joins us as an appointed non executive director from Newcastle University. Professor Chris Day has been Vice-Chancellor and President of Newcastle University since January 2017. Previously a Consultant Hepatologist with an international reputation in medical research, he is a Fellow and former Clinical Vice-President of the Academy of Medical Sciences and joins us to Chair the Academic Committee. Finally Liz Barnes, non executive director leaves us this month to take up the role of Lord Lieutenant of Staffordshire. The Lord-Lieutenant of Staffordshire is the King's representative for the county and oversees Royal visits, Honours investitures and the presentation of awards, as well as numerous other activities on behalf of the King.

Appraisals for non executive directors are underway in the same format as last year which was agreed with the Nomination Committees. My appraisal has been undertaken and feedback will be provided at the Council of Governors meetings.

1.6 Tees Valley Research Symposium

I was really pleased to be asked to provide the opening speak to the Tees Valley Research Symposium held on 22 April the focus was on **"Connecting partners: A Research and Innovation symposium - improving patient care in the Tees Valley".** There was a fantastic turnout and it was great to celebrate and share recent research successes and aspirations within the Tees Valley.

1.7 New Governors

Welcome to our new governors joining us in South Tees Council of Governors, it was great to meet with them this month at our induction programme which offered us the opportunity to chat and share information on the roles which they have been elected or appointed to. We look forward to working with you all.

1.8 Veterans Awareness

Armed Forces Day takes place on the last Saturday each June, falling this year on 28 June 2025. It is a chance for University Hospitals Tees (UHT) to continue to show our support to the Armed Forces Community: from currently serving personnel to service families, veterans and cadets. It also marks the culmination of a week of celebrations, beginning on Monday 23 June 2025. It also includes Reserves Day (25 June 2025), which provides the country with an opportunity to recognise our Reserve Forces.

On Monday 23 June 2025, between 1000- 1030 the Armed Forces Day flag will be raised at JCUH, FHN, UHNT, UHH. This will be followed by a short service led by our team of Chaplains that will be attending each site. Colleagues from the Board will be attending and

it would be great if Council of Governor colleagues were able to show their support to their local flag raising events.

2. Recommendation

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

Professor Derek Bell
Group Chair

University Hospitals Tees

Chief Executive Officer Report

Meeting date: 3 July 2025

Reporting to: Group Board

Agenda item No: 8

Report authors: *Jackie White, Company Secretary / Abigail Smith, Executive Assistant to CEO*

Executive director sponsor: Stacey Hunter, Chief Executive Officer

Action required:
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The secretary of state for health announced on June 23rd 2025 a rapid independent investigation into maternity and neonatal services which will report by Christmas. He will also chair a national maternity and neonatal taskforce alongside immediate actions to improve care.

The independent investigation will conduct urgent reviews of up to 10 trusts where there have been specific issues.
The NHS E CEO and CNO wrote to chairs and CEOs on the same day a copy of which is provided for Board colleagues at appendix one.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Nil to note.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The report includes a number of significant achievements across UHT that colleagues have supported over this last period. They are highlighted at section 5

Recommendations:

The Group Board of Directors are asked to note the report.

Chief Executive's Report

1. Introduction

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

2. National Priorities

On Monday 19 May, I attended a **Community Health Service Roundtable** event in London hosted by Minister Stephen Kinnock. The key focus was to hear from a selection of CEOs with responsibility for community health services focused on the critical factors that will enable the left shift of activity (hospital to community) as part of government's priority for neighbourhood health. The discussion focused on the need for reform across the health and care sector as part of transforming to offer for local communities, workforce development, resource allocation and financial flows, service delivery models, the essential role of digital and predictive data analytics and mechanisms that will foster providers to collaborate and integrate services. This is part of a significant amount of work that is being undertaken to influence the forthcoming 10 year plan for health which is expected to be published prior to the governments' summer recess.

NHS England has released the draft **Model ICB Blueprint**. This outlines how the functions of Integrated Care Boards (ICBs) will develop as they focus their future role on strategic commissioning, and as they deliver the national expectation over a 50% reduction in running costs. The strategic commissioning role will require each ICB to focus on providing system leadership for population health, setting evidence based and long-term population heath strategy and working as healthcare payers to deliver this, maximising the value that can be created from available resources. Across the country it is anticipated that the blueprint and associated reduction in running costs will require a number of smaller ICBs to cluster. ICBs submitted their proposals at the end of May and we await the formal feedback. Neither of our two main commissioners are not proposing any changes in respect of clustering. The impact on providers is likely to involve a greater expectation of driving system-wide service transformation and potentially taking on over functions that are currently done by the ICBs. We continue to work with partner organisations and the ICBs on how we take this forward jointly with primary care, mental health services ,social care and local VCSEs in neighbourhood and community health services, and with our wider system partners in secondary and tertiary acute services.

I was pleased to attend the **NHS ConfedExpo** national conference in June that brought together over 7,000 health and care leaders to hear emerging policy ambitions in advance of the publication of the government's 10 Year Health Plan and to learn from innovation and best practice across the NHS. Key messages included an emerging future direction of travel that aims for a stronger role for joined-up neighbourhood health systems aligning care that is based in the community and in people's own homes and greater devolution from the centre. We are expecting a shift to commissioning for outcomes rather than activity (which may be brought out in the framework for the odel) and an ambition to recapture the strongest elements of st model. The conference took place on the same day at the

government Spending Review, that has confirmed a 3% 'real terms' increase in revenue funding for the NHS and a freeze on capital budgets over the next three years. It earmarked an existing £10bn for new technology and requires delivery of £9bn in efficiency gains by 2029. Sir Jim Mackey signalled that NHS England will be exploring flexibilities for accessing capital.

ConfedExpo further highlighted the importance of recapturing public confidence in the NHS that has dropped to its lowest levels in recent years. Along with the future reform agenda outlined above, this emphasises the importance of our strategy in delivering the reform and in engaging patients and communities in the design and the journey. It is essential that we build the confidence of the people whose care we provide in how we are making our services meet their needs. Our shift to the community and development of neighbourhood health models with partners will be central to this, along with our work on productivity and use of technology to support the sustainable delivery of our ambitions for clinical services. The access to capital funding will be critical as we seek to tackle the critical condition of our estate at the University Hospital of North Tees as part of our wider estates strategy. As we look to the future we will seek to strike the right balance between delivering today's services well with a focus on quality, safety and productivity, and reforming for the future as we put in place arrangements to deliver our strategy through our emergent Clinical Service Units.

Another key theme throughout the conference was the use of **digital, data and IT** in the NHS as the service looks to harness the power of technology to enable high quality care. Vicky Cardona our Head of Patient Flow for North Tees and Hartlepool FT presented on her work to develop OPTICA on the Federated Data Platform, which enables us to track admitted patients and helps to coordinate tasks to plan timely discharge. I also joined a panel to discuss the use of data to improve decision-making as part of our evolving work with Beamtree as part of the Evolve Collaborative. This latter work is in its early stages as we have been invited to work with a small number of other providers across England who are exploring novel approaches to visualising data including predictive modelling. It provides an opportunity for us to build on international good practice in data analytics and to be part of a learning community across the NHS. This work will be led by Matt Neligan, Chief Strategy Officer with the support of Ken Anderson, Chief Information Officer on behalf of the group.

Maternity and neonatal care

It was announced on 23 June 2025 by the Secretary of State for Health and Social Care a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

The Secretary of State for Health and Social Care is keen to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

The timeline for this work will commence immediately through to December, and the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. There will be an opportunity to meet with systems leaders to hear what [illegible]pport providers to go further and faster in improving maternity

3. Regional Update

NENC CEO Leadership Group

Sam Allen, Chief Executive of the ICB NENC held a meeting on 22 May 2025 for Local Authority CEO's, Combined Authority CEOs and regional Trust CEOs. Meeting focused on the changes in ICB and what this will mean for providers of health and care services and the focus on PLACE based services.

System Recovery Board

The System Recovery Board continues to meet monthly and is focussed on four key areas to help us to recover financial stability across the region. These are: workforce, elective recovery, urgent and emergency care and procurement.

With regard to workforce work there has been a focus on the triangulation of CIP submissions / Opportunity Packs / Planning Guidance asks, supporting a redeployment and careers house proposal. Progress has been made to develop an Options Appraisals for bank, recruitment and sickness at scale which will be considered at a future meeting. Our Chief People Officer and Chief Finance Officer are engaged in this work.

I lead on the procurement work stream, and work has focussed on the consolidation of Trust work plans and the Procurement Board membership has been identified. Work on other initiatives including digital, transport and equipment continues.

NENC Provider Collaborative Leadership Board (PLB)

Matt Neligan, Chief Strategy Officer attended the PLB on my behalf on 6 June 2025 to provide an update on University Hospitals Tees Strategy and the progress towards horizontal integration as part of the nested collaborative updates to the Board. The focus of the rest of the meeting was on the changes to ICBs and the model blueprint which is described above and reaffirming the responsibility agreement between the ICB and the Provider Collaborative which is made up of the provider organisations in the North East and North Cumbria. The agreement sets out the strategic approach to the key priorities including unplanned and planned care, financial recovery, supporting strategies such as workforce, digital and infrastructure and time limited projects.

Health Innovation North East and North Cumbria

As members will be aware the University Hospital Tees is a member of the Health Innovation North East and North Cumbria whose role it is to support the health and care system to accelerate innovation which improves people's health and the regional economy. It was good to hear about the innovative work happening across the system and specifically locally in Tees on a project to develop an existing training mannequin into a more advanced prototype form, through to a fully working model, which could be commercialised.

4. Local update

I am pleased to report that following a successful campaign to appoint a Deputy Chief Executive, Matt Neligan Chief Strategy Officer was successful in securing the role.

Board will be appraised of our current performance against our 25/26 plan via the IPR, the finance report and our Board committee reports. As Board members are aware this is a challenging year and it is imperative we continue to support colleagues in the delivery of their CIP plans and assess/monitor the impact on the quality and safety of services.

In this last period we have commenced the process we agreed in respect of offering a voluntary severance scheme. Our Chief People Officer will keep the Board appraised of the progress over the coming weeks.

As discussed with Board colleagues at our development sessions we have developed proposals for a new target operating model across UHT that is aligned and designed to deliver the UHT strategy that the Board approved in May 2025. I know Board members will appreciate that for colleagues whose roles are included in the scope of the changes that we are consulting on, this can feel daunting. We have provided details of how people can access support as well as provide their feedback to the proposals as part of the consultation period.

5. In other news!

I am pleased to share that South Tees Hospitals NHS Trust has achieved reaccreditation as a menopause friendly employer. Menopause in the Workplace recognises high standards and proven practices that embrace menopause in the workplace. The Menopause Friendly Accreditation is industry-recognised and the only accreditation that sets clear standards which must be met. As such, it is truly meaningful and considered as a mark of excellence for menopause in the workplace

The Tees Valley Community Diagnostic Centre is now open, offering our patients access to rapid health tests, checks and scans, from a convenient out-of-hospital setting in Stockton town centre. Right from the planning stages, to the first spade in the ground, to where we find ourselves today, it has been a great achievement by all involved. Special thanks goes to Stockton-on-Tees Borough Council and Kier for their support, as well as all of the staff involved from across University Hospitals Tees.

I am so pleased to report our £35.5million Friarage Surgical Centre opened its doors recently. I was lucky to get a behind the scenes tour, seeing the six brand new operating theatres with 12 recovery bays, two minor operating theatres with four recovery bays, a regional block room and a dedicated admission and discharge area. Accredited by the national Getting it Right First Time (GIRFT) programme, the centre will allow us to treat more people, reduce wait times and provide the best outcomes for our patients while also providing an outstanding work environment for our staff with modern facilities. Special thanks to our clinical, operational and estate teams who put in a huge amount of effort to ensure these facilities are designed to provide excellent and effective working environments while also maximising comfort and experience for patients and families.

In March, I had the pleasure of unveiling the new multi-million pound robotic and emergency [illegible]re at the University Hospital of North Tees alongside those teams [illegible] instrumental in making this happen. This suite spans the space

above the atrium near the main entrance to create a state-of-the-art facility. Anil Agarwal, consultant surgeon, and the team have put huge effort into designing and overseeing this project and I would like to thank everyone who has been involved, including trust clinical and non-clinical staff, colleagues from NTH Solutions, construction company Geoffrey Robinson Ltd and charities MUSICvCANCER and Support Your Bowel which provided additional funding.

North Tees and Hartlepool NHS Foundation Trust Maternity team have been shortlisted for a HSJ National Patient Safety Award as finalist in the following category; Reducing Major obstetric Haemorrhage to less than 3.3% in line with MBRRACE targets. Representatives from the team will be attending the award ceremony on Monday 15 September in Manchester. This is a huge achievement for the team and I would like to convey good luck to them on the evening.

I am pleased to share that South Tees Hospitals NHS Foundation Trust has been awarded the Multi-Professional Preceptorship Quality Mark through the early implementer programme! Recognising the high standards of support and development provided to newly registered professionals across Allied Health Professions, Nursing and Midwifery.

6. Conclusion

The Board is asked to note the contents of this report.

APPENDICES

Letter from Jim Mackey and Duncan Burton on maternity and neonatal investigation/taskforce

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

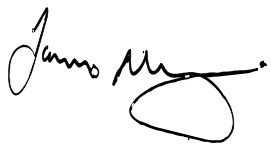
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

University Hospitals Tees

Chairs Log – Group Management Team

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 9

Report author: *Abigail Smith, Executive Assistant to CEO and Chair*

Executive director sponsor: *Stacey Hunter, Group Chief Executive*

Action required:
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *n/a*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All Board Assurance Framework domains

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The Chief Operating Officer for NTH reported a significant risk with respect to a recent UKAS assessment of Biochemistry, Haematology and Blood Transfusion Lab services which took place at the North Tees site on the 14/15th May. In respect to Haematology and Blood Transfusion recommendation of partial suspension of accreditation for a period of 3 months will be applied. There will be with an on- site revisit to consider re instalment of accreditation. The actions that need to be delivered will be overseen by the Group Pathology Board.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

CDDFT are facing pressures in relation to capacity in their breast services which NTH are providing mutual aid for. This is giving rise to increased pressures on our services which whilst manageable in the short term need a more sustainable solution going forward. The Northern Cancer Alliance are supporting providers to develop a strategic plan with particular focus on Breast services in the Tees Valley.

The delivery of CIP is behind plan at month 2. To avoid duplication the detail of this will be shared in the Board finance report.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

North Tees and Hartlepool NHS Foundation Trust;

- Delivering the commitments in the elective recovery plan at month 2 acknowledging this has been achieved in the context of disruption to theatre sessions due to the building works for the new theatres

South Tees Hospitals NHS Foundation Trust;

- Emergency Department performance improving, continuing to see sustained positive changes through all elements of patient pathway
- The focused improvement work in the Urology Cancer pathway is demonstrating tangible gains in performance which is encouraging given this pathway and the Lung pathway account for 71% of patients who breach the national 62 day cancer standard. We have increased executive oversight of all the improvement work for 62 day cancer standards and the teams have developed detailed analysis and improvement trajectories for all of the pathways that are not compliant with the standard. This will minimise the risks to the delivery of the commitments we have made in the 62 day [illegible]6.

Key agenda items

GIRFT Further Faster 20

Tom Briggs recent visit to the Friarage Hospital at Northallerton and shared data with clinical and operational colleagues re South Tees performance in the further faster programme relative to other trusts in the programme who are making more progress. The visit was productive providing some challenge and support for out teams to accelerate their improvements as part of this programme. Our team had an opportunity to show him the new surgical centre which was recent accredited by the GIRFT team. He like others was very impressed with the efforts colleagues have taken with the design and flow of the new facilities

The NHSE national validation sprint continues to run from 7th April to 30th June 2025, with no cap on the financial incentive linked to clock stops above baseline (same period in 2024/25). Both South Tees and North Tees are currently running at 4% cumulative clock stops above baseline as at latest data week ending 4th May 2025.

Following successful reduction in PTL size at other FF20 Trusts, South Tees have engaged MBI Health to undertake some targeted validation which will commence on 27th May. 10,000 additional records will be validated, focusing particularly on the outpatient review (OPR) waiting list to improve data quality. The income from the validation sprint is expected to cover the costs of external validation support. Work is progressing internally on the use of robotic process automation (RPA) in waiting list validation.

Key areas of focus;

- Neurology
- Orthopaedics
- Urology
- Maxillofacial Surgery
- Sleep Medicine
- Growth in PTL size
- Outpatient pathways and utilisation of clinics.
- DNA rates

The Very Senior Management (VSR) Pay Framework

The latest VSM pay framework was released week commencing 12 May 2025. Key highlights;

- New pay bands: The pay bands have been redrawn to account for organisational size more appropriately, better align with the complexity and responsibilities of the roles in each specific organisation and bring greater consistency between pay for NHS providers and ICBs.
- Recruitment premier for challenged organisations: The new framework will increase the recruitment premium for challenged organisations (those in segment 5 in the new NHS Performance Assessment Framework) from 10% to 15%.

- Bonus: The new framework includes the option of a local bonus scheme of up to 10% for VSMs who have exceeded expectations and made achievements which go beyond the standard remit of their role.
- Pay awards: VSMs who do not make improvements and their organisation remains in the Recovery Support Programme and allocated to the lowest NPAF segment 5 will be automatically ineligible for the annual pay award, unless certain limited exemptions apply.

Strategy Progress Update

The UHT strategy was approved by the group board on 8 May and the programme board meets for the third time on Weds 21 May; it is now in a monthly cycle. We are successfully escalating and working through the issues raised in workstreams.

Estates Strategic Outline Case Draft Report

With regards to the clinical model, there were some concerns raised by clinical board members regarding the demand and capacity assumptions made. This may result with a delay until consensus is achieved in bed numbers in particular the assumptions around Hospital at Home beds

A number of required activities have been completed and further key activities are planned and will be incorporated into a developing action plan that will support achieving the final SOC deadline date

PLACE Committees

Executive leads have been allocated to each PLACE to ensure clear links with the Scrutiny Committees and Wellbeing Committees within the Local Authorities.

PFI Exit Strategy / Hand Back

Work continues on the decant to ensure timelines for hand back are met.

There is work ongoing across the region to try and share resource and expertise (sub group of ICS Infrastructure Board).

An internal PFI steering group has been set up and it will report into Executive Team and Resource Committee.

Board Assurance Framework & Operational Risk Report

Standardised and consistent Board Assurance Framework reporting arrangements are now embedded at Committee and Board level and have been in place since November 2024. This includes the format, content and reporting arrangements. The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

The Risk Management Policies for each Trust have been reviewed and a single Risk Management Policy has been written to reflect the standardised and consistent approach. This is in the final stages of approval with the Group Company Secretary.

Other Business

Notice to ballot
Both trusts have received notice to ballot from the BMA regarding resident doctors.

Group Restructure
Following feedback sessions with staff in both Trusts, The Group Management Team agreed to change the name of the new Clinical Business Units to Clinical Service Units (CSUs).

Recommendations:

The Group Board are asked to receive the report; acknowledge the monthly meeting of the Group Management Team meeting and the oversight and assurance it provides to the Trust.

University Hospitals Tees

UHT Strategy Update

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 10

Report author: *James Bromiley, Associate Director of Group Development and Matt Neligan, Deputy Chief Executive and Chief Strategy Officer*

Executive director sponsor: *Matt Neligan, Deputy Chief Executive and Chief Strategy Officer*

Action required:
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *n/a*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Work on the implementation of the UHT strategy continues to progress at pace. Significant progress is being made on the clinical elements of the strategy through the six 'horizontal integration' pilot projects. Wider enablers and approaches to implementation are being established to ensure that we are able to progress work effectively and achieve our strategic objectives.

Recommendations:

The Group Board are asked to:

- note the progress on implementation of the UHT strategy; and
- comment on the approach being take

Caring Better Together

Group Board
3 July 2025
UHT Strategy Update

1. PURPOSE OF REPORT

The report updates the board on progress with implementation of the University Hospitals Tees strategy. This will develop into a regular report to the Board to ensure that we are effectively delivering the ambition set out in the strategy. It summarises headline progress against the three pillars of the strategy, the key enablers (specifically estates in this instance) and wider mechanisms for ensuring that the organisation and partners are supporting the delivery of the strategy.

2. BACKGROUND

The UHT strategy was approved on 8 May. It confirms the vision, values and strategic objectives for the group. It sets out the ways in which we will need to work differently to deliver against those objectives, through reforming ways of working in relation to three pillars:

- **Patients and populations:** our work to reform our clinical services so that we develop new models of care across the UHT footprint that meet the needs of patients and address population health priorities;

- **People:** being an employer of choice for our existing people and potential new colleagues, developing our people through living our values and creating an outstanding experience across all teams in UHT. Ensuring that we are a learning health organisation with a culture of continuous improvement; and

- **Partnerships and places:** our close collaboration with all of our partners to develop and deliver our shared integrated care strategy and ambitions in local places. Working in communities to maximise our impact as an anchor institution.

Supporting these pillars is the transformation of key enabling functions (in particular our work in quality, digital, estates and productivity) and the development of our revised operating model.

Since then work has continued at pace to implement the strategy, through specific changes in key areas and through continuing to define further some of the longer term work streams.

3. DETAILS

Headlines on progress to implement the strategy include:

<u>Engagement on the strategy</u>

gement. We are now working to embed the voice and views of staff, rs in how the detail of the strategy is developed and implemented.

The strategy makes it clear that our ambition is about much more than working together as a UHT group, rather it is about redefining services within a wider healthcare system in the area, including primary care, local authorities and the third sector. This work builds on our earlier work with Healthwatch across seven local authorities to understand the priorities from patients and service users for inclusion in the strategy. We are now building patient voice into our work to implement the strategy through our existing patient engagement channels and new work to embed patient perspectives into strategic change projects.

Potential consultation. In addition we have begun dialogue with the ICB to prepare for more formal consultation where that may be required in relation to specific services. As business cases and implementation plans for specific services are finalised, we will agree with the ICB and confirm with relevant scrutiny committees the planned service changes that require formal public consultation.

Pillar 1: Patients and populations

Horizontal integration pilots. The strategy establishes a clear direction of travel that all services will be working in a horizontally integrated way within the next 2-3 years. The horizontal integration pilots are the early work to test this approach, with the aim of establishing integrated services by March 2026. Each of the services (cardiology; Integrated Single Point of Access/Hospital at Home; urology; urgent care; reproductive medicine and stroke) are developing joined-up care in a different way within a standard framework and planning process.

The pilots (along with earlier work to develop a Tees Valley Pathology Service) are vital for testing how to work across UHT and will enable us to draw out general principles and generate solutions. Across these areas early learning is developing on how to work across different digital systems, how to manage budgets across two statutory organisations and how to recruit and performance manage staff across the group.

Clinical boards. The aim is that the role of the clinical boards in developing future clinical strategy will pass to the new clinical leadership teams from September. The implementation of a single clinical management and leadership structure across UHT will give us the capacity and focus to develop service-level responses to the strategy for each clinical area over the next five years, with aligned pathways, equity of access and services working in a truly integrated way.

Pillar 2: People

Leadership and operating model. The ongoing work to align clinical and operational leadership teams (led by triumvirates at all levels) will be a key enabler for helping our teams to develop consistent service models and standards across UHT and to implement the strategy. We have heard views from teams across the group and have tested with Trade Unions as we have finalised proposals to develop 10 Clinical Service Units that will be responsible for operational management of services and for implementation of plans to transform and improve services in line with the strategy. [illegible] on the resulting structure runs until August and we expect that the

formal feedback from individuals and teams across the organisations will help to further shape the final leadership structures that we will put in place from September.

Improvement framework. We are beginning work to embed a framework for continuous improvement within UHT. This will need to link up and align work across all teams to (i) transform services to meet the strategic objectives; (ii) deliver priority improvements in operational service delivery, quality and performance across UHT; and (iii) continuous quality improvement in services driven in individual teams and services against the framework. To ensure success this will need to bring together all existing work against these areas and to realign ambitions to delivery of the strategic objectives within a culture and expectation of continuous improvement.

Pillar 3: Partnerships and places

Joint working with local authorities. The strategy sets out our ambition to work at scale but also retain our focus on communities by working at place. We have agreed with local authority chief executives that we will develop a small number of projects to tackle joint priorities with each council and should support the development of neighbourhood health models.

Executive directors and deputies have been named for each of the local authority areas to ensure that there is consistency in senior relationships and consistency of communication in forums such as health and wellbeing boards and scrutiny committees. These relationships will be crucial in considering the needs of specific communities in making changes.

Key enablers

Focus on estates. The Strategic Outline Case for the replacement of a substantial part of the North Tees estate is under development and we are planning this with the advice of the ICB. Our future long-term service model as set out in the strategy involves a major reform of services to deliver long term benefits for patients through a significant expansion of community-based services and considering the consolidation of inpatient and specialist services within the acute hospital estate. It specifically anticipates a move towards an acute general hospital on one principal site (with an Emergency Department linked to most general medicine and surgery) and an acute specialist hospital on the other principal site (with an Emergency Department linked to specialist and tertiary services). That requires major capital investment to fund the estates development to enable the relocation and consolidation of services. The scale of these potential changes will require a Pre-Consultation Business Case to sit alongside the Strategic Outline Case for estates across the group. We will update on that work in the autumn subject to feedback from ICB and NHS England colleagues.

Measuring progress and evaluating the benefits of the strategy

Metrics for success. In the strategy we said we would measure the outcomes of the strategy against the three reform “pillars” – patients and populations, people, and partnerships and places. While the impact of the strategy will be on our ability to deliver high quality and performance of service in the long-term, we are now working on a suite of measures that illustrate delivery of the short- and medium-term

changes to services that set us up to make progress on the longer-term outcomes. Our overall approach is to avoid unnecessary duplication and where possible to use measures that are well-recognised, for example those reported through the Integrated Performance Report.

We will publish these measures later in 2025 with baselines to be set at the start of the 2025/26 financial year unless there is a specific reason to set it differently. Over time these measures will enable us to evaluate the impact of the group across the reform pillars and to take corrective measures where a measure is not improving.

The enabling strategies (key areas being digital, estates, finance and quality) will have process measures to ensure that they are being delivered in support of the clinical benefits we are expecting to see through the strategy reforms.

Ensuring strong governance to provide assurance over delivery

Strategy Programme Board. The Group Strategy Programme Board is now becoming embedded in a monthly cycle and provides the forum to check progress on the strategy through exception reporting and agreeing corrective action where necessary. While some other forums have oversight of specific areas within the UHT strategy, the Programme Board takes the broad view across the whole of the strategic change programme and is the only place where interdependencies can be logged and addressed.

Board Assurance Framework. The UHT strategic objectives are now also embedded within the Board Assurance Framework and the risks associated with failure to achieve the strategy at an agreed pace are managed through that mechanism.

We know that our strategy will need to evolve. The imminent publication of the Government's 10 Year Health Plan may provide more detail on the ambitions around digitisation; community services and prevention which will be built into the strategy and through it the Board Assurance Framework.

4. RECOMMENDATIONS

The Board are asked to:

- note the progress on implementation of the UHT strategy; and
- comment on the approach being taken.

University Hospitals Tees

Board Assurance Framework Report 2025/26 (reporting to 30 April 2025) NTHFT/STHFT

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 11

Report author: *Stuart Irvine, Director of Risk, Assurance & Compliance*

Executive director sponsor: *Stuart Irvine, Director of Risk, Assurance & Compliance*
Action required:
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: n/a

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to

NTHFT BAF – All domains

STHFT BAF – All domains

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Standardised and consistent Board Assurance Framework reporting arrangements are now embedded at Board and Committee level and have been in place since November 2024. This includes the format, content and reporting arrangements. The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

The Board Assurance Frameworks have been reviewed and refreshed for 2025/26.

Headlines

NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 10 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite.
- There are 111 planned mitigating actions within the BAF across the 8 domains.
- Planned action timescale range is April 2025 – October 2027.

STHFT

- There are 30 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 11 strategic risks are outside of approved risk appetite, of which there are 8 red/high strategic risks outside of approved risk appetite.
- There are 115 planned mitigating actions within the BAF across the 8 domains.
- Planned action timescale range is April 2025 – April 2035 (this includes planned timescales linked to PFI exit strategy, 2033 and eradicating RAAC, 2035).

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Risk Management Policy/Strategy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Work has commenced to draft a Risk Management Strategy which will be completed by the end of August 2025.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Assurance Statement

This report provides assurance that a comprehensive refresh of the Board Assurance Framework has been undertaken for 2025/26. This provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported.

Mitigating actions (with timescales) are in place for all strategic risks. Full details are reported to the assurance committees of the Group Board, allowing oversight and to allow for further actions to be identified for assurance purposes. Chair Escalation Reports are the mechanism to report assurance concerns to the Group Board.

External Assurance

Internal audits of the Board Assurance Framework and risk management processes has been completed for each Trust by their respective internal auditors in 2024/25. The report for STHFT provides an overall medium level of assurance and the audit for NTHFT provides good assurance, which are positive assurance outcomes. Agreed recommendations are in the process of being implemented and are overseen by respective Audit Committees.

Recommendations:

The Group Board is asked to;

- Receive the report and assurance that the Board Assurance Frameworks for each Trust has been reviewed and refreshed for 2025/26.
- Note the content of this report to 30th April 2025.
- Note the 7 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Approve the content of the Board Assurance Framework for each Trust, strategic risks, risk scores and proposed risk appetites.

North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 30th April 2025)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 7 red/high strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 111 planned mitigating actions. • Planned action timescale range - April 2025 – October 2027.	• 30 identified strategic risks. • 8 red/high strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 115 planned mitigating actions. • Planned action timescale range - April 2025 – April 2035.

1. Background

The development and maintenance of a Board Assurance Framework (BAF) has been a mandatory requirement since 2001 for NHS Trusts. The Board Assurance Framework is the key mechanism to reinforce the strategic focus of the Board of Directors to manage strategic risks. It enables the Trust to capture, reporting and monitor key risks that may prevent the delivery of strategic objectives. Operated efficiently and effectively, it provides assurance to the Board of Directors that the Trust is managing strategic risks. The BAF is the key driver to inform the agenda of the Board of Directors and Committee meetings.

2. Purpose

The purpose of this report is to provide assurance to the Group Board (and each Unitary Board) regarding the identification, management and mitigation of strategic risks to support the delivery of strategic objectives. Furthermore, this provides a clear and robust mechanism for Ward to Board and Board to Ward reporting (linking strategic and operational risks).

3. Report Detail

BAF Arrangements

Under Group arrangements an action was to standardise and achieve consistency with Board Assurance Framework format, content and reporting. This action was implemented and reported to the committees of the Group Board from November 2024. Reporting arrangements and timing of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

Key Point: The reporting period of the BAF and Integrated Performance Report are aligned to support triangulation of key performance metrics and the mitigation of strategic risks.

BAF Format

University Hospitals Tees has 6 newly approved strategic objectives for 2025/26 and the Board Assurance Framework makes direct reference to them and identifies the strategic risks that may prevent the delivery of each objective.

The strategic risks are linked to a BAF domain, which reflects key areas of our business/activity and enables an understanding of the nature of the risk. There are 8 BAF domains for each Trust. The BAF domains were informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

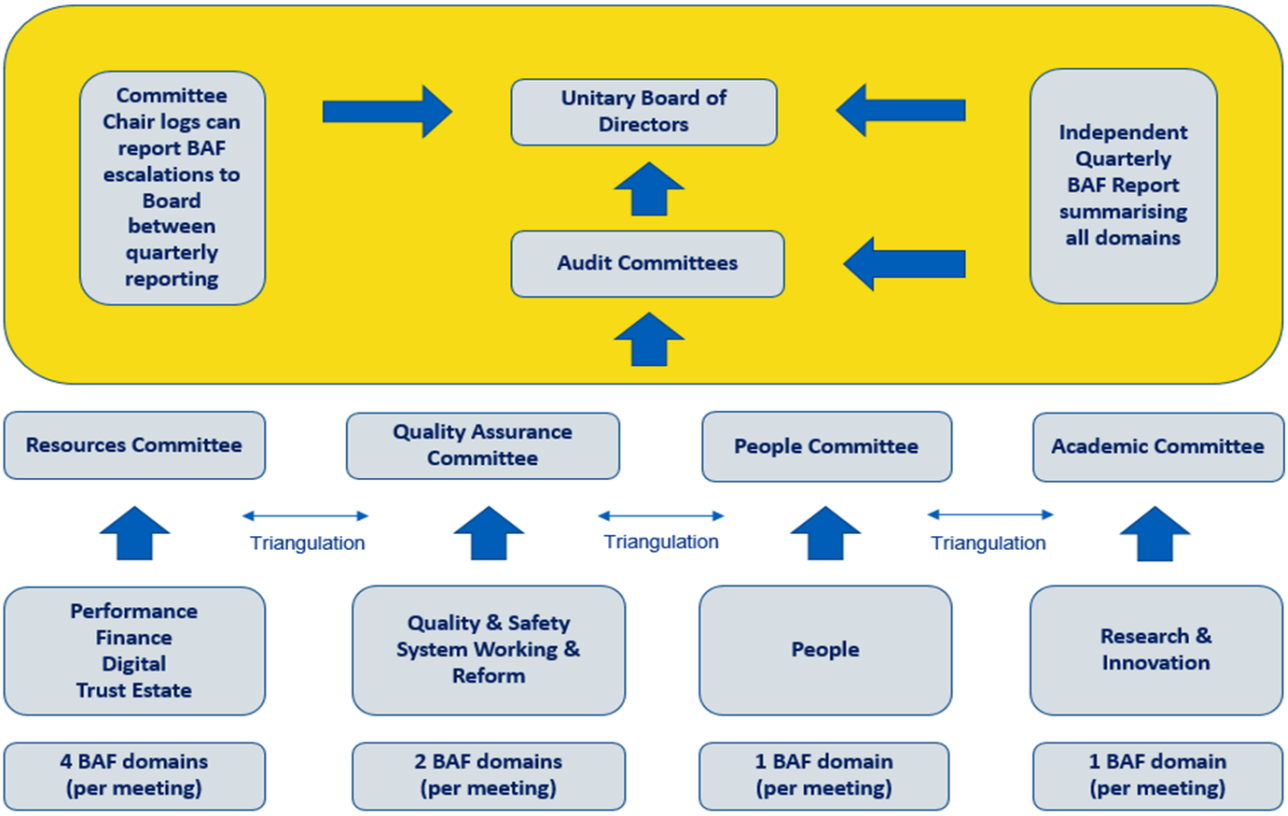
The 8 BAF domains for each Trust are led by a Director, with identified BAF authors and the Board Committee that is responsible for oversight and escalation reporting to Board. The table below provides full details.

BAF Domain	Responsible Director	BAF Author	Committee oversight
Quality & Safety	Group Chief Nurse	Group Deputy Director of Patient Safety/Deputy Chief Nurse	Quality Assurance Committee
Performance & Compliance	Group Managing Director/Chief Operating Officers	Deputy Director of Strategy & Planning/ Associate Director of Planning & Performance	Resources Committee
People	Group Chief People Officer	Deputy Director of People Services/ Head of Workforce Planning, Quality & Projects	People Committee
System Working & Reform	Group Chief Strategy Officer	Associate Chief Operating Officer/ Care Group Director, Healthy Lives	Quality Assurance Committee
Finance	Group Chief Finance Officer	Deputy Chief Finance Officer/ Deputy Director of Finance	Resources Committee
Digital	Group Chief Information Officer	Interim Head of IT/ Deputy Chief Information & Technology Officer	Resources Committee
Trust Estate	Group Director of Estates	Associate Director of Estates & Capital (NTH Solutions LLP)/Deputy Director of Estates, Capital and Programmes	Resources Committee
Research & Innovation	Group Medical Director	Associate Director, TVRA/Director of Innovation	Quality Assurance Committee

(*) Review of this domain has been completed by the Chief Strategy Officer.

Question to Board: Do the 8 BAF domains reflect the key areas of Trust business/activity? The BAF domains will be subject to an annual review for relevance and will be considered against available benchmarking information in readiness for 2026/27.

For continued illustration purposes, the reporting arrangements for the BAF are set out below, with the addition of the Academic Committee, which held its first meeting in April 2025 and meets on a quarterly basis going forward. The benefit of this approach allow Board Committees to receive BAF reports at each meeting focus on their areas of expertise, reports are presented by subject matter experts who manage and mitigate the risks. Key to the management and mitigation of strategic risks is the triangulation between Board Committees.



BAF Domain Alignment to Strategic Objectives

It is important that all strategic objectives of each Trust is aligned to at least one BAF domain to support the delivery of strategic objectives. The BAF domain template require the BAF domain to be linked to at least one strategic objective. The mapping of BAF domains to strategic objectives for 2025/26 is set out below and provides assurance that the identified BAF domains are relevant for each organisation.

BAF Domain (8)	GROUP Strategic Objectives (6)						
	Putting patients first with **consistent high-quality care** that delivers best practice in effectiveness, safety and experience	**Working with partners** to tackle shared population health challenges and to reduce health inequalities for our population	**Reforming models of care** across our services and supporting the development of neighbourhood health systems	Developing **excellence as a learning organisation** through our work in research, education, improvement and innovation	Creating an **outstanding experience for our people** by leading well and being an employer of choice	**Using our resources well** by driving productivity in services to achieve financial sustainability	**BAF Domain Links**
Quality & Safety	✓		✓		✓		3
Performance & Compliance	✓					✓	2
Digital	✓					✓	2
Finance						✓	1
People	✓			✓	✓	✓	4
Trust Estate			✓			✓	2
System Working & Reform		✓	✓				2
Research & Innovation		✓		✓			2
Links to strategic objectives	4	2	3	2	2	5	

Question to Board: Are the domains clearly linked to strategic objectives?

Risk Appetite

The proposed risk appetites for the BAF domains for each Trust are set out below and have been reported to Committees in June 2025. The proposed risk appetites for 2025/26 are consistent with 2024/25, reflecting the increased risk environment and challenges to deliver annual plans.

Risk domain	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
Quality & Safety	Cautious	Cautious	4-6
Trust Estate	Open	Open	8-12
Performance & Compliance	Open	Open	8-12
People	Open	Open	8-12
Digital	Open	Open	8-12
Finance	Open	Open	8-12
Research and Innovation	Open	Open	8-12
System Working & Reform	Open	Open	8-12

Risk Appetite Supporting Statements

The approved risk appetites and supporting risk appetite statements of each Trust are consistent. This provides each Trust and the Boards with the ability consider future decision

making against approved risk appetites by domain and supporting risk appetite statement. This maintains existing governance arrangements and ensures compliance with good governance requirements. Risk appetite is formally reviewed on an annual basis by the Board and an annual Board seminar on risk appetite is held. Attached at **Appendix A** is the approved risk appetite supporting statements.

Key Point: The proposed risk appetites and supporting risk appetite statements of each Trust are consistent. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by domain and supporting risk appetite statement. The risk appetite position will remain under review and is formally reviewed annually.

Strategic Risk Score Analysis

The following table shows by Trust, the number of strategic risks, number of strategic risks outside of approved risk appetite, steps away from approved risk appetite and the number of planned mitigating actions.

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Quality & Safety	3	3	**3**	**3**	1	1	9	9
Performance & Compliance	3	4	0	**2**	0	1	8	16
Digital	4	3	0	0	0	0	16	14
People	4	4	0	0	0	0	17	15
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	24	22
System Working & Reform	2	2	0	0	0	0	20	20
Research & Innovation	5	5	**3**	**3**	1	1	12	14
Total Number	**30**	**30**	**10**	**11**			**111**	**115**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 10 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is April 2025 – October 2027.	• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 11 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is April 2025 – April 2035.

Included in the planned timescales are the actions linked to PFI exit strategy (2033) and eradicating RAAC 2035.

NTHFT Red/High Strategic Risks outside Approved Risk Appetite

The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.	Finance	**4 x 4 = 16**	1	Resources Committee
Failure of Trust infrastructure (including buildings).	Trust Estate	**3 x 5 = 15**	7	Resources Committee
Insufficient capital funding to maintain Trust estate.	Trust Estate	**5 x 4 = 20**	4	Resources Committee
Reduction of system capacity if the Trust is unable to provide services.	Trust Estate	**5 x 3 = 15**	3	Resources Committee
Over-reliance on external income leads to R&D financial uncertainty and limits growth.	Research & Innovation	**4 x 4 = 16**	5	Academic Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Innovation growth is limited by investment and resource constraints.	Research & Innovation	**4 x 4 = 16**	2	Academic Committee
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.	Research & Innovation	**4 x 4 = 16**	1	Academic Committee

The reported position is illustrated and supported by the Trust's Strategic Risk Overview **(See Appendix B)** and the Trust Risk Radar **(See Appendix C).**

STHFT Red/High Strategic Risks Outside Approved Risk Appetite

The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 8 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Inability to controls costs within allocated resources	Finance	**4 x 4 = 16**	1	Resources Committee
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	7	Resources Committee
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	2	Resources Committee
Insufficient capital funding to maintain Trust estate	Trust Estate	**4 x 5 = 20**	2	Resources Committee

Trust estate does not allow for the provision of optimal clinical services	Trust Estate	**3 x 5 = 15**	2	Resources Committee
Over-reliance on external income leads to R&D financial uncertainty and limits growth	Research & Innovation	**4 x 4 = 16**	5	Academic Committee
Innovation growth is limited by investment and resource constraints	Research & Innovation	**5 x 3 = 15**	2	Academic Committee
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.	Research & Innovation	**5 x 4 = 20**	3	Academic Committee

The position is illustrated by the Trust's Strategic Risk Overview **(See Appendix D)** and the Trust Risk Radar **(See Appendix E).**

Trust Operational Risks

Attached as appendices for information are the Top 10 operational risk for each Trust (**Appendix F** – NTHFT and **Appendix G** – STHFT) for information. Operational risks of each Trust are reviewed on a monthly basis by respective Risk Management Groups.

Risk Management Policy/Strategy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Work has commenced to draft a Risk Management Strategy which will be completed by the end of August 2025.

External Assurance

Internal audits of the Board Assurance Framework and risk management processes has been completed for each Trust by their respective internal auditors. The report for STHFT has been received and provides an overall medium level of assurance and the audit for NTHFT provides good assurance. Agreed recommendations are in the process of being implemented.

4. Conclusion/Summary

The refresh of the BAF for 2025/26 has now been completed. This incorporates;

- The requirement to maintain separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF domain to the relevant newly approved Group strategic objectives.
- Proposed risk appetite for each BAF domain and supporting statement for 2025/26.
- The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.
- Board Committees have full oversight of the BAF report, in additional to the oversight responsibility allocation for BAF domains. A copy of the full BAF report for each Trust is placed in the Reading Library of each Committee.
- Board Committees will escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Logs.
- The medium/long term strategy/plan that each BAF domain is linking/referencing strategic risks e.g. UHT Strategy, Quality Priorities, People Plan etc.
- Ensuring strategic risks in each BAF domain are strategic in nature (they may run beyond a 12 month period).
- Ensure mitigating planned actions are strategic and will either maintain a current risk score or achieve a target risk score.
- Review of linked operational risks to ensure they are they up to date and linked to strategic risks. Work in this area remains ongoing.
- Carry forward the learning from 2024/25 and internal audit report findings.
- There are 30 strategic risks relating to NTHFT and there are 7 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- There are 30 strategic risks relating to STHFT and there are 8 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- This report is also presented to respective Audit Committees.

Assurance Statement

This report provides assurance that a comprehensive refresh of the Board Assurance Framework has been undertaken for 2025/26. This provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported.

Mitigating actions (with timescales) are in place for all strategic risks. Full details are reported to the assurance committees of the Group Board, allowing oversight and to allow for further actions to be identified for assurance purposes. Chair Escalation Reports are the mechanism to report assurance concerns to the Group Board.

Board Seminar – Board Assurance Framework & Risk Appetite

A Board Seminar took place on 5th June 2025 on the Board Assurance Framework and risk appetite. This exercise takes place on an annual basis.

5. Recommendation

The Group Board is asked to;

- Receive the report and assurance that the Board Assurance Framework for each Trust has been refreshed for 2025/26.
- Note the content of this report to 30th April 2025.
- Note the 7 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Approve the content of the Board Assurance Framework for each Trust, strategic risks, risk scores and proposed risk appetites.

Supporting Appendices

- Appendix A – Risk Appetite Supporting Statements
- Appendix B – NTHFT Strategic Risk Overview
- Appendix C – NTHFT Risk Radar
- Appendix D – STHFT Strategic Risk Overview
- Appendix E – STHFT Risk Radar
- Appendix F – NTHFT Top 10 Operational risks
- Appendix G – STHFT Top 10 Operational Risks

Trust Risk Appetites & Supporting Statements (*)

Board Assurance Framework Domain	Proposed Risk Appetite	Proposed Risk Appetite Supporting Statement
Quality & Safety	**Cautious**	We have a **cautious** attitude to the delivery of the **Quality and Safety** agenda within the Trust to balance low risk against the possibility of improved patient outcomes, ensuring appropriate controls are in place. We will continue to protect the quality and safety of care with a cautious approach to the risks that may have a detrimental impact on patient safety, experience and clinical outcomes.
Performance & Compliance	**Open**	We have an **open** approach to **Performance and Compliance**. This will mean being willing to consider options available to support the delivery of performance targets and recognising the significant challenge to deliver Trust/System level targets and the needs to work with our system partners.
Digital	**Open**	We have an **open** attitude to the **Digital** agenda underpinning clinical innovation and the transformation of services to become more efficient and effective, including system collaboration. While we are prepared to accept some level of risk to implement changes for longer-term benefit, we will ensure that information governance and data security remains a priority.
People	**Open**	We have an **open** risk approach to our **People** challenges as we look at new and innovative ways to recruit, retain and support our people, whilst recognising the importance of a strong focus on engagement and culture.
Finance	**Open**	We have an **open** attitude to risk in relation to **Finance**. It is acknowledged that there are significant finance challenges across the healthcare system and options will need to be considered to support delivery of challenging financial plans and achieve favourable outcomes. The Trust will continue to apply robust financial controls and comply with governance requirements.
Trust Estate	**Open**	We have an **open** attitude to the **Trust Estate** due to the associated risks and need to consider all potential options to ensure the estate remains fit for purpose to deliver safe and effective care.
System Working & Reform	**Open**	We have an **open** approach to **System Working & External Threats** to ensure future safe, effective and sustainable services are provided to our population. We will explore new opportunities on an ongoing basis to deliver major reform knowing that will involve taking a measure of risk.
Research & Innovation	**Open**	We have an **open** approach to **Research and Innovation** in recognition of the requirement of new ways of working. In developing and delivering our clinical research and innovation ambitions we accept that these carry a higher level of inherent risk. We will seek opportunities to work collaboratively with system partners, contribute to the delivery of priorities and develop new ways of working through a range of partnerships.

(*) The risk appetites and supporting risk appetite statements are the same for each Trust.

NTHFT - Board Assurance Framework

Risk Appetite				
Avoid 0	Minimal 1-3	Cautious 4-6	Open 8-12	Seek 15 -25

Quality & Safety	Digital	People	Finance	Performance and Compliance	System Working & Reform	Trust Estate	Research & Innovation
Patient safety – Failure to protect people from abuse or avoidable harm	Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda	A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future	Adverse financial impact due to system working requirements (Health & Care Act 2022)	Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment recovery priorities	The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy	Failure of Trust infrastructure (including buildings)	Lack of integration of research with digital infrastructures prevents the delivery of effective research
Patient experience – Failure to provide care that is compassionate, kind and inclusive	Failure to protect the information / data we hold as a result of non-compliance with legislation and/or non-compliance with Trust policy	A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements	Insufficient funding in existing contract arrangements for services provided to the population	Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities	The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales	Insufficient capital funding to maintain Trust estate	Growth research is constrained by infrastructure, capacity and culture
Failure to provide clinically effective treatment in line with best evidence	Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack)	A Health and Wellbeing offer that doesn't meet the needs of our workforce	Inability to controls costs within allocated resources	Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities		Trust estate does not allow for the provision of optimal clinical services	Over-reliance on external income leads to R&D financial uncertainty and limits growth
	Pressured resources within Digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process)	Workforce planning and people practices don't support the Trust to deliver its services	Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan			Reduction of system capacity if the Trust is unable to provide services	Innovation growth is limited by investment and resource constraints
						Non-compliance with legal and regulatory standards of the Trust's estate	Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture

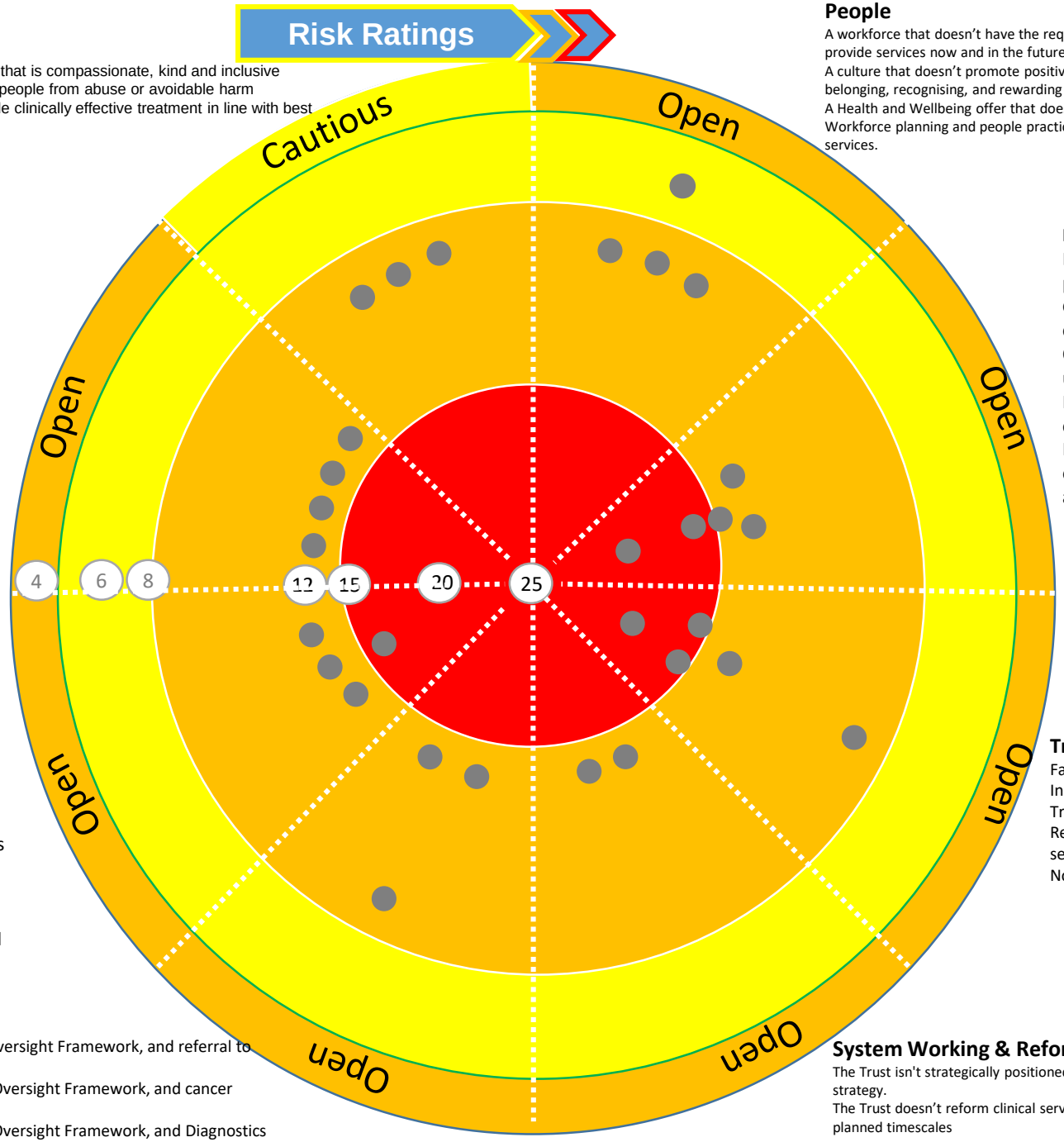
Strategic Risks

Strategic Risk Level			
Very Low 1-3	Low 4-6	Moderate 8-12	High 15- 25

Appendix C

NHS
North Tees and Hartlepool
NHS Foundation Trust

30th April 2025
BAF Risk Radar



High
Moderate
Low

Quality & Safety
Patient safety – Failure to provide care that is compassionate, kind and inclusive
Patient Experience – Failure to protect people from abuse or avoidable harm
Clinical Effectiveness - Failure to provide clinically effective treatment in line with best evidence

People
A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future.
A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.
A Health and Wellbeing offer that doesn't meet the needs of our workforce.
Workforce planning and people practices don't support the Trust to deliver its services.

Digital
Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda
Failure to protect the information / data we hold as a result of non-compliance with legislation and/or non-compliance with Trust policy
Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack)
Pressured resources within Digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process)

Research & Innovation
Lack of integration of research with digital Infrastructures prevents delivery of effective research.
Growth in research is constrained by infrastructure, capacity and culture.
Over-reliance on external income leads to R&D financial uncertainty and limits growth.
Innovation growth is limited by investment and resource constraints.
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.

Finance
Adverse financial impact due to system working requirements (Health & Care Act 2022).
Insufficient funding in existing contract arrangements for services provided to the population.
Inability to controls costs within allocated resources.
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.

Trust Estate
Failure of Trust infrastructure (including buildings)
Insufficient capital funding to maintain Trust estate
Trust estate does not allow for the provision of optimal clinical services
Reduction of system capacity due to the Trust being unable to provide services, impacting on reputation
Non-compliance with legal and regulatory standards of the Trust's estate.

Performance & Compliance
Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment recovery priorities
Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities
Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities

System Working & Reform
The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy.
The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales

STHFT - Board Assurance Framework

Risk Appetite				
Avoid 0	Minimal 1-3	Cautious 4-6	Open 8-12	Seek 15 -25

Quality & Safety

- Failure to protect people from abuse or avoidable harm
- Failure to provide care that is compassionate, kind and inclusive
- Failure to provide clinically effective treatment in line with best evidence

Digital

- Failure to implement planned digital programmes and infrastructure projects through lack of adequate funding
- Failure to adequately maintain and upgrade current systems and infrastructure
- Failure to prevent a successful cyber attack or data breach

People

- A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future
- A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements
- A Health and Wellbeing offer that doesn't meet the needs of our workforce
- Workforce planning and people practices don't support the Trust to deliver its services

Finance

- Adverse financial impact due to system working requirements (Health & Care Act 2022)
- Insufficient funding in existing contract arrangements for services provided to the population
- Inability to controls costs within allocated resources
- Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan

Performance and Compliance

- Risk that the A&E 4-hour standard is not met
- Risk that the referral-to-treatment 18-week NHS Constitution standard is not met
- Risk that the diagnostic 6-week NHS Constitution standard is not met
- Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met

System Working & Reform

- The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy
- The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales

Trust Estate

- Failure of Trust infrastructure (including buildings)
- Insufficient capital funding to maintain Trust estate
- Trust estate does not allow for the provision of optimal clinical services
- Reduction of system capacity if the Trust is unable to provide services
- Non-compliance with legal and regulatory standards of the Trust's estate

Research & Innovation

- Lack of integration of research with digital infrastructures prevents the delivery of effective research
- Growth research is constrained by infrastructure, capacity and culture
- Over-reliance on external income leads to R&D financial uncertainty and limits growth
- Innovation growth is limited by investment and resource constraints
- Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture

Strategic Risk Level			
Very Low 1-3	Low 4-6	Moderate 8-12	High 15- 25

Strategic Risks

Appendix E

NHS South Tees Hospitals NHS Foundation Trust

Quality & Safety

Patient safety – Failure to provide care that is compassionate, kind and inclusive
Patient Experience – Failure to protect people from abuse or avoidable harm
Clinical Effectiveness - Failure to provide clinically effective treatment in line with best evidence

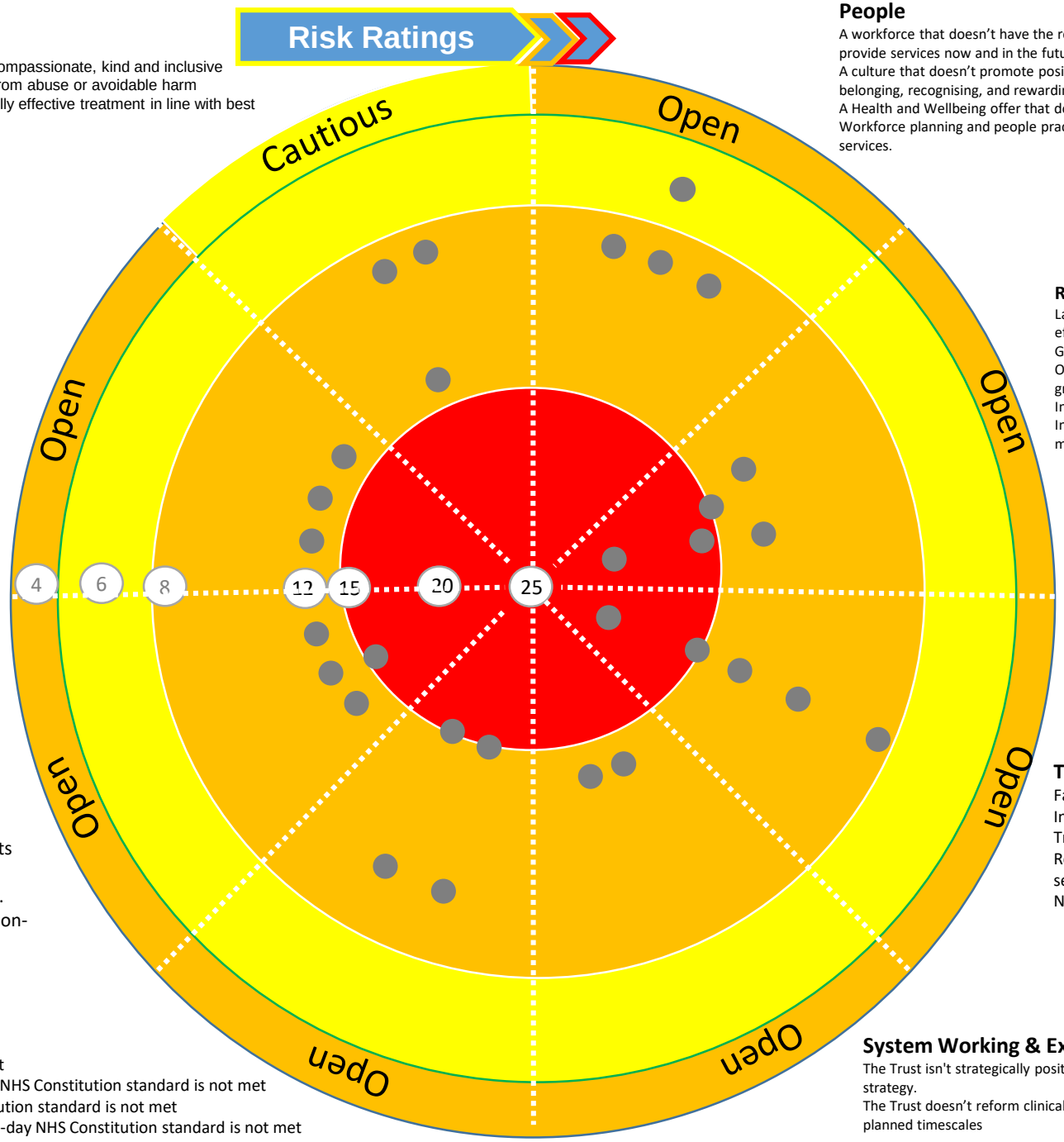
- High
- Moderate
- Low

People

A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future.
A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.
A Health and Wellbeing offer that doesn't meet the needs of our workforce.
Workforce planning and people practices don't support the Trust to deliver its services.

Digital

Failure to implement planned digital programmes and infrastructure projects through lack of adequate funding
Failure to adequately maintain and upgrade current systems and Infrastructure
Failure to prevent a successful cyber attack or data breach



30th April 2025
BAF Risk Radar

Research & Innovation

Lack of integration of research with digital Infrastructures prevents delivery of effective research.
Growth in research is constrained by infrastructure, capacity and culture.
Over-reliance on external income leads to R&D financial uncertainty and limits growth.
Innovation growth is limited by investment and resource constraints.
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.

Finance

Adverse financial impact due to system working requirements (Health & Care Act 2022).
Insufficient funding in existing contract arrangements for services provided to the population.
Inability to controls costs within allocated resources.
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.

Trust Estate

Failure of Trust infrastructure (including buildings)
Insufficient capital funding to maintain Trust estate
Trust estate does not allow for the provision of optimal clinical services
Reduction of system capacity due to the Trust being unable to provide services, impacting on reputation
Non-compliance with legal and regulatory standards of the Trust's estate.

Performance and Compliance

Risk that the A&E 4-hour standard is not met
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met
Risk that the diagnostic 6-week NHS Constitution standard is not met
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met

System Working & External Threats

The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy.
The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales

Appendix F

North Tees and Hartlepool NHS Foundation Trust

Top 10 Operational Risks (30 April 2025)

InPhase Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
141	Significant sickness absence and vacancy within the Resus team impacting on the capacity to deliver required Resus training for Trust staff which could impact on patient safety and resus outcomes.	Trust wide (People Directorate)	Rachel DeSilva, Head Of Culture, Leadership And Development	12
21	Poor patient outcomes due to dis-jointed layout of the EAU Assessment Area estate. Potential impact of delays to assessment, diagnosis, and treatment commencement, as well as responding to and managing clinical incidents.	Responsive Care	Claire Ranson, Service Lead, Responsive Care	12
212	Due to resource constraints we do not complete the required number of Structured Judgement Reviews (SJRs) and therefore do not meet the national Learning from Deaths standards which may result in problems in patient care are not recognised and opportunities to learn are missed. (Updated)	Medical Directors Office	Julie Christie, Consultant in Palliative Medicine and Trust Lead for Mortality and Learning from Deaths	12
69	Medical Job Planning Compliance.	Medical Directors Office	Caroline Metalf, Senior Rota lead	12
61	FIT testing provision.	Trustwide, Quality & Safety	Rebecca Denton Smith, Associate Director of Nursing	12
55	Risk of Patient Harm due to Aseptics reduced experience / capacity.	Pharmacy, Healthy Lives	Marco Pione, Lead Pharmacist For Aseptics And Sqcl Quality Assurance	12
36	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton.	Wheelchair Services, Healthy Lives	Fiona Hardie, Senior Clinical Professional	12
25	Delivery of Aseptics Services to the Trust are at risk due to current estate provision.	Pharmacy, Healthy Lives	Richard Scott, Associate Director of Pharmacy: Transformation & Business Lead	12
5970	Increase in levels of banding resulting from job evaluation requests.	Trust wide (People Directorate)	Michelle Taylor, Head Of Workforce Planning, Quality And Projects	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway.	Surgery & Urology, Collaborative Care	Steve Heavysides, Care Group Operational Manager	12

201	There is a potential that the Trust will not achieve appropriate fire safety training standards following changes to the HTM 05:03 Part A (2024) which emphasises the requirements of bespoke fire safety training, impacted by a lack of resources to deliver the increased volume of training and could lead to a sub optimal response in a fire situation.	Health & Safety, Corporate	Stephen Cuthbert, Fire Safety Advisor	12
195	Service delay and potential non compliance with GDPR / DPA IG if IG team are unable to provide a full IG service due to insufficient resources.	Information Governance, Digital	Kerry McLean, Information Governance Manager & Group Data Protection Officer	12
53	Sickness absence and vacancy within the Simulation service is reducing the ability to deliver a full simulation service which may impact on the quality and quantity of teaching provided to staff across the Trust	People, Corporate	Rachel DeSilva, Head Of Culture, Leadership And Development	12
5669	Workforce and skill mix deficit in critical care impacting on service delivery	Critical Care & ITU, Collaborative Care	Tom Bingham, Senior Clinical Matron, Critical Care	12
174	There is an expected reduction in newly qualified nurse availability in 2028 which affects nursing safe staffing levels impacting on patient safety, delivery of quality care and services. This will also result in reduction in associated financial tariff coming into NTH	Nursing & Patient Safety, Corporate	Emma Roberts, Associate Director of Nursing and Professional Workforce	12
183	Risk of suboptimal outcomes for patients due to being an outlier for the implementation of the National Wound Care Strategy Programme: Lower Limb Lower Recommendations	Nursing & Patient Safety, Corporate	Andy Brown, Senior Tissue Viability Nurse	12
239	Inability to appoint more than 1 competent persons to undertake PAS-79 Fire Risk Assessment impacting on the amount of risk assessments that can be completed within a 12 month period	Health & Safety, Corporate	Stephen Cuthbert, Fire Safety Advisor	12
6404	Risk to service delivery due to ICT Staffing Levels and BAU	Digital	Mick Fox, Head of ICT	12
30	Fragility of Infection Prevention and Control Workforce can lead to a loss of service and affect patient outcomes	Nursing & Patient Safety, Corporate	Victoria Hancock, Lead Nurse for IPC	12

Appendix G

South Tees Hospitals NHS Foundation Trust

Top 10 Operational Risks (30th April 2025)*

Datix Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
829	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Cellular Pathology	Sharron Pooley	20
797	RAAC - Panels - located in Women's and Children's area - James Cook - Area at risk of uncontrolled structural failure in areas where RAAC is present - Eradication required by 2035	Women and Children Services	Paul Swansbury Deputy Director of Estates, Capital, and Programmes	20
688	Unsupported SQL 2012 instance STAS461 leading to risks relating to cyber security and our ability to report essential information.	Information Technology	Michael Souter, Senior Information Manager	16
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neurorehabilitation outpatients.	Neurohabilitation	Jenna Moffitt	16
357	Risk that trust is not compliant with mandatory DCB 0129/0160 regarding risk management for Healthcare IT	Information Technology	Ian Willis	16
219	Risk that staff may suffer harm from violence or aggression due to not utilising lone worker devices.	Health and Safety	Catherine Maughan, Facilities Project / Staff Safety Lead	16
777	The Flouroscopy room at JCUH has been condemned reducing capacity, single remaining equipment has significant downtime due to age, This in impacting on Patient flow and treatment therefore patient may experience suboptimal outcome	Radiology	Callum Pearce Interventional Radiology and Fluoroscopy Modality Manager	15
729	Risk that patients may come to harm due to unavailability of critical care outreach practitioners to respond to a deteriorating patient.	Perioperative and Critical Care Services	Kerry Akther, Associate Nurse Consultant	15
356	Risk that the trust does not have accurate medical device training records causing insufficient competent users.	Trustwide, Quality & Safety Risk	Ian Bennett, Group Deputy Director of Quality	15
278	Risk that lack of isolation rooms in the Critical Care footprint can lead to cross infection (2121).	Critical Care - Intensive Care 2	Karen Banks, Clinical matron	15

(*) The Trust is working with all risk owners (via Collaborative and Corporate areas) to ensure all risks are validated.

NHS
University Hospitals Tees

Quality Assurance Committee

27 May 2025

Connecting to: Group Trust Board

Key topics discussed in the meeting:

The following reports and updates were considered at the 27 May 2025 meeting. It was noted how the quality of reports had improved and were mainly presented from across the Group, presenting updates from both Trusts.

- Board Assurance Framework
- Integrated Performance Report
- Infection Prevention & Control (IPC) Monthly Report – Group
- Safer Medication Monitoring Report - Group
- Safeguarding Report Q4 – STHFT
- Patient Experience and Involvement Report – NTHFT
- Quality Priorities and Quality Account
- Maternity Report – Perinatal Quality Surveillance Model Q4 Report : March 2025 NTHFT & STHFT
- Chairs Logs
    - STHFT Safe and Effective Care Strategy Group : May 2025
    - NTHFT Safe and Effective Care Strategic Group : May 2025
    - Quality Oversight Group : May 2025
    - Group Health Inequalities Steering Group : April 2025
- Board Assurance Framework

Caring Better Together

Quality & Safety

Infection prevention and control – infection rates continue to be a major focus across both Trusts and the challenges of maintaining good infection prevention control continue due to admission rates and movement of both patients and staff. Teams are working toward Gold Standard of cleaning to prevent infection rates, with onsite IPC teams auditing practices and site monitoring by the Directors of Nursing. A task and finish group has been set up to look at line and cannula care. There is an alert for C Auris which is increasing on other sites.

Maternity and Neonates Neonates have had an outbreak, which has been contained. There was a concern that it was an environmental issue, but it is thought to be from comfort items, and these are now being treated the same as other items which need to be cleaned and not shared. Neonatal staff were thanked for the efforts made to reassure families and their focus on managing the outbreak.

Maternity Neonates Voices Partnerships are facing increased pressure particularly on the time requested for the Chair to attend meetings . This is unrealistic given the nature of the role. A letter has been written to the ICB and the National Improvement Team regarding this and we are looking at mitigations, as it is a requirement of the LMS. ST has been accepted onto the maternity and safety support programme, and a deep dive is being undertaken into still birth rates as part of a national audit.

Cancer Standards

The standards are still not being met. The teams are actively contacting patients who are waiting for treatment, tracking individuals to see where there may be deterioration. Diagnostics are improving which in turn has an impact on further waiting times.

Training, Safeguarding and Compliance

There has been a drop in safeguarding training compliance, and there is a renewed focus on training within the teams. This is being tracked weekly in those areas where there is little compliance and movement, and the work is being led by Deputy Medical Director. There has been good uptake of Learning Disability awareness training.

An area for focus, with an audit to take place in Q1, is Children Not Brought for appointments, actions will be led by the Health Inequalities Group. Immediate actions include phone calls to remind about appointments to try and increase attendance, and the potential for care navigators. This raises an affordability and sustainability issue.

Complaints being closed within the timeframe remain an issue at both Trusts. There is 100% compliance of acknowledgement of a complaint, however both Trusts are well below the 80% compliance of closure within the timeframe. There remain several that are not closed after 6 months. There is work to align across both Trusts and although systems and processes are being developed concerted efforts need to be maintained.

Escalated items:

- The stillbirth data is being interrogated at a regional level to understand any differences between the Trusts, and the LMS national MSDS dashboard. Further updates will be brought to QAC
- The Draft Quality Priorities and accounts were discussed, and agreed that 8 out of the 9 the priorities would be carried forward for more work. The drafts will come to the June committee for sign off.

Risks (Include ID if currently on risk register):

No new risks identified

Quality Assurance Committee

23 June 2025

Connecting to: Group Trust Board

Key topics discussed in the meeting:

The following reports and updates were considered at the 23 June 2025 meeting. The quality of reports had improved greatly and were mainly presented from across the Group, presenting updates from both Trusts. There was a considerable shift of focus from look back to current issues and plans to address any outstanding issues.

- Board Assurance Framework
- Integrated Performance Report
- Infection Prevention & Control (IPC) Monthly Report, Improvement Plan and Strategy, STHFT and NTHFT Annual Report.
- Clinical Effectiveness Report
- Clinical Audit Annual Report 2024/25 and Forward Plan
- Learning From Deaths Report Q3 & Q4 - NTHFT
- Patient Experience Annual Report – STHFT
- Organ Donation Report – NTHFT & STHFT
- Quality Priorities and Quality Account 2024/25 – STHFT & NTHFT
- Perinatal Quality Surveillance Model Report : NTHFT & STHFT
- Population Health Inequalities Health Update – STHFT & NTHFT
- Chairs Logs
    - STHFT Safe and Effective Care Strategy Group : June 2025
    - NTHFT Safe and Effective Care Strategic Group : June 2025

- Quality Oversight Group : June 2025

- An additional AOB item was discussed – the Secretary of State Wes Streeting had announced a National Maternity Investigation which is likely to include 10 Trusts from across the Country. We are awaiting further information.
- Board Assurance Framework

Quality & Safety

Infection prevention and control – infection rates continue to be a major focus across both Trusts and the challenges of maintaining good infection prevention control continue due to admission rates and movement of both patients and staff.

A monthly dashboard has been developed for ease of identification of areas of concern, and improvement. Compliance against policies and procedures is being reviewed and presented at team meetings with action taken by lead nurses, and areas of potential concern are being audited. The audit is proving that in some areas, fundamentals of good practice are not being adhered to and this is being actioned by managers / IPC team and there is a renewed focus on training, with a Group IPC plan being developed. IPC methods are being reviewed on a ward by ward basis, and this is being fed into the weekly patient safety meetings and discussed at SLT meetings.

There has been a national notification related to cleaning products, in that what is being used is not effective enough, but we are waiting NHSE guidance and the ICB are facilitating the conversations and what will be a regional approach.

Fogging in areas is increasing (85%) but still not up to the 95% as per the action plan, and conversations are being held to ensure the standard is met.

A plan on a page is being developed that will come back to QAC and this is part of compliance monitoring.

Quality Initiatives

A joint evaluation has been commissioned for the implementation of the Patient Safety Incident Response Framework (PSIRF). The quality risks have been reviewed alongside the quality priorities, and it was acknowledged that a good job had been undertaken by the quality team to transition the process. The maximum transition has been achieved that can happen so far across the Group.

Complaints remain a focus in particular to address those out with the 6 month response. There has been a reliance on a single point of contact for response which is affecting targets, so this is being addressed and escalated to the senior leadership team where needed. The committee acknowledged the work to date and that there has been improvement, however the more complex complaints are where patients pass through multiple teams /departments causes delay. This is being addressed with an MDT approach which is proving positive.

Quality Accounts

The committee, on behalf of the Board, approved the Quality Priorities and Accounts for both STHFT and NTHFT

Clinical Effectiveness

The Committee noted that workforce and resource issues are affecting our ability to contribute to some national audits. There is work being progressed to look at the more structured approach to share learning from audits.

Health Inequalities

It was noted the huge amount of work being taken across the Group to address this with arrange of projects, but there is a concern that most are funded by non recurring monies. The ICB confirmed that the alcohol team and waiting well project will receive funding. There is a concern that the care navigator role at ST which is having a positive impact on DNAs may not be funded due to the financial pressures, alongside the personalised care service, substance misuse in ED. There may be a potential impact on achieving some of the quality priorities as some of these services are needed to deliver on these.

Maternity and Neonates

At NT the intrapartum service at the Rowan Suite; Hartlepool General has been suspended with a review due in July, and the women have been given an alternative offer and had the opportunity to discuss their care plan with the service.

There is a deep dive being undertake on still births, with an external consultant offering support and objectivity.

We are recruiting to the Maternity Neonates Voices Partnership lead and have had a good interest from potential applicants. There are ongoing discussions with the national team on process.

ST have embarked on the National Maternity Support Programme.

Both maternity services have had confirmation that they have achievement the 10 safety compliance standards.

The maternity team at North Tees have been nominated for a HSJ Award.

Cancer Standards

The standards are still not being met, although diagnostic have shown a small improvement in May. Areas of concern are prostate and teams are actively contacting patients who are waiting for treatment, tracking individuals to see where there may be deterioration.

Learning from deaths

The Committee considered the Q3 and Q4 reports for North Tees. The Committee agreed to support aligning the approach to learning from deaths across UHT with a more detailed and comprehensive review, analysis and presentation of learning to be presented to the Committee and Board in a future report.

Escalated items:

- The stillbirth data is being interrogated at a regional level to understand any differences between the Trusts, and the LMS national MSDS dashboard. Further updates will be brought to QAC
- The Quality Priorities and accounts were discussed, and approved for both Trusts on behalf of the Board.
- The Committee agreed to support aligning the approach to learning from deaths across UHT with a more detailed and comprehensive review, analysis and presentation of learning to be presented to the Committee and Board in a future report.

Risks (Include ID if currently on risk register):

No new risks identified

University Hospitals Tees

Patient Experience Annual Report 2024/25 - STHFT

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 13

Report author: *Nicola Arkless, Patient, Involvement Facilitator, Jamie Bell, Patient Survey Facilitator, Jemma Zata, Patient Experiences and Bereavement Service Manager, Jen Little, Patient Experience, Involvement and Bereavement*

Executive director sponsor: *Emma Nunez, Group Chief Nurse*

Action required:
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Caring

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

There continues to be a challenge in responding to all complaints within 6 months of receipt.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

In January 2024, we adopted the Parliamentary and Health Service Ombudsman (PHSO) complaint framework. In adopting the new complaint framework, there was a change to the terminology used, in the organisation, from PALS concern to complaint. Every concern unresolved within a 24-hour timeframe, is logged as a complaint.

There are currently 114 closed complaints requiring final grading completion, work is ongoing to support the completion.

With the support of the Senior Leadership Team the complaints open longer than 6 months have significantly reduced from 17 in August 2024 to 8 at the time of writing this report.

There were 4 Parliamentary and Health Service Ombudsman reports received, this year. 1 was not upheld. 3 were partially upheld, requiring an apology and an action plan and 1 requiring financial remedy.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Compliance with the legislated 100% acknowledgment of all complaints in 3 working days. 63% of all complaints received in 2024/25 were responded to as a stage 1 complaint, directly by the staff in the Collaborative, within 10 working days.

The timeframe to respond to complaints has remained challenging. However, the continued support of the Senior Leadership Team, is gradually improving the timeframe for complaint responses.

6% of complaints received in 2024/25 were reopened.

With the exception of antenatal, birth and postnatal FFT, scoring just below the national average, all other services scored in line or above the FFT national average score.

The overall monthly total number of Friends and Family Test (FFT) question returns has gradually increased from 4,394 in March 2023 to 6,281 FFT returns in March 2025, peaking at 7,519 in January 2025.

A pilot for the use of InPhase for the trust's local surveys commenced in January 2025. The 5 wards included in the pilot were, Wards 2, 7 and 35, the Clinical Decisions Unit (Friarage Hospital) and the Central Delivery Suite (CDS). All wards have seen an increase in the response rate with the exception of the CDS, who joined the pilot in February and can only provide 3 months data.

Patient involvement activities across the organisation continue to increase. Staff are requesting assistance from the Patient Involvement Bank to support with service development and new initiatives.

Patient stories continue to be a feature at the Trust Board and committee meetings, providing insight to the individual experiences of care at this organisation.

Recommendations:

- Continue to monitor the timeframe for responses to written complaints to improve compliance in line with the 80% target.
- Continue to monitor complaints open longer than 6 months, escalating to the Senior Leadership Team for support as required.
- Provide training sessions to staff, embedding the complaint process across the organisation.
- Improve the quality of learning from complaints, supporting staff to identify actionable improvements to patient care.
- Continue to support the discharge work into 2025/26.
- Local patient surveys to move to InPhase to support the increase in the response rate to the FFT questions.
- Continue to promote the Patient Involvement Bank and the importance of involving patients, carer and family members in reviewing pathways and new initiatives.
- Continue to identify marginalised groups through involvement activities.
- Increase the Patient Involvement Bank, seeking other methods of communication to provide a wider view of public opinion.
- Continue sharing patient stories, encouraging staff to identify experiences of care for learning and development.
- Note the progress and work achieved in 2024/25
- Note the key priorities for 2025/29.

Group Board
3 July 2025
STHFT Patient Experience Annual Report 2024/25

1. PURPOSE OF REPORT

The purpose of this report is to share how the Trust learns from patient experience during 2024/25. This includes an analysis of patient feedback received including complaints, compliments, local surveys including the Friends and Family Test (FFT) and published national survey reports.

There is information about the new complaints process, examples of learning identified from patient feedback and actions taken to deliver improvement. There are also details of patient and public involvement activities and community engagement.

This report is compiled on an annual basis for the Quality Assurance Council to provide assurance of achievement of the Patient Experience Quality Priorities and to demonstrate there is a robust complaint process in place within the Trust.

Quality Priority - We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.

We aim to provide equitable opportunities for patients, carers and families to proactively provide feedback on services and to ensure the needs of the local population are met.

Achievements:

- Ensured there is patient representation on all key meeting across the Trust.
- Set up a Carers Group and developed a Carer's Charter led by South Tees.
- Integrated a good practice report within the Group Patient Experience and Involvement quarterly report. This provides examples of learning and sharing good practice.
- The Patient Experience Team have received Health Literacy Awareness and How to Write Simply training which supported the review and development of patient information leaflets by Trust staff.
- Increased engagement with marginalised communities including visits to Hartgables and children in care.
- Undertook a community mapping exercise to update a stakeholder register of diverse groups and VCSE organisations to allow the Trust to link in with them when needed.
- Community engagement with Faith Groups, LGBTQ+ and BAME people across Hartlepool, Billingham, Stockton, Middlesbrough and East Durham. To receive feedback.
- Worked with staff in the organisation to utilise the Patient Involvement Bank to involve bank members in key pieces of work, including sharing the experience of care in training sessions, accessibility of menus, research projects, reviewing the patient engagement portal and reviewing pathways of care.

Quality Priority - We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

Achievements

- We have improved the monitoring of agreed timeframes for responding to a complaint. The over 5-month open complaints are reviewed weekly by senior leaders in the organisation for awareness and action. This information is included in the Patient Experience & Involvement quarterly report.
- We have increased the number of family liaison officers available to support families during distressing complaint investigations.
- All complainants now receive signposting information to Independent Complaint Advocacy Services. The ICA service will support them through the complaint process
- We produce monthly, quarterly and annual reports. This includes monthly and quarterly Group reports (North Tees and South Tees).
- We introduced a key performance indicator of 80% of complaints should be responded to within the agreed timescale.
- We have improved the number of complaints where there is evidence of learning and where that learning was shared.

Patient story

A patient story is presented during Group Board, Council of Governors meetings and Quality Assurance Councils, this is either attendance in person by a patient, supported by a staff member who was part of their patient journey, a video recording or a written patient story. The patient story is shared as well as improvements made as a result of that experience. An example is Appendix A in this report, together with learning and improvements, which was presented in Patient Experience Steering Group.

Maternity and Neonatal Voices Partnership

South Tees Maternity and Neonatal Partnership (MNVP) is open to open to everyone, particularly service users, service user representatives, voluntary sector representatives, midwives, maternity staff, neonatal staff, nurses, doctors and commissioners, all working to review and contribute to the development of local maternity and neonatal services.

We prioritise hearing from women, birthing people, babies and families who are most at risk of experiencing health inequalities, including but not limited to: Black, Asian, Minority Ethnic Groups, Refugees, Asylum Seekers, and those living in the most deprived areas. Building relationships with and collaborating with the voluntary sector organisations that work hard to support all these local families is key to this work. We also value the team going into the community to offer a listening ear where families feel comfortable and safe so that we can amplify their voice. Feedback is obtained in person, at groups or on the wards, in addition to via social media pages, an online questionnaire, paper questionnaires at in-person events and formal MNVP meetings, with ongoing work to ensure that these are available in multiple languages and formats.

Raising awareness of the role of the MNVP remains a top priority for 2025, as well as building the team, with an emphasis on incorporating Neonatal Voices. The other key [illegible]ear are informed consent, maternal mental health, pelvic health and [illegible] important that we listen and reflect the views and experiences of

everyone in the local community, to keep those voices at the heart of Trust and LMNS decision-making.
Each year the MNVP complete a workplan with the group and set out priorities for the year. This year one of the groups focuses will be hearing from the voices of bereaved parents within maternity services and the voices of parents who's babies have been on our neonatal unit, although we appreciate feedback from anyone who has used maternity and neonatal services at South Tees.

2. RECOMMENDATIONS

- Continue to monitor the timeframe for responses to written complaints to improve compliance in line with the 80% target.
- Continue to monitor complaints open longer than 6 months, escalating to the Senior Leadership Team for support as required.
- Provide training sessions to staff, embedding the complaint process across the organisation.
- Improve the quality of learning from complaints, supporting staff to identify actionable improvements to patient care.
- Continue to support the discharge work into 2025/26.
- Local patient surveys to move to InPhase to support the increase in the response rate to the FFT questions.
- Continue to promote the Patient Involvement Bank and the importance of involving patients, carer and family members in reviewing pathways and new initiatives.
- Continue to identify marginalised groups through involvement activities.
- Increase the Patient Involvement Bank, seeking other methods of communication to provide a wider view of public opinion.
- Continue sharing patient stories, encouraging staff to identify experiences of care for learning and development.
- Note the progress and work achieved in 2024/25
- Note the key priorities for 2025/29.

3. BACKGROUND

The Patient Experience Annual Report, inclusive of complaints, is a statutory requirement and provides an analysis of the management of complaints regarding patient care and treatment received by an NHS Trust as per the National Health Service Regulations 2009. This report provides a detailed analysis of complaints received by the Trust in 2024/25. The report reviews timeframes for acknowledgments within the legislated 3 working days and written responses. The organisation aims to achieve the legislated six-month timeframe for completion of a complaint. It recognises the themes identified through complaint investigation, which informs learning to improve the patient experience of our services. The report shares the final reports received from the Parliamentary and Health Service Ombudsman (PHSO).

Complaint definitions

Stage 1 - Local/early resolution, staff in the ward/department contact the complainant to resolve the complaint within 10-working days. This is followed [illegible]omplaint Resolution Form'.

Stage 2 - Following an investigation by the Collaborative, a meeting with senior staff is arranged by the Care Group and can be face-to-face or virtual. Meeting notes and a cover letter are sent to the complainant.

Stage 3 - An investigation is undertaken, and an executive letter of response is provided by the Collaborative to be reviewed and approved by the Group Chief Executive and the Site Medical Director or Site Director of Nursing.

The report includes local and national survey results. The response to the FFT question, which is included in all local surveys. The data is uploaded monthly to NHS England. The FFT question invites feedback on the overall experience of using a service and offers a standardised range of responses. High level results of the mandated National Surveys. The surveys published by the CQC during 2024/25 include, the Adult Inpatient, Maternity, Urgent and Emergency care and Cancer Patient Experience surveys.

The principle of Section 242 of the National Health Service Act 2006 is that, by law, NHS Commissioners and Trusts must ensure that patients and / or the public are involved in certain decisions that affect the planning and delivery of NHS services. The report informs the completed and ongoing work involving our local communities in new developments, review of pathways, ensuring the patient voice is used to inform our improvements.

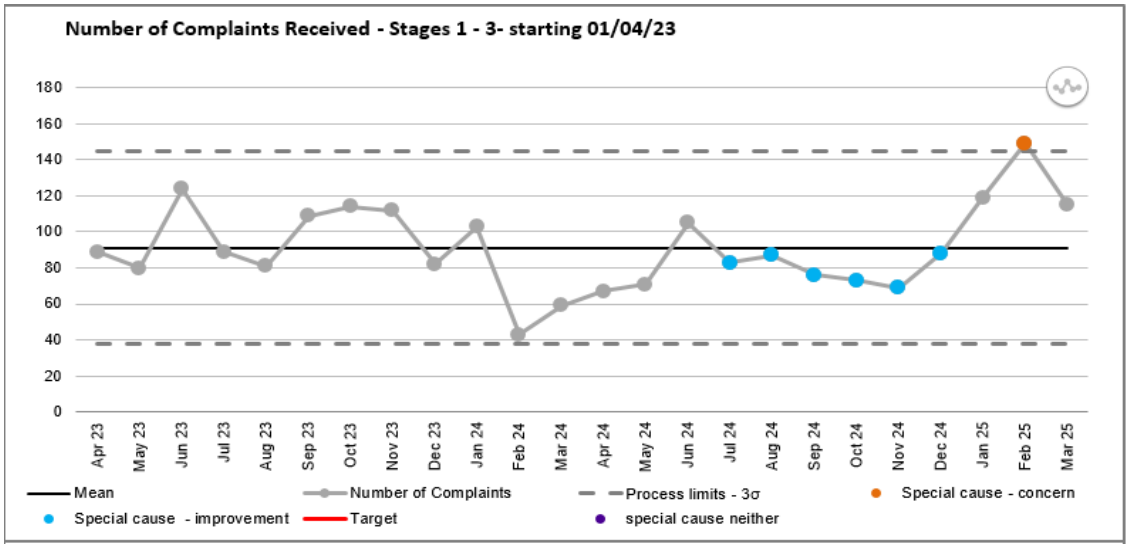
4. Overall Complaint Status

4.1 In January 2024, we adopted the Parliamentary and Health Service Ombudsman (PHSO) complaint framework. In adopting the new complaint framework, every concern received which is not resolved within a 24-hour timeframe is logged as a complaint.

4.2 In 2024/25 we received 1,102 complaints into the trust. This is a 182% increase on the previous financial year 2023/24. This increase is due to the implementation of the PHSO framework in January 2024, resulting in a higher number of complaints logged. This is due to the change of terminology from PALS concern to complaint.

4.3 It is noted there was a significant increase in complaints received during Q4. Complainants have 12 months to register a complaint, therefore, complaints received in this quarter may relate to care and treatment received in a different quarter.

Figure 1 - Total number of complaints received



4.4 Table 1 shows the complaints received by stage as detailed in section 3. Of the complaints received 63% were responded to as a stage 1 complaint. 11% were responded to at a meeting, and 26% received a written executive response.

Table 1 – Complaints received by Stage

Type of complaint	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024-25 Q4	Total
Stage 1	137	155	145	254	**691**
Stage 2	33	28	27	38	**126**
Stage 3	73	63	58	91	**285**
Total	**243**	**246**	**230**	**383**	**1102**

4.5 The number of complaints received by collaborative, by stage during 2024/25 are detailed in Table 2.

Table 2 - Total number of complaints received by Collaborative.

South Tees - Collaboratives	Stage 1	Stage 2	Stage 3	Total
Cardiovascular Care Services	9	7	20	**36**
Clinical Support Services	24	0	5	**29**
Corporate Services	42	2	10	**54**
Digestive Diseases, Urology and General Surgery Services	87	22	28	**137**
Growing the Friarage and Community Services	29	16	19	**64**
Head and Neck, Orthopaedic and Reconstructive Services	145	10	41	**196**
James Cook Cancer Institute and Speciality Medicine	42	11	12	**65**
Medicine & Emergency Care Services	102	26	80	**208**
Neurosciences and Spinal Care services	153	13	40	**206**

Perioperative and Critical Care Services	10	1	6	**17**
Women and Children Services	48	18	24	**90**
TOTAL	**690**	**126**	**285**	**1102**

4.6 All complaints are triaged on receipt and the subjects of the complaint are identified, as shown in table 3. There may be multiple subjects found per complaint. Communication with patient and Care needs not adequately met were the most commonly assigned subject in 2024/25. It is not possible to compare this data to the previous year following a change to the subjects and sub-subjects to align with those used in the K041a submission to NHS England.

Table 3 – Top 5 complaints received by Sub-subject (Primary)

South Tees - Sub-subjects	Q1	Q2	Q3	Q4
Care needs not adequately met	22	27	28	32
Communication with patient	23	21	23	44
Attitude of Medical Staff	6	16	6	18
Appointment delay (inc length of wait)	25	19	12	20
Appointment cancellations	6	14	10	23

5. Performance

The Trust endeavours to close all complaints within the agreed timeframes, however it measures performance against a target of 80% complaints closed within the timeframe. As shown in Table 4, the 80% target was not met in the previous 6 months but the complaint response rate increased to 58.43% in February, which is an improvement on the previous 6 months.

Table 4 - Performance against timescales (Stage 1, 2 and 3)

Collaborative	October 24		November 24		December 24		January 25		February 25		March 25	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Cardiovascular Care Services		-	3	33.33%	1	0.00%	3	33.33%	3	66.67%	5	80.00%
Clinical Support Services		-	0	-	0	-	0	-	2	50.00%	2	50.00%
Corporate Services		0.00%	6	33.33%	3	33.33%	4	25.00%	7	28.57%	10	40.00%
Digestive Diseases, Urology and General Surgery		0.00%	7	57.14%	9	44.44%	8	37.50%	10	50.00%	12	58.33%
Growing the Friarage and Community Services		-	5	40.00%	3	100.00%	3	33.33%	8	75.00%	6	33.33%
Head and Neck, Orthopaedic and Reconstructive Services		-	14	42.86%	17	35.29%	14	50.00%	10	60.00%	23	60.87%
James Cook Cancer Institute and Speciality Medicine		0.00%	1	100%	5	40.00%	6	66.67%	3	100.00%	2	50.00%
Medicine & Emergency Care Services		50.00%	17	35.29%	8	62.50%	25	76.00%	21	71.43%	20	65.00%
Neurosciences and Spinal Care Services		50.00%	14	42.86%	12	8.33%	25	24.00%	18	50.00%	26	38.46%
Perioperative and Critical Care Services		-	3	33.33%	3	66.67%	2	0.00%	3	66.67%	2	50.00%
Women and Children Services		-	5	20.00%	5	20.00%	9	44.44%	12	66.67%	17	47.06%
Total		33.30%	75	40.00%	66	37.88%	99	46.46%	89	58.43%	125	52.00%

5.1 There were 943 complaints closed in 2024/25, compared to 426 complaints closed in 2023/24 which is a 131% increase. This increase is due to adopting the Parliamentary and Health Service Ombudsman (PHSO) complaint framework. Table 6 shows the outcome classifications of closed complaints by outcome (upheld/partly upheld or not upheld). There are currently 114 complaints that have not had their outcome codes completed, work with the Collaborative staff to complete the outcome codes is ongoing.

Table 6 – Outcome classification for closed complaints

2024/25		2023/24	
Upheld/Partly upheld	Not Upheld	Upheld/Partly upheld	Not Upheld
667 (70%)	162 (17%)	241 (56.7%)	185 (43.3%)

5.2 Table 7 shows the final grading of all complaints following the completion of investigation. Complaints graded 'high' or 'extreme' post investigation must be shared with the Integrated Care Board (ICB). The 3 complaints graded high are linked to an incident and investigated alongside the complaint. A Family Liaison Officer (FLO) is deployed to support the patient, carer and family during the investigation, ensuring their questions are responded to in the report. On completion of the incident investigation the report is shared with the ICB. There are currently 109 complaints, closed complaints, requiring the final grade completing, work is ongoing with Collaborative staff to complete this.

Table 7 – Grading of closed complaints 2024/25

Grade	Initial Grade	Final Grade
Extreme	3	0
High	30	3
Moderate	361	76
Low	549	755
Total	**943**	**834**

5.3 Table 8 shows all complaints received by the Trust in 2024/25 were acknowledged within the legislated 3 working days. This is an improvement on the 2023/24 acknowledgement rate of 90%.

Table 8 - Complaints acknowledged within 3 working days

	Q1 2024-25	Q2 2024-25	Q3 2024/25	Q4 2024/25
Ack 3 days	100%	100%	100%	100%

5.4 The Trust encourages complainants to return if they have outstanding concerns following receipt of the complaint response. This is good practice to ensure that all concerns are responded to the complainant's satisfaction. The number of reopened complaints for 2024/25 was 68 which is a 94% increase from 35 in 2023/24. This increase is due in part to the change in PSHO framework, which has resulted in a higher number of complaints being logged. Table 10 shows the number of reopened complaints by collaborative in 2024/25.

Table 10 - Reopened complaints by collaborative

Collaborative	Total 2024/25	Total 2023/24	Total 2022/23
Cardiovascular Care Services	3	2	2
Clinical Support Services	1	2	2
Corporate Services	1	0	0
Digestive Diseases, Urology and General Surgery Services	15	8	9
Growing the Friarage and Community Services	3	0	4
Head and Neck, Orthopaedic and Reconstructive Services	13	4	9
James Cook Cancer Institute and Specialty Medicine	4	4	6
Medicine & Emergency Care Services	11	7	10
Neurosciences and Spinal Care Services	7	4	5
Perioperative and Critical Care Services	4	1	2

Women and Children Services	6	3	5
Total	**68**	**35**	**54**

5.5 Table 11 identifies the reasons complaints were re-opened. As there can be multiple reasons why a complaint is re-opened this data does not correlate to the number re-opened. 62% of re-opened complaints had new related questions.

Table 11 – Reason for re-open

Reason	Total 2024/25	Total 2023/24
Complaint process	6	1
Disagrees with response	32	9
Inaccuracies in the response	5	3
Meeting requested after receiving response	15	5
New related questions	42	19
New unrelated questions	6	0
Original questions not answered satisfactorily	36	9
Total	**142**	**48**

5.6 Learning from Feedback

At a trust-wide level, following a number of complaints and CQC concern raised with the organisation, during 2024/25. An analysis was undertaken by the Head of Nursing - Patient Flow, of the patient, carers and family feedback regarding discharges, CQC enquiries and safeguarding concerns. A task and finish group was created and an action plan developed using the analysis to provide workstreams around the discharge process. These include, forming closer working relationships with the care homes our patients are discharged to, improving communication, reviewing discharge paperwork, medication and patient flow. This work will continue into 2025/26

5.7 Table 12 summarises some actions taken as a direct result of a complaint in 2024/25 in the Collaboratives.

Table 12 – Identified learning actions taken from complaints 2024/25.

Collaborative	Actions
Cardiovascular Care Services	• Timely multidisciplinary team meetings to discuss complex patients care, ensuring all opinions are considered when coordinating the patients care. Providing appropriate communication from the MDT with the patient, carer and their family. • The requesting criteria for neuroradiology has been disseminated to all staff - an emergency in one hour, urgent and routine. • Amended the resources at pre assessment and letters to advise on services available to support post operatively.

Clinical Support Services	• Turnaround times targets for Neuroradiology scanning to be circulated trust wide.
Corporate Services	• Reasonable adjustments are requested and documented on Datix to support the complainant and handler when responding to complaints. • Patient Experience voicemail changed to encourage people to leave a message. • Instructions provided for recording complaint meetings to ensure no failure to record, loss of recording and meetings are easily identifiable.
Digestive Diseases, Urology and General Surgery Services	• Review of the prostate pathway which has • Patient story developed following a complaint about consenting, this will be used for junior doctors training. • Following a delay in identifying sepsis the Acute Illness Management, National Early warning score and Sepsis training course(s) has now been approved to be included in the role specific mandatory training. To include appropriate escalation and treatment options for sepsis. The training was rolled and completed by all staff within 12 months. • Raied awareness of the Call 4 Concern for ward staff • To implement consistent use of the smart page escalation system for the urology service
Growing the Friarage and Community Services	• Provide the patient information leaflet to support the communication of DNACPR decision to patients and families. • Chaperone policy updated to reflect community nursing practice. • Refresher training for digital rectal examination for community staff. • Medical and community staff to complete mandatory safeguarding training. • Palliative Care Educator to use a scenario-based learning, from complaints, for staff.
Head and Neck, Orthopaedic and Reconstructive Services	• Skin CNS team to have oversight of scans and appointments for skin cancer patients. • Patient passport system in the melanoma service to highlight what tests and treatments are needed, ensuring these do not get missed or delayed
James Cook Cancer Institute and Specialty Medicine	• Oncology advice line – shared learning from rheumatology – streamlined process to ensure the call is directed to the correct member of staff. Paper forms have been put online to ensure they do not get lost. Digitalisation of UKONS tool. • Shared learning from Rheumatology and patient was lost to follow up (LTFU) – created a disease-modifying anti-rheumatic drugs (DMARDS) standard operating procedure to follow. • End of life care room created on Ward 4, designed by the staff, follow feedback from family about the area being to clinical • Transfusion chair for Haematology 3 x week in Cancer Institute Assessment Bay (CIAB) • Opened further stations at the Friarage Hospital renal unit working transport team due to patients having to travel to

	JCUH, – opened and is full to capacity and has an isolation. • Improving capacity and access at Robert Ogden for preassessment prior to treatments • LINAC machines to treat cancer patients x 2 Specialist Commissioning NHS England Superficial skin machine Radiotherapy • Expansion of Home Therapies team so Renal services care is closer to home – National mentor for shared care and home dialysis on the mentorship programme. • Call 4 Concern displayed in the area for patients and relatives, so it is more visible • Wraps created for the entrance to the doors and reception desk on Ward 14 to show the visiting times and shares other details such as the carers passport.
Medicine & Emergency Care Services	• Communication Standard Operating Procedure developed to ensure the appropriate staff member is identified to communicate with the patient and/or family. Audit completed to monitor the compliance. • The Older Persons Medicine Wards have in place adapted cutlery for appropriate patients. • All staff are up to date with physical restraint and conflict resolution training. • The ED senior team will implement regular meetings with the cardiology colleagues to review challenging cases and ECGs, to improve learning and development. • Revised the triage process to ensure that a dedicated health care assistant carries blood tests at the first point of contact. • Implementation of improved signage within the Emergency Department waiting room to facilitate communication and address concerns of patients and family members. • Establishment of an Emergency Department waiting room pathway to ensure regular reassessments of patients from a nursing staff.
Neurosciences and Spinal Care Services	• Review of the booking system – new appointments to be given 6 weeks in advance as opposed previous booking as soon as received. • Holding letter to patients regarding the Botox Clinic appointment delays to prevent complaints.
Perioperative and Critical Care Services	• Management of patient following spinal anaesthesia (Adults and Children) Policy developed. The spinal observations charts were adapted to include looking for sensory deficit and motor block following spinal procedures.
Women and Children Services	• Navigator role introduced to Gynaecology to concentrate on communication levels with patients waiting for diagnosis. • Refreshed appointments staff to check appointments made within window of opportunity for Trisomy screening in first trimester of pregnancy. Posters in the department with timeframe included to assist with the process • A lack of understanding of a patient's pain score. Learning highlighted the importance of listening to individual children, sometimes children will be experiencing high levels of pain

	without outwardly showing this. It is important for children to feel listened to, and assumptions are not made from colleagues treating the patient. A specific pain management session is part of mandatory training for all nursing staff, and a specific segment of the training emphasises the importance of listening to individual children. • Prescribing of emergency medications following an admission. Learning for the Paediatric team that emergency medications must be prescribed on admission for any child who has emergency treatment for seizures. This can mitigate any delays in obtaining/administration of mediation. There must be clear documentation if the patient has received any emergency treatment for seizures in the last 24 hours, either at home or in ED. This will inform the doctors as to which emergency treatment should be administered if further emergency treatment is required. • Communication with parents not always clear or sensitive. Learning for the Paediatric team that all concerns raised, whether from family/patient/colleagues, should be listened to, with an appropriate response provided along with any rationale for decisions made. A question has now also been added to the National Paediatric Early Warning Score (PEWS) to ask parent/carer if the patient is better or worse than the last time they were reviewed.

5.8 Parliamentary and Health Service Ombudsman (PHSO)

The role of the PHSO is to investigate complaints from members of the public who believe that they have suffered injustice by being treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. The PHSO has two stages, the assessment of the complaint to identify if there are any outstanding concerns to investigate. If outstanding concerns are identified, they proceed to investigation of the outstanding concerns.

Table 13 – Status of cases with the PHSO 2024/25

PHSO	Q1 2024-25	Q2 2024-25	Q3 2024-25	Q4 2024-25	Total
Assessment	4	1	5	0	10
Informed of Investigation	0	0	1	0	1
Final Report Received	2	0	0	2	4

5.9 Table 14 provides the details of the final reports, where the outcome was partly upheld or upheld, received following the investigation of the PHSO in 2024/25. In addition, the Trust received one final report on 2024/25 which was not upheld.

Table 14 – PHSO final reports received 2024/25

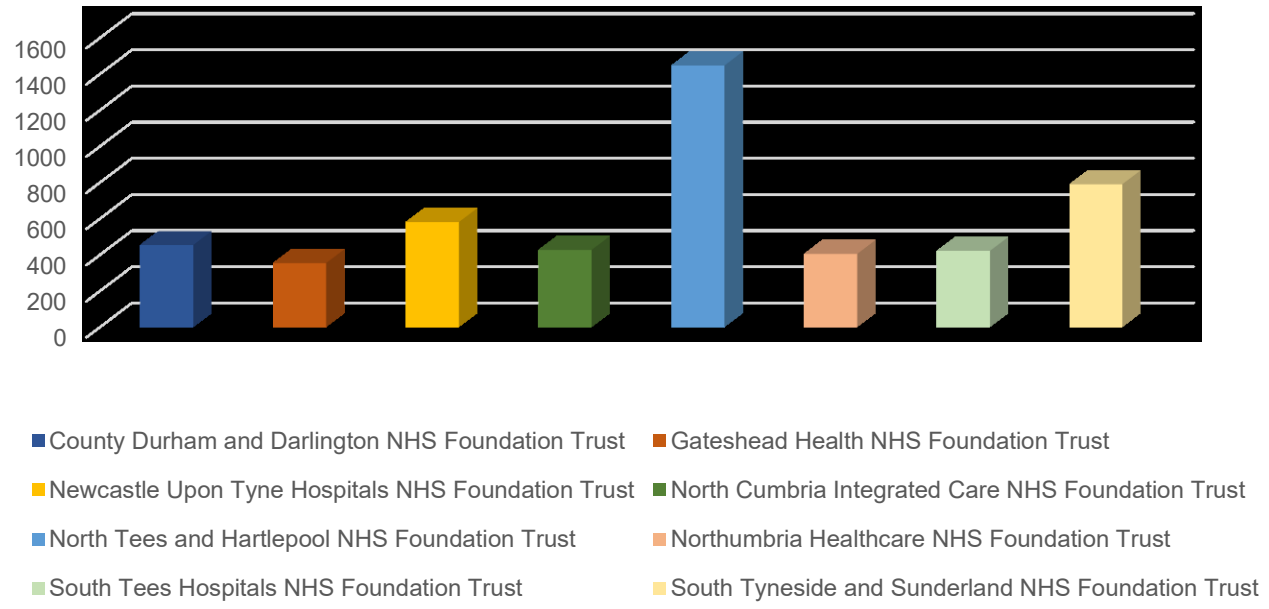
ID number	Primary Specialty	Primary Subject of complaint	Date complaint received	Outcome	Recommendation

ST 153-20	Diabetes & Endocrinology	Care and treatment	08/10/2020	Partly upheld	• Apology • Action plan
ST 204-20	General Surgery	Wait for admission / surgery / treatment too long	20/11/2020	Not upheld	NA
ST 38-22	Neurology	Appointment availability and delays. Lack of support from the service Complaint handling	18/05/2022	Partly upheld	• Apology • Financial remedy
ST 158-22	Respiratory	Failure to diagnose Medication Discharge issues Nursing care Poor communication	05/10/2022	Partly upheld	• Apology • Action plan

5.10 Regional complaints comparison 2023/24

Figure 2 shows the regional comparison for complaints as per the published data obtained from NHS England, per finished consultant episode. The collection covers complaints made by or on behalf of patients between 1 April 2023 and 31 March 2024, published on 17 October 2024. The submission date for complaints received during 2024/25 is May 2025. North Tees and Hartlepool NHS Foundation Trust reported a higher number of complaints due to the implementation of the PHSO complaint framework in 2024. It is expected that our trust will see a similar increase in complaints for the same reason in 2024/25.

Figure 2 – Regional comparison – numbers of new complaints per 10,000 FCEs



5.9 All compliments received by the Patient Experience Team are logged on Datix, to be shared with wards and departments. Not all compliments received by the Trust are logged
nt directly to the ward or department, although there is the facility
ments to log their compliments. The Patient Experience Team have

a significant backlog of compliments to log, so the data in Table 15 is not reflective of those received.

Table 15 – Compliments received by Collaborative 2024/25

Collaborative	Received
Cardiovascular Care Services	22
Clinical Support Services	30
Corporate Services	17
Digestive Diseases, Urology and General Surgery Services	47
Growing the Friarage and Community Services	55
Head and Neck, Orthopaedic and Reconstructive Services	97
James Cook Cancer Institute and Specialty Medicine	40
Medicine & Emergency Care Services	112
Neurosciences and Spinal Care Services	27
Perioperative and Critical Care Services	15
Women and Children Services	74
Total	**536**

6.0 Friends and Family Test (FFT)

The FFT question is currently included in all Trust local surveys, with the data usually uploaded monthly to NHS England. The FFT question invites feedback on the overall experience of using a service and offers a standardised range of responses. Table 13 shows data for A&E/UTC, inpatient, outpatient and community services for 2024/25 compared to 2023/24. It is important to note that the FFT data has not been published since January 2025 and is currently paused due to future arrangements being finalised within NHS England.

6.1 The A&E/UTC percentage positive score decreased from 82% in 23/24 to 80% in 24/25 but remains above the national average of 79%. The overall inpatient percentage positive score increased from 97% in 23/24 to 98% which is above the national average of 95% and had a response rate of 16%. This includes Friarage Hospital who had an inpatient percentage positive score of 99% and James Cook Hospital with a percentage positive score of 98%.

6.2 The outpatient percentage positive score maintained at 97% and remains above the national average of 94%. The community percentage positive score maintained at 98% and remains above the national average which decreased by 1% to 94% since 23/24.

Table 13 – FFT percentage positive for 2024/25 compared to 2023/24 and national data.

Department	Total Surveys Completed	Total Number Eligible	% Response Rate	% Positive Experience 23-24	% Positive Experience 24-25	% Positive National Average
A&E / UTC	**12,123**	**142,280**	**9%**	**82%**	**80%** ↓	
A&E JCUH	7,897	*91,218*	*9%*	77%	76%	*79%* ↔
UTC - FHN	2,490	*21,769*	*11%*	90%	91%	
UTC - RPCH	1,736	*29,293*	*6%*	88%	89%	
Inpatient	**8,561**	**54,385**	**16%**	**97%**	**98%** ↑	
FHN	1,114	*9,493*	*12%*	99%	99%	*95%* ↑
JCUH	7,447	*44,892*	17%	97%	98%	
Outpatient	**35,870**	**444,649**	**8%**	**97%**	**97%** ↔	94% ↔
Community	**4,882**	**63,357**	**8%**	**98%**	**98%** ↔	94% ↓

6.3 Table 14 shows the maternity surveys at the four touchpoints (antenatal, birth, postnatal inpatient, and postnatal community). The antenatal percentage positive score maintained at 91% which is slightly below the national average, which increased by 1% since 2023/24. The birth percentage positive increased from 88% in 2023/24 to 91% but remains slightly below the national average which decreased to 92%, with a response rate of 15%.

6.4 The postnatal inpatient positive score increased to 91% but remains slightly below the national average which maintained at 92%. The postnatal community scores decreased by 1 point to 94% in 24/25, but this remains above the national average of 93%.

Table 14 – Maternity FFT percentage positive for 2024/25 and 2023/24 compared to national data.

Department	Total Surveys Completed	Total Number Eligible	% Response Rate	% Positive Experience 23-24	% Positive Experience 24-25	% Positive National Average
Antenatal	**2,217**	-	-	**91%**	**91%** ↔	
FHN	144	-	-	92%	88%	*92%* ↑
JCUH	2,073	-	-	90%	91%	
Birth	**484**	**3,147**	**15%**	**88%**	**91%** ↑	
FHN	26	-	-	97%	-	*92%* ↓
JCUH	458	-	-	85%	89%	
Postnatal Inpatient	**184**	-	-	**87%**	**91%** ↑	
FHN	5	-	-	-	-	*92%* ↔
JCUH	179	-	-	87	91%	
Postnatal Community	**152**	-	-	**96%**	**94%** ↓	*93%* ↑

6.5 Wards and departments regularly review the patient feedback from surveys. This is used to highlight improvements and actions taken as a result of feedback on 'You said, We did' displays, figures 3 and 4 show examples of this.

Figure 3 "You said, We did' in Accident and Emergency

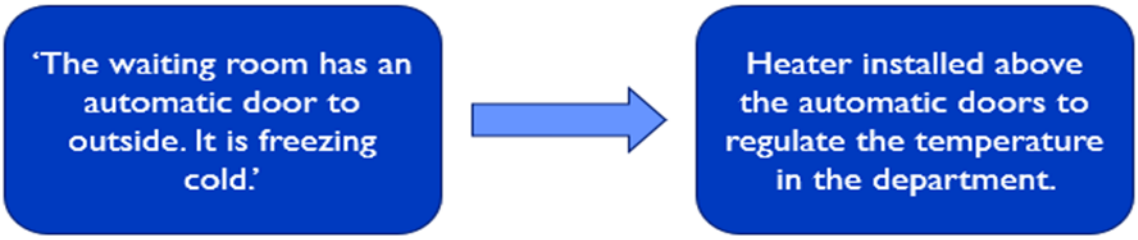
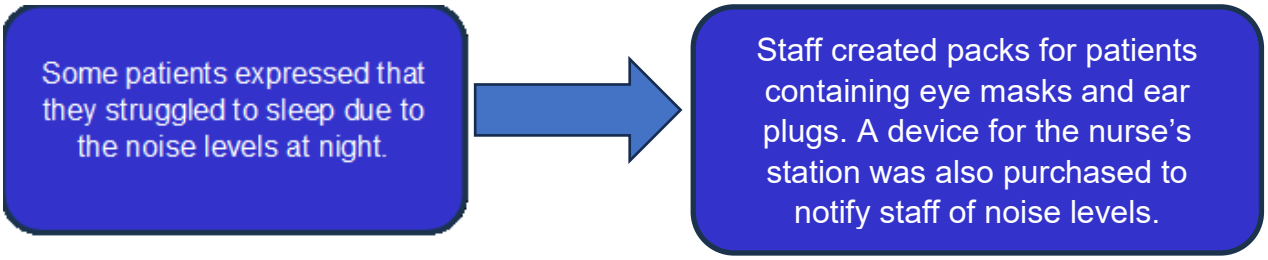
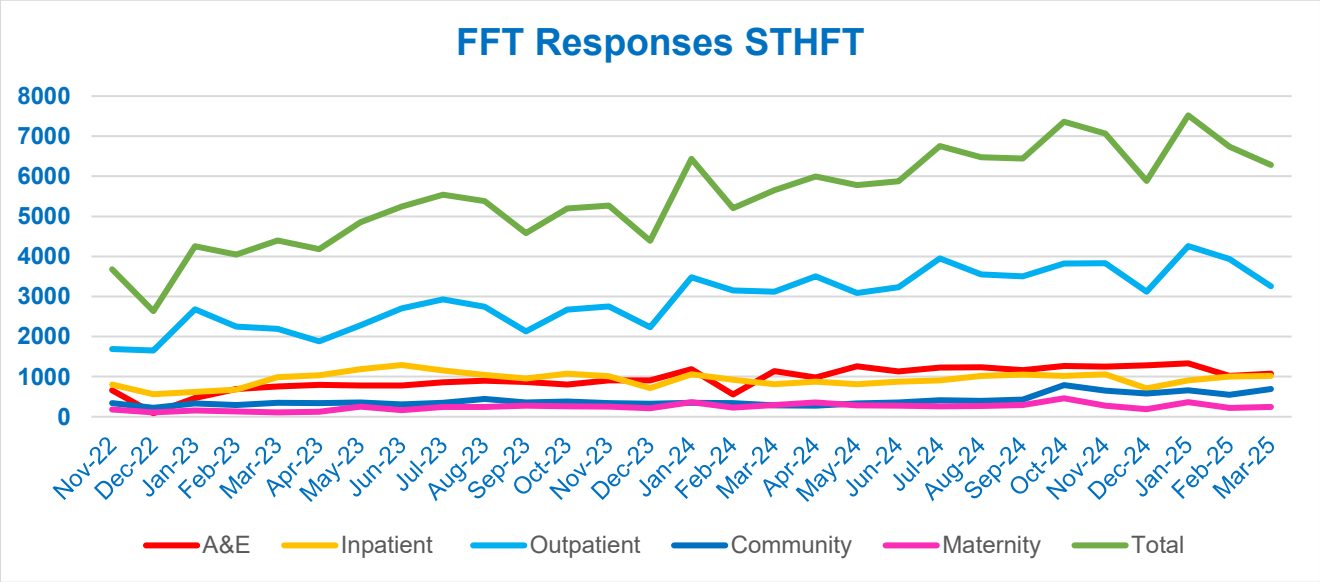


Figure 4 – 'You said, We did' – PACU



6.5 The overall monthly total number of FFT returns has gradually increased from 4,394 in March 2023 to 6,281 FFT returns in March 2025, peaking at 7,519 in January 2025 (figure 5).

Figure 5 – Monthly response rate by survey

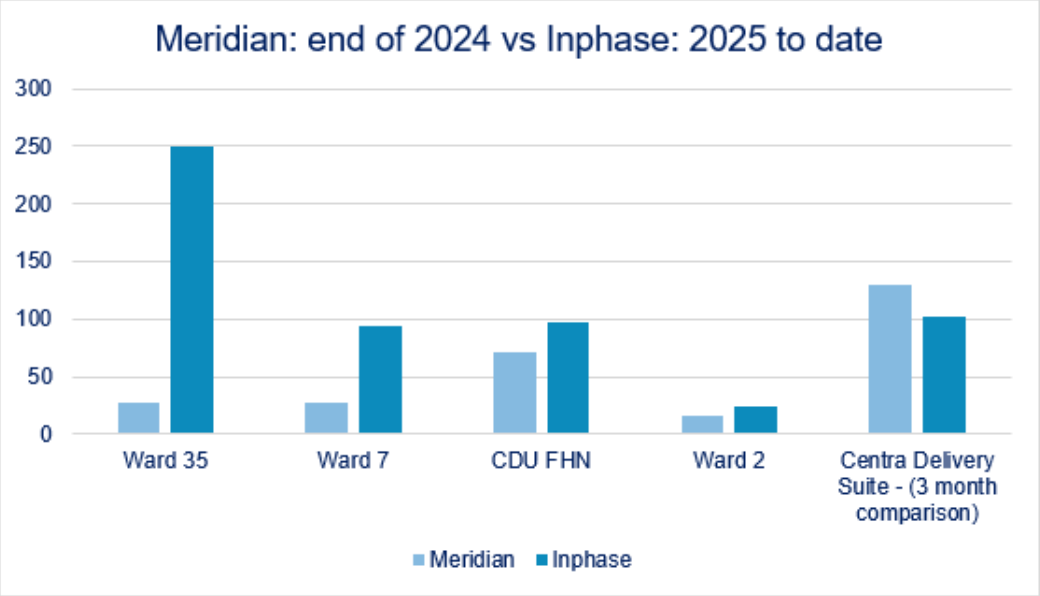


6.4 A pilot for completing the FFT on InPhase was commenced in January 2025. Five wards were included in the initial pilot. Figure 6 provides a comparison to the response rates in the last 4 months against Meridian. The Central Delivery Suite (CDS) moved to InPhase at the end of January 2025, therefore, a 3-month comparison. Following the

Caring Better Together

positive results the forward plan is, using a staged approach to move all of the surveys to InPhase during 2025/26.

Figure 6 – InPhase pilot survey response comparison to Meridian



7. Local Surveys

There are currently 107 patient surveys utilised in the Trust. These include the A&E, inpatient, outpatient and community surveys for adults, children and young people, as well as the maternity surveys. All surveys allow the opportunity for the patient to request contact from the ward or department, particularly if there has been a poor experience. It is an opportunity for the staff to resolve any concerns and prevent the need for the patient to make a complaint. However, the details of the complaint process can be shared with the patient if necessary. Table 16 provides detail of actions that have been taken as a result of patient feedback in 2024/25.

Table 16 – Actions taken by staff from feedback in patient surveys

Feedback	Action Taken
Staff member did not introduce themselves or check the patient's details before proceeding with appointment.	Department Manager contacted the patient to apologise. Offered advice regarding dressings and an alternative appointment. Reassurance provided, to discuss with staff members to remind them to engage and advise patients – patient happy with outcome of conversation.
Patient was unable to discuss scan results with community midwife or GP, also telephoned antenatal clinic but received no answer.	Manager contacted to the patient to apologise. Advised the patient they had met with community midwife matron to discuss patient access to advice and to review processes. Informed of midwifery advice line that has been set up to answer non-emergency patient queries, patient happy with outcome and did not wish to escalate further.
Patient felt as though they were weight shamed during consultation; [illegible]ient they	Manager contacted the patient to apologise. Patient did not wish to see same clinician again and was booked into different clinic and happy with the outcome. Manager spoke

needed to be under certain BMI for specific referral to be made.	to clinician, established that weight was a relevant issue that needed to be discussed but clinician will reflect on the comments and how to better approach consultations in future.
Patient mistakenly informed that they needed a pregnancy scan 4 weeks too early, patient was not informed it was not required until they attended hospital for the scan.	Manager contacted the patient to apologise. Explanation that the appointment should have been cancelled before they attended hospital. The scan was rebooked for correct date, patient happy with apology and no further action required. Manager confirmed with obstetric consultant that scans would not be done as early as patient was informed.
Patient felt that concerns were not listened to or taken seriously by ward staff, felt that appropriate care was not given even to the point of neglect.	Manager discussed issues with patient. Was able to resolve some care concerns and apologised. Patient did not wish to escalate further. Manager escalated to other MDT members for review and discussed concerns with ward team so learning can be identified.

8. National surveys

The Trust participates in several national surveys run by the Care Quality Commission (CQC). Action plans are developed to address any areas for improvement, and these are monitored by the Patient Experience Steering Group, on a 6-monthly basis. The key findings of reports published in 2024/25 are as below.

8.1 National Adult Inpatient Survey

1,250 patients who spent at least one night in hospital during November 2023 were invited to take part, 485 patients responded to the survey giving a 41% response rate.

The comparison is made against 133 NHS trusts and the Trust scored:

- 'Much better than expected' in no questions.
- 'Better than expected' in one question.
- 'Somewhat better than expected' in four questions.
- 'About the same' in 44 questions.
- None of the questions scored worse than other trusts.

The service saw a statistically significant decrease from 2022 results in two questions, with the other questions being the same.

A detailed review of the report and the comments received has been undertaken by the Patient Experience Team. An action plan was developed to address the following areas identified for improvement:

- Waiting time and access
- Discharge process and/or information
- Pain management
- Environment / Noise and disruption

8.2 National Urgent and Emergency Care Survey

1,250 Type 1 (ED) patients who attended Accident and Emergency Care services during [illegible]ted to take part in the survey and 224 responded, giving a response

The comparison is made against 120 NHS trusts and the Trust scored:

- ‘Better than expected’ in one question.
- ‘Somewhat better than expected’ on no questions.
- ‘About the same’ in 26 questions.
- ‘Somewhat worse than expected’ in 2 questions.

580 Type 3 (UTC) patients who attended UTC in February 2024 were invited to take part in the survey and 152 responded, giving a response rate of 27%.

The comparison is made against 120 NHS trusts and the Trust scored:

- ‘Better than expected’ in no questions.
- ‘About the same’ in 26 questions.
- ‘Worse than other trusts’ in one question.

A detailed review of the report and the comments received has been undertaken by the Emergency Department and the Patient Experience Team. An action plan was developed to address the following areas identified for improvement:

- Privacy when discussing conditions with reception staff
- Length of waiting times.
- Patients to be kept informed of waiting times.
- Communication needs.
- Pain management.
- Access to food and drinks.
- Involving patients in decisions about care and treatment.
- Providing information on further health and social care services.

8.3 National Cancer Patient Experience Survey

1369 patients who attended hospital for cancer related treatment between April and June 2023 were invited to take part. 722 patients responded to the survey giving a 53% response rate.

The comparison is made against 132 NHS trusts and the Trust scored:

- ‘Better than expected’ in three questions.
- ‘About the same’ in 54 questions.
- ‘Worse than expected’ in two questions.

A detailed review of the report and the comments received has been undertaken by the Emergency Care service and Patient Experience Team. An action plan was developed to address the following areas identified for improvement:

- Lung and Upper Gastro tumour groups overall care.
- Dissemination of results trust wise.
- Dissemination of results and review across all tumour sites.
- Staff ability to communicate and explain treatment options.
- Waiting times for treatments and clinic OPAs in Haematology/Lung/Upper GI tumour sites.
- [redacted]oriate support in community and voluntary sector (Upper GI and [redacted]ervices)

- Administrative processes.

8.4 National Maternity Survey

335 patients who had a live birth between January and February 2024 were invited to take par., 125 patients responded to the survey giving a 38% response rate.

The comparison is made against 120 acute NHS trusts and the Trust scored:

- 'Better than expected' in one question.
- 'Somewhat better than expected' in five questions.
- 'About the same' in 51 questions.
- None of the questions scored worse than other trusts.

A detailed review of the report and the comments received has been undertaken by the Maternity Service and Patient Experience Team. An action plan was developed to address the following areas identified for improvement:

- Availability of staff to help patients when needed.
- Information and explanations provided to patients after birth.
- Partner or someone else close to the patient involved in care able to stay as much as they wanted.
- Pain management after birth.
- Help/advice from midwife regarding feeding baby.
- Patients feeling listened to.

9. Patient Involvement

The Patient Involvement Facilitator (PIF) continued community engagement during the year, visiting groups the trust has existing links with and also engaging with new groups of people. Some of the activities we asked our patients to be involved in are listed below.

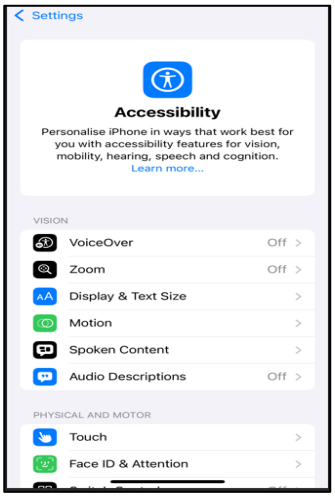
9.1 Accessible menus

It was identified through patient and staff feedback that we needed to make our menus more accessible for patients with sight loss. It was discussed that we should have our menus translated into Braille.

The Patient Involvement Facilitator attended the Teesside Society for the Blind to discuss possible options for patients who cannot access the standard menus.

They shared that they have devices such as iPhones and iPads which have an accessibility function to add a voice over. This reads aloud whatever is on the screen.

Menus were added to our website to allow patients to access them when they wanted. Allowing them to make choices of what they wanted at their leisure.



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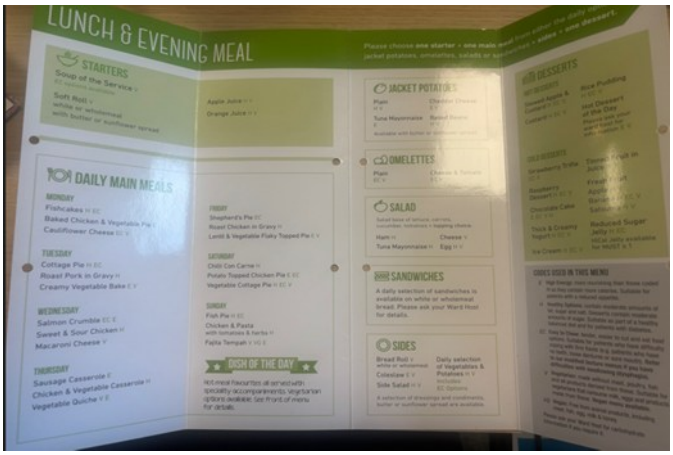
Feedback from the patients suggested the menus needed to be more accessible to lots of people

- Average reading age is 9-11 years old
- The font size needs amending for patients who are partially sighted
- Images of the meals next to the wording can support the meal choice
- Menu read out by staff, was still an option

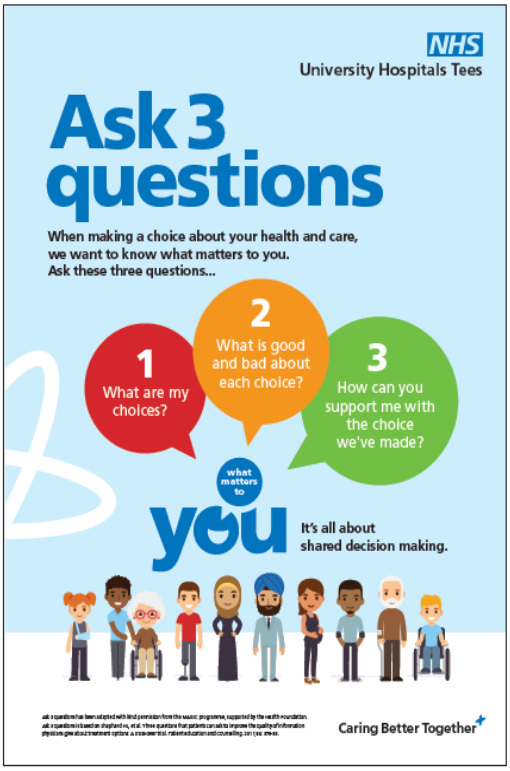
The Macular Group for people who are partially sighted provided an opportunity to gain further feedback from those who are visually impaired about the trust generally, as well as new online inpatient menus.

This project was initially supported by The Teesside and District Society for the Blind who suggested font sizes, colours and apps that they frequently use.



9.2 Personalised care – Ask 3 questions

The Personalised Care Lead contacted Patient Experience for support to gain patient feedback on the poster. Ask 3 Questions is a new strategy that will be implemented to support patients when making decisions about the treatment and care they receive.
The Patient Involvement Facilitator emailed this poster to the Patient Involvement Bank and asked for feedback.



Here is some of the feedback which will support making crucial changes:

- Surely question 3 should say 'What choices I have made.'
- I have some reservations about the choice of colours for the speech bubbles because red, orange and green brings to mind traffic lights so could result in mixed messages.
- The red in question one is a little harsh, (red means danger) consider using a softer tone or colour.
- Ask "who" these three questions?
- The poster mentions "we" but I'm not clear who we is, perhaps a role or contact point is needed in the text.
- I think question 2 needs rewording. Rather than using what is good or bad I would rather answer "how do I feel about the choices" as its less negative and gets a more personal answer.

9.3 Emergency Department Mental Health study day

Patient experience team arranged for three lived experience patients to attend the staff training day. They shared their experiences of visiting the Emergency Department whilst they were under the influence of drugs and/or alcohol. They also shared their insight when they have supported someone in ED and the impact on mental health. There was good engagement between the volunteers and staff: positive feedback from staff has highlighted they would like more opportunities to speak to those with lived experience. More study days to be arrange in the near future.

9.4 Patient Involvement group Senior Research Project Manager

Supported the research team to reach out to Involvement Bank members to attend a research morning to discuss the CAREFUL study, a Continuous ARterial monitoring in Elderly and Frail Patients for hip fractUre surgery to prevent Low blood pressure. They wanted to hear patients on a research project they are planning to try to improve the care we provide for s in the future. They think measuring blood pressure continuously uld help, rather than once every few minutes as is currently the case.

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They believe this may reduce medical problems (like kidney damage or confusion) and improve patient experiences during a challenging time. Four members of the bank attended. Feedback from the Senior Research Project Manager, the morning was successful, and the team want to work with patient experience again, for their next project.

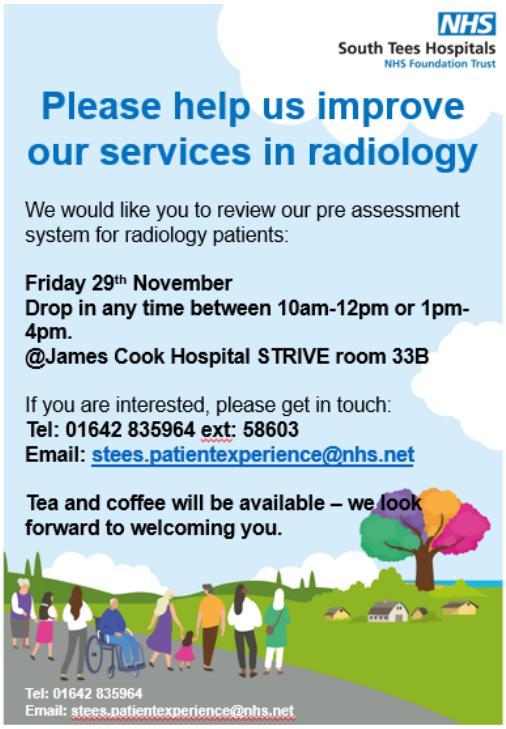
9.5 Carers Charter

Patient Experience were approached to develop a Carers Charter with our local Carer organisations and Healthwatch's. The group met in November 2024 to being developing commitments to carers. As part of this work the commitments were shared with local carer groups for feedback. Following which the group produced a poster. This has been a positive piece of work, supporting our staff and carers to provide the best person centred care for our patients. Below is some of the feedback we received which supported the changes to the commitments:

- How can staff build that personalised care? For example, forget me not cards for patients with dementia. What about other patients who are unable to communicate? Staff need to gain personalised info from carers/family that is available at the bedside for all staff to access. Need something in place to support care when family/carers absent.
- Staff need to ask questions such as: is your person on any medication? Have they got any medical history? Who is the main carer? Some carers recall that this info is not asked at the first point of contact but days later.
- I would like to see volunteers who support carers to help fulfil the commitments.
- Order the above list in terms of priority, for example, triangle of commitment between staff-patients-carers. Build commitments on that.

9.6 Radiology Pre-assessment Project

The Radiology team wanted support from patients to improve their pre-assessment system for patients using their service. A drop-in session was arranged in November 2024

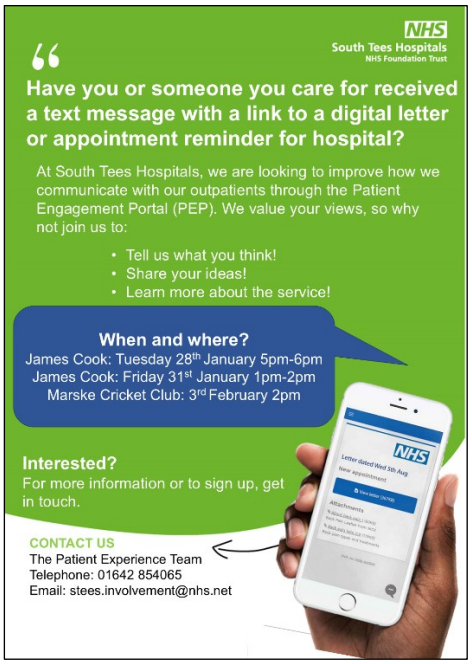


Here is some of the feedback received during the event to support the review:

- Easy, quick only asked what needed. Navigation easy
- Comprehensive and speedy
- Could maybe asked whether patient is a carer
- Better than paper
- 90% said they would prefer this digital method in future healthcare
- What will it look like on a phone?
- Straight forward

9.7 Patient Engagement Portal (PEP)

The Outpatient Improvement Manager and Digital Project Manager contacted patient experience to organise a patient engagement portal (PEP) session for patients, carers and public to attend to give feedback on the DrDoctor service. The PEP allows patients to receive their appointments and letters digitally. The engagement session was held to understand the views of our patients for this vital piece of work.



9.8 Epilepsy study day

The Consultant Neuropsychologist contacted patient experience for support with
ney were delivering at Teesside University to a group of trainee
epilepsy. The Consultant Neuropsychologist wanted a patient to join

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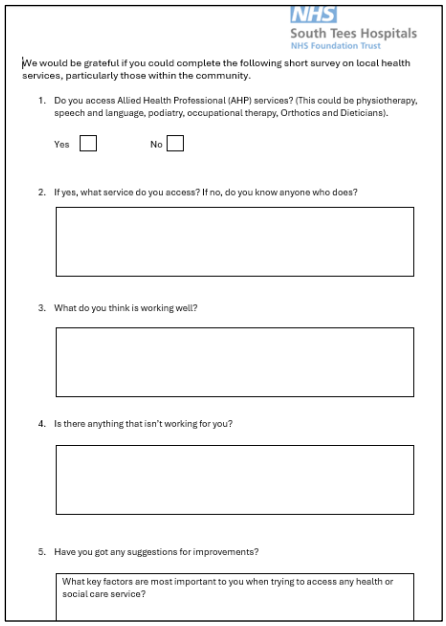
the session to talk about their experiences of living with epilepsy. The PIF has links with a local epilepsy group, and two volunteers agreed to attend the session. They spoke about their diagnosis and life living with epilepsy which were two very different accounts. They received very positive feedback and thanks, from the students for sharing their experiences.

9.9 AHP research

The Professional Lead for Allied Health Professionals contacted patient experience for support with gathering feedback on local health services, particularly those within the community. The PIF arranged to attend a number of community groups to have discussions with those who may have used one or more of these services. The Professional Lead for Allied Health Professionals attended some session with the PIF and together collected lots of qualitative information from many people including patients and their carers. Although a survey was created, speaking to people face-face and in small groups generated lots of valuable discussion.



NHS
South Tees Hospitals
NHS Foundation Trust

We would be grateful if you could complete the following short survey on local health services, particularly those within the community.

1. Do you access Allied Health Professional (AHP) services? (This could be physiotherapy, speech and language, podiatry, occupational therapy, Orthotics and Dieticians).

   Yes ☐ No ☐

2. If yes, what service do you access? If no, do you know anyone who does?

3. What do you think is working well?

4. Is there anything that isn't working for you?

5. Have you got any suggestions for improvements?

What key factors are most important to you when trying to access any health or social care service?

Community groups attended include:

- Teesside Stroke Group
- Dementia Dance Acklam
- Senses Wellbeing CIC
- Aapna Services
- Parkinson's group Redcar
- Age UK

10. Patient Stories

Videos and presentations continue to be created as a powerful way of sharing the [illegible] and their relatives or carers. They are an effective way of

celebrating and sharing good practice or improvements that have been made following poor experiences. The participant chooses how and where they wish to share their story.

The PIF supported the Heart Failure and Palliative Care team with a conference held for staff.

The Heart Failure Nurse Consultant asked the PIF to support with two patient stories; this was with two daughters whose fathers had passed away and had been under the care of the heart failure and palliative care teams.

10.1 Stories were captured on video and two separate stories were created. There was some important learning of good practice from both stories. Feedback from staff, attending the study day, around the patient stories rated highly with 98% scoring them 10/10.

11. CONCLUSION

The Patient Experience Annual Report provides the feedback received through various sources to ensure the patient, carers and families voice is included when seeking to improve or implement new processes or services. It provides a comprehensive summary of how ht quality priorities aligned to patient experience are being met and will continue to be developed upon.

The recommendations in the report are aimed at enhancing the processes already in place in the organisation to seek out feedback. Identifying new ways to improve involving patients, carers and families in everything that we do.

Patient Story
Date of Patient Experience Steering Group meeting: 4 October 2024

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The patient and his wife attended the Patient Experience Steering Group (PESG) meeting to share their experience of care. Staff from Ward 34 joined the meeting to hear the patient story.

At the end of May 2024, the patient was preparing to leave for a family holiday in Majorca later in the day. After checking passports etc, he sat down on the bed to watch some TV and, when he went to get back up, he found he could not move or get himself up and fell on the floor. A call was made to 999 and his son, who lives next door, came to assist. His wife is an ex-nurse who immediately recognised he had suffered a stroke. He could not speak, had a facial droop and his left side was severely affected.

The paramedics arrived very quickly, and he was taken to JCUH. The patient was admitted to Ward 34 and had to be hoisted; such was the severity of his symptoms. Initially he was on the high dependency area where there was constant care, he was then moved to the more regular area of the ward. He remained on Ward 34 for 5 days before he was transferred to Zetland Ward at Redcar Hospital. At this point, he was hoisted as he had no posture and was immobile.

The patient had a lengthy admission on Zetland Ward from the end of May to the end of July. He developed a great rapport with the staff on the ward from the outset. He recalled one of the most important things was when he first arrived and how he was introduced and shown around the ward. He recalls how staff (Chris and Kerry) took the time to introduce themselves.

During this time, he underwent almost daily physiotherapy whilst an inpatient and recalled how the staff would push him to achieve his best, whilst recognising when he had reached his peak or when he was having an off day. He recalled it being like a “bootcamp” for some sessions, but this was exactly what he needed and was the right approach for him. The patient had ran his own business for many years and is a motivated person and keen to achieve the best outcome he could. He recalled when he took his first steps in hospital the staff clapped and cheered, and it was clear to him staff take immense job satisfaction in seeing their patients improve and progress. Staff put a lot of effort in, and it is important that they feel valued.

Whilst an inpatient it was the patients and his wife’s 43rd Wedding Anniversary and staff supported them to celebrate that important milestone, which meant a lot to the couple.

The patient shared how he had made great progress on the ward and reached the point he felt ready to go home so he could make further progress in the real world. He recalled his first few days at home were an experience, things that were so simple before such as getting in and out of the shower or walking down steps to access his garden were a challenge. He explained how it was a case of ‘trial and error’ learning how to best tackle the obstacles. He realised how he had left the ‘safety net’ of the hospital where staff were there to support his every step and progression to being put back in the real world.

The patient continues to receive OT and physio support in the home. He has also been well supported by his grandchildren which has helped his recovery. He was recently able to attend a Middlesbrough football match, which was great as they won, and has enjoyed a

The PESG asked the patient,

- what he thinks went well during his admission? He explained it was the staff engagement, that all staff introduced themselves and that initial introduction to the ward as well as the ongoing care and support he has received.

- if anything could have been better during his admission? He explained that one thing that could improve the patient experience is knowing what time they will have their physio/rehab and that those patients who are earlier on the list are gotten up sooner. This would help patients plan their day.

- In addition, the patient experienced difficulties trying to claim PIP benefit. An information leaflet on discharge and potentially a letter to support with a benefit claim being available on discharge would be helpful.

The patient explained he spoke with staff about returning to the ward to speak with patients. He has recorded himself throughout his admission to evidence his progress. Once he reaches the point where he feels he is at his maximum he will arrange to return to Zetland. He is also keen for staff on Ward 34 at JCUH to see his progress as he feels they will not recognise him as the patient who was initially admitted. The patient told us how the staff at JCUH keep you alive, but they do not get to see the outcome; he feels it would motivate and inspire staff and patients meeting someone who has lived the whole experience.

University Hospitals Tees

IPC Improvement Plan 2025/26 including Strategy Report

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 14

Report author: *Sharon Lance*

Executive director sponsor: *Emma Nunez, Group Chief Nurse*

Action required:
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☒

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Safe

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The standard contract objectives for 2025/26 have now been received and are as follows,

Trust	CDI	MRSA	ECOLI	Klebsiella	Pseudomonas
South Tees	122	0	138	52	16
North Tees	66	0	81	30	15

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

This 2025-26 IPC Improvement Plan underpins the Tees IPC Strategy for 2025-28 in respect of the IPC agenda, we know effective IPC underpins the fundamental principles of our clinical practice. That is why we have focused on a whole system approach to managing, mitigating and eliminating infection including outbreaks across all health and social care settings.

This essential framework plan will enhance learning, evidence and leadership, helping us all keep pace with best practice and share successful strategies with others.

Together, we will continue to make IPC a priority for residents, patients and colleagues, wherever they work in the health and social care sector.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Strengthening IPC knowledge skills and behaviours across all health and social care sectors is important to support the provision of safe and effective care and deliver on the actions outlined in the NHS Long Term Plan and the Trust IPC Improvement Plan.
This plan is multifaceted and contains the following (although not exhaustive):

- HCAI management and reduction strategies
- Decontamination support and involvement
- Community development of care homes and domiciliary care
- A Detailed and robust audit and education programme
- Development of a robust and resilient Tees IPC team
- Fit Testing compliance in line with national guidance
- Antimicrobial stewardship plans and involvement

A key objective of the IPC plan is to develop, monitor and deliver national, regional and local IPC measures to:

- support system-wide improvement in IPC and AMS
- align practice to a national IPC manual
- align practice to evidence-based best practice
- support IPC practitioner professional development.

Recommendations:

It is requested that the Group Board note the content of the Tees Improvement Plan which underpins the Tees Strategy. This will be reported through the IPC Quarterly report to identify progress and any concerns identified.

University Hospitals Tees

INFECTION PREVENTION & CONTROL (IPC) STRATEGY 2025-2028 - UNIVERSITY HOSPITAL TEES IPC OBJECTIVES (Based on National Strategies and the National IPC Manual)

Minimise the risk from avoidable patient harm by complying with IPC best practice and achieve a reduction in healthcare associated infections (HCAI) by achieving nationally and locally set reduction thresholds.

Create and develop an experienced and resilient IPC team across the sites.

Contribute to the reduction of antimicrobial resistance by raising awareness of infection prevention control and inappropriate prescribing of antibiotics.

Objective 1: Reduce the incidence of HCAI / other infections

What are our priorities?

- Review of data for target quality improvement (QI) initiatives.
- Review process for all HCAI cases & simplify terminology by the review of data to identifying trends and themes in line with PSIRF to share good practice & identify learning needs.
- Thematic reviews to be completed on HCAI 6 monthly and learning shared.
- Review documentation for IPC risk assessment for patients on admission to improve correct patient placement.
- Link with stakeholders for policy review and develop IPC policies across Tees.
- Collaborative CDI & AMR ward rounds across Tees in line with the HASCA.

Outcomes:

- Reduce all HCAI on last year's performance by at least 1 case as identified in national standards.
- Timely samples – collected & sent to laboratory.
- Early identification of potential infections and treatment.

Objective 2: Increased compliance with IPC best practice through Education and Audit.

What are our priorities?

- Improve hand hygiene and commode competencies across organisation to achieve over 90%.
- Improve commode and hand hygiene audit compliance to over 85% for Peer audits.
- Support with delivery of training to ensure a high level of knowledge for antimicrobial stewardship (AMS) for prescribers and non-medical prescribers including Doctors in Training updates.
- Focussed campaigns including 'gloves off'
- Review and develop consistent toolbox training resources that are supported by the national IPC educational framework.
- Develop IPC link groups across sites.
- Develop and expand IPC 3-day course across Trust.
- Audit compliance with policy for HCAI.

Outcomes:

- Consistent IPC practice to prevent avoidable patient harm.
- Improved workforce knowledge.
- Reduced HCAIs.
- Improved shared learning across the organisation.
- Consistent message in respect of IPC measures and interventions

Objective 3: Support the Trust with their overarching decontamination strategy.

What are our priorities?

- Comply with national standards in the HASCA and the NIPCM on decontamination of communal patient care equipment reusable devices.
- Support and advise on the trusts decontamination Strategy and priorities to provide assurance and minimise risk to patients.
- Sustained focus on effective decontamination in relation to cleaning and hand hygiene through education and audits.
- Completed refurbishment projects that are compliant with IPC.
- Sustained focus on water safety and ventilation hygiene both internal to the Trust and with external partners.
- Plan to reintroduce the dedicated deep cleaning programme with a decant ward available across sites to support effective decontamination.
- Develop and utilise IPC Decontamination Nurse across Trust.

Outcomes:

- Improved collaborative working across system.
- Cleaner healthcare environments.
- Improved patient experience in respect of HCAI.
- Reduced transmission of infections.
- Empowered staff.

Objective 4: Reduce antimicrobial resistance.

What are our priorities?

- MDT collaborative AMS ward rounds to promote appropriate prescribing across all sites to be embedded as per HASCA.
- Review and improve awareness of data collection of prescribing compliance for assurance of AMS, with reporting to IPC Committees.
- Support prescribers with the appropriate knowledge and education to make informed best practice choices through audit and education.
- Raise awareness and promote appropriate prescribing to change behaviours through education and audit.
- Support with the Trust AMR targeted plan.
- Collaborative meetings with IPC and AMS Pharmacist implemented and developed.

Outcomes:

- Improved prescribing in line with the AMR Plan and local strategy resulting in increased compliance with AMS.
- Reduced HCAI's.
- Reduced harm to patients.
- Reduction in AMR locally, contributing regionally and nationally.
- Improved knowledge of workforce and shared working.

Objective 5: Collaboration, surveillance and intelligence to inform action.

What are our priorities?

- Rationalise all IPC policies and align across group.
- Incorporate the National IPC Manual for England into all relevant IPC policies.
- Review national guidance changes for implementation locally and ensure effective communication in respect of this.
- Monitor prevalence of outbreaks/increased prevalence and review / share any learning both locally and regionally.
- Assist with appropriate prescribing in community where appropriate.
- Monitor, review and reduce patient and staff movement across the organisation in line with Clinical Matrons and Safecare practices.
- Involvement with regional and national initiatives and collaboratives to improve standards and policy using data and intelligence.

Outcomes:

- IPC policies in line with national guidance and aligned across Tees.
- Correct placement of patient for infection risk using a risk based approach.
- Improved patient flow.
- Improved patient experience.
- Increase in retention of workforce.

This Plan on a Page is informed by the following,

Antimicrobial resistance (AMR) - GOV.UK and NHS England » Reducing gram negative blood stream infections (BSI) across the whole health economy and Actions to contain carbapenemase-producing Enterobacterales (CPE) - GOV.UK

Clostridioides difficile infection: how to deal with the problem - GOV.UK (www.gov.uk) and Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK

NHS England » National infection prevention and control and NHS England » Infection prevention and control education framework

University Hospitals Tees

2025/2026 IPC Improvement Plan

HCAI

Mandatory Surveillance completed in line with standard contract objectives - NHS England » Minimising Clostridioides difficile and Gram-negative Bloodstream Infections
Plan for reduction on cases from previous year with targeted areas on increased prevalence
Learning and review of all HCAI cases in line with PSIRF – Share learning in appropriate forums
Weekly review of HCAI incidents with patient safety team and AMS Pharmacist – to include safety champion for 25/26
Development of IPC patient pathways and care plans for the electronic patient systems
Review of Trust screening programme in respect of MRSA, CPE etc to ensure consistent approach
Further development of care of invasive devices across the Trust to support with ANTT and the HCAI reduction plan
Continuous audit and education across all clinical areas in line with HCAI's and learning identified including best practice
Translate national guidance and support the organisation in respect of respiratory management including testing and vaccinations

FIT TESTING

Review of fit testing services across Tees to plan for the future model in conjunction with NTH Solutions
Enable timely reporting for clinical areas in respect of Fit Testing and FFP3 compliance
Appropriate recruitment to vacant posts for the vital service
Engagement with comms in respect of messaging and alerts to staff
Ongoing development of an educational programme to support the number of fit testers across the organisation to support such a small team
Potential development of the service wider than the Trust to generate income

ANTIMICROBIAL STEWARDSHIP

Collaboration with AMS team in respect of audits and education across organisation
AMS and Sepsis Study day to be repeated
Promotion in Trust regarding IVOS and review of Antimicrobials (EPMA reporting and revision of Q's)
Learning from incidents in line with PSIRF – Shared learning

DECONTAMINATION

Support with Trust Decontamination Strategy and developments including water, ventilation etc.
Review of development of role of IPC Decontamination Lead across Tees
Monitoring and involvement with Trust procurement, maintenance and cleaning of equipment
Collaboration with Trust Hard and Soft FM services to ensure compliance and monitoring is effective and reported appropriately
Support the IPC message and plans in respect of dedicated ward decant facilities across Tees
Development of theatre bespoke audits across all areas in Tees
Support in refurbishment plans regarding appropriate decontamination and IPC practices

AUDIT & EDUCATION

Detailed Education plan including; toolbox teaching, 3-day IPC Course, mandatory training and bespoke sessions
Development of 3-day IPC Course across Tees and possible income generator
Increased profile of IPC Link Practitioners programme across all areas within Tees
Development of programmes for Volunteers, Student Nurses, Preceptorships etc.
Detailed audit plan for 25/26 including sluice, commode, environmental, hand hygiene, ANTT, VIP, Isolation
Audit and compliance with the national data set on UKHSA
Development of audit tools within In Phase to support the IPC agenda

COMMUNITY

Secure funding through Local Authority for Community Care Home/Domiciliary B4 support role
Detailed audit and education plan for all care homes and domiciliary care across Tees
Review of service delivery and shared practice across Tees
Support with HCAI management including reporting mechanisms and monitoring
Close liaison with UKHSA for support in outbreak management
Ensure IPC Champions study day completed twice per year in conjunction with Local Authorities

STRATEGIC PLANNING

Development of a Tees IPC Team structure to support organisational change
Review of all Job Descriptions to ensure consistency and clarity around particular roles
Development of competencies across Tees with focus on any gaps and in line with IPC National Competencies
Review and alignment of policies across Tees in line with National IPC Manual
Review of governance processes across Tees to ensure robust and resilient

University Hospitals Tees

Annual Infection Prevention and Control Report 2024/25 - NTHFT

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 14.2

Report author: *Sharon Lance*

Executive director sponsor: *Emma Nunez, Group Chief Nurse*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Safe

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The NHSE Standard Contract Objectives at North Tees for 2024/2025 were all above trajectory other than Klebsiella and E Coli.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

The Trust reported 26 outbreaks in total of COVID-19, Influenza, Norovirus and Diarrhoea in 2024-25, which is a reduction of four, from the previous year. Ten of these were Diarrhoea and Vomiting and nine were confirmed as Norovirus by stool sampling. 14 COVID-19 outbreaks were reported and two Influenza outbreaks. Outbreak management has maintained patient safety and cases have been limited in numbers and have been able to be managed and closed quickly, with minimal bed closures to limit operational disruption, through effective outbreak measures being implemented. The infection control team has continued to assess risk and aims to limit bed closures in line with patient safety, working closely with the clinical teams and clinical site managers.

In 2025-26 flu campaign, regionally, there has been a target set to increase last year's uptake by 5%. To assist with achieving this, the focus will be on peer vaccinators being identified prior to the start of the campaign to help deliver vaccinations to their colleagues, and the training sessions will be commencing early, in August. Encouraging an early and increased uptake in immunisation. Mobile hubs will be advertised so staff do not need to leave their clinical areas.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

The IPCT unannounced visit annual audit programme continues. The programme includes completion of a hand hygiene facilities audit, a standard precautions audit and an environmental audit. All planned audits were completed by the IPCT during 2024/25. A new schedule is planned for 2025/26 with all inpatient areas and theatre audits completed annually and outpatient areas audited two- yearly.

In addition to the above audits, the IPCT audit programme also includes monthly hand hygiene observation audits and monthly commode audits on each ward. Results are shared with clinical areas and are presented and discussed at the Infection Control Committee meetings.

The key aims in 2025/26 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with the Trust services. Patient safety is at the heart of IPC, and to ensure our work is sustainable the Trust promotes that every member of staff takes responsibility for IPC in order that that no person is harmed by a preventable infection.

At North Tees and Hartlepool, we have been part of the Surgical Site Infection (SSI) reporting since 2017, all infections are reviewed continuously across the year within surgery and orthopaedics. Within surgery we review breast, gastric, small bowel and large bowel. Within Orthopaedics we review long bone, repair of neck of femur, hip replacement, knee replacement and spinal.

2024-25 saw the launch of the IPC InReach programme. With the successful recruitment of an IPC support nurse, overseen by the IPC team, a program of training and education has been delivered to clinical areas, through a variety of methods. The support nurse worked on the ward, alongside the staff for a period of two weeks in each area, providing teaching and role modelling good practice for IPC whilst caring for patients and therefore being able to put the theory into practice. The programme has proven to be a very effective way of instilling knowledge and improving practices in clinical areas, with the training bespoke to each area and their current requirements in relation to IPC and ensuring the staff do not need to take time away from the clinical area to benefit from the learning.

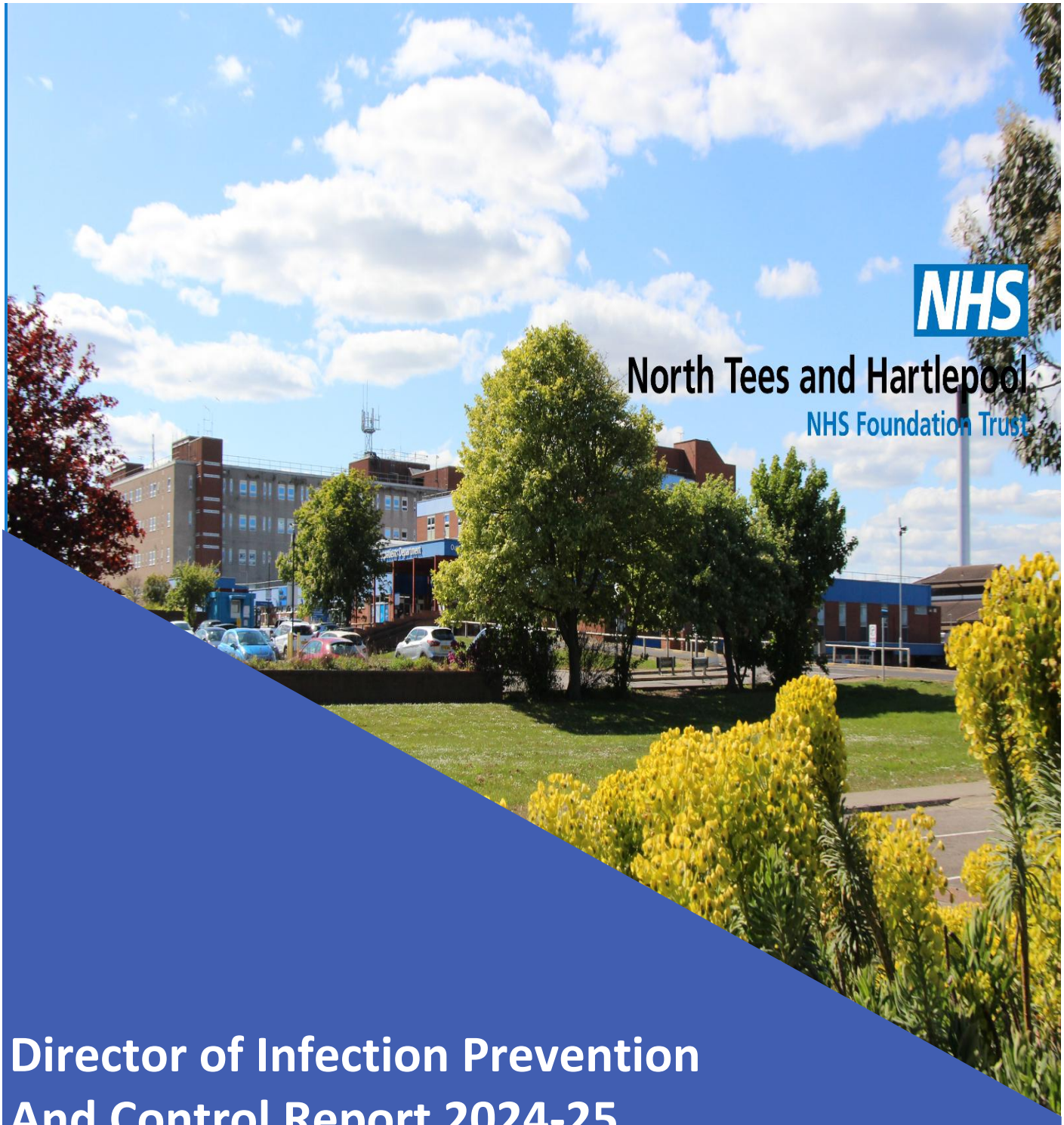
The programme has been very well evaluated by both staff and patients and has meant that it can be continued into 2025-26. Work is being undertaken to incorporate the principles of InReach into our core business and get all of the IPC team involved.

Recommendations:

It is requested that the Group Board note the content of the North Tees Annual Report for 2024/2025 in respect of the year end HCAI position and acknowledge the actions that are being taken to address this.

The recommendation from the report is to continue with the ongoing actions, recognising that reducing the rates of infections is multi-factorial and improvements need to be sustained over a period of time to impact the data.

There is a plan that the Annual Report for 2025/2026 will be a combined Tees IPC report.



Director of Infection Prevention And Control Report 2024-25

Executive Summary

This report gives a summary of infection prevention and control activities which have been undertaken to improve and sustain safety for our patients, visitors and staff across all of our healthcare settings, during 2024-25. There has been collaborative working with partner organisations and close multi-disciplinary working with internal Trust departments to achieve the annual objectives and initiatives.

2024-25 has remained a challenging year for Infection Prevention and Control, with an increased occupancy and activity within the Trust as well as regional and national increases in infection rates observed. The trust continues to be committed to reducing infection rates and ensuring that our population receives the highest standard of care.

Our commitment and focus to achieve excellence as standard for our population has continued to be demonstrated in the last year and will remain the focus for upcoming years.

Emma Nunez
Director for Infection, Prevention and Control

Sharon Lance
Deputy Director for Infection, Prevention and Control

Victoria Hancock
Lead Nurse for Infection, Prevention and Control

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- Healthcare Associated Infection Surveillance & Performance
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- Pseudomonas bloodstream infections
- Surgical Site Surveillance
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- Hand Hygiene
- Outbreaks
- COVID-19
- Policies
- Audit Programme
- Education and Training
- Antimicrobial Stewardship
- Decontamination of the Environment and Equipment
- Conclusion

Infection prevention and control arrangements

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

The DIPC provides an update to each Board of Directors via an Integrated Performance Report. A performance update is provided monthly to the Quality Committee, which is a subcommittee of the Board and is chaired by a Non-Executive Director. There is a quarterly Infection Control Council (ICC) and quarterly Healthcare Associated Infection (HCAI) Operational Group which provides operational information to the ICC. The HCAI Operational Group undertakes targeted pieces of work as required by publication of new guidance, recommendations from incident investigations or audit findings. This meeting has been reviewed and for the next financial year, will take place monthly and feed into ICC.


"Our vision is that no patient, visitor or staff member will be harmed by a preventable infection"

Healthcare associated infection surveillance and performance

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

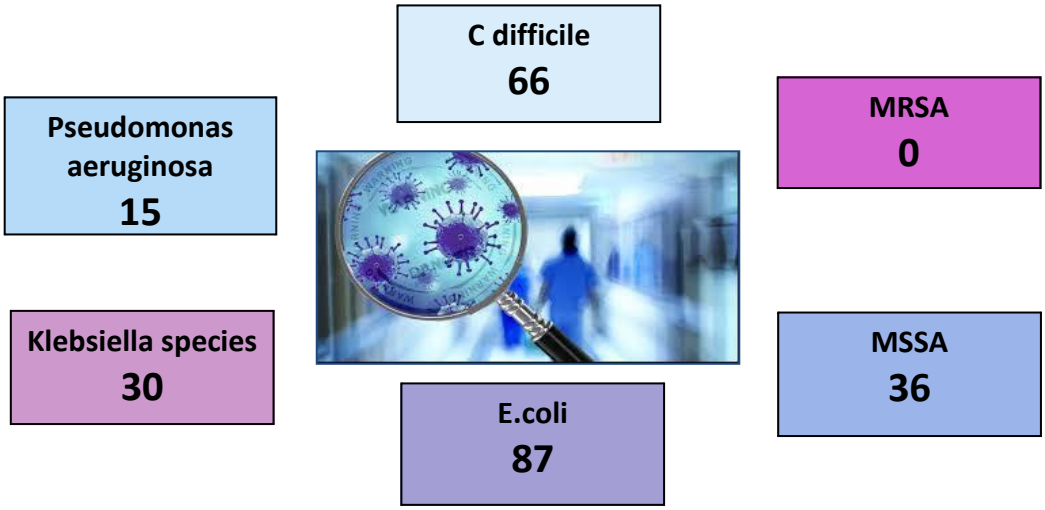
- Clostridioides difficile infection (CDI)
- Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection (bacteraemia)
- Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia
- Escherichia coli (E coli) bacteraemia
- Klebsiella species bacteraemia
- Pseudomonas aeruginosa bacteraemia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

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

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

National reduction thresholds have been set for five of the six infections shown below. MSSA is the only infection without a national objective, however the Trust set an internal objective to achieve a reduction in cases.

Fig 1. Reduction objectives for infections in 2024-25



Clostridioides difficile infection (C.difficile/CDI)

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

During 2024-25 we reported **79** healthcare associated cases of CDI which was against the **threshold of 66 cases**. This is an increase on the 2023-24 reporting period, by 9 cases and is the highest number of healthcare associated cases we have seen since 2019-20. It should be noted that hospital admissions have remained pressured throughout the year, and that there remains an elevated use of broad-spectrum antibiotics, which increases the risk of CDI. Case reviews are completed on each healthcare associated case through InPhase, by a multi-disciplinary team including, IPC Team, clinical/ department staff, antibiotic pharmacist and microbiologist. Antibiotic usage is being monitored though the Trust antimicrobial stewardship (AMS) group.

Fig 2. C difficile cases 2019-25

Year	Healthcare associated cases	Community onset cases
2019-20	53	39
2020-21	49	44
2021-22	50	55
2022-23	48	45
2023-24	70	35
2024-25	**79**	**48**

The pressured position is echoed throughout the Integrated Care Board (ICB) and across the UK. C.difficile infection rate remain at the highest they have been for several years. Actions to reduce C.difficile infections have been discussed as an ICB and nationally, with national teams tasked to deep dive into cases to identify any potential causes of the increase in infections and ways to reduce the number of infections. Improvements such as a change in Trust policy to improve rates of gold standard HPV cleaning, increasing inpatient reviews by the IPC team, AMS group meeting regularly-reviewing antibiotic use and implementing teaching, participating in regional initiatives to reduce CDI rates and introducing a CDI reduction action plan managed by the care groups.

The implementation of the Patient Safety Incident Review Framework (PSIRF) has also supported a move from completing individual Root Cause Analysis documents and focusing on thematic analysis to identify new learning. These reviews are completed and monitored via the In Phase system, with input from the IPC team, the ward/ department staff, medical colleagues and pharmacy, ensuring a multi-disciplinary oversight of trust attributed cases.

MRSA bacteraemia

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

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

In 2024-25 we reported **five** healthcare associated MRSA blood stream infection **against a zero tolerance threshold**. This is a reduction in performance against the previous year. All MRSA cases are investigated individually, two of the cases found that there was no trust learning identified, three cases identified areas of learning in relation to admission screening. A daily visit has been implemented to EAU, to promote all admission screening, including MRSA. This has led to an increase in compliance with screening and staff awareness, the daily visits continue.

Fig 3. MRSA bacteraemia cases 2015-25

Year	*Healthcare associated cases*	*Community onset cases*
2015-16	2	3
2016-17	1	2
2017-18	4	2
2018-19	0	0
2019-20	0	3
2020-21	1	2
2021-22	0	1
2022-23	2	1
2023-24	4	6
2024-25	**5**	**3**

MSSA bacteraemia

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

In 2024-25 we reported **48** healthcare associated cases of MSSA bacteraemia against the **internal objective of 36 cases.** This is a reduction of five cases from the previous year. The most common reported source has been intravascular devices. Cannula audits have been planned and specific training around intravascular devices as well as “scrub the hub” promotion has also been

implemented as part of the IPC InReach programme, which is further discussed in the training and education section of the report.

Fig 4. MSSA bacteraemia cases 2021-25

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	38	54
2022-23	47	65
2023-24	53	60
2024-25	**48**	**70**

E coli bacteraemia

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

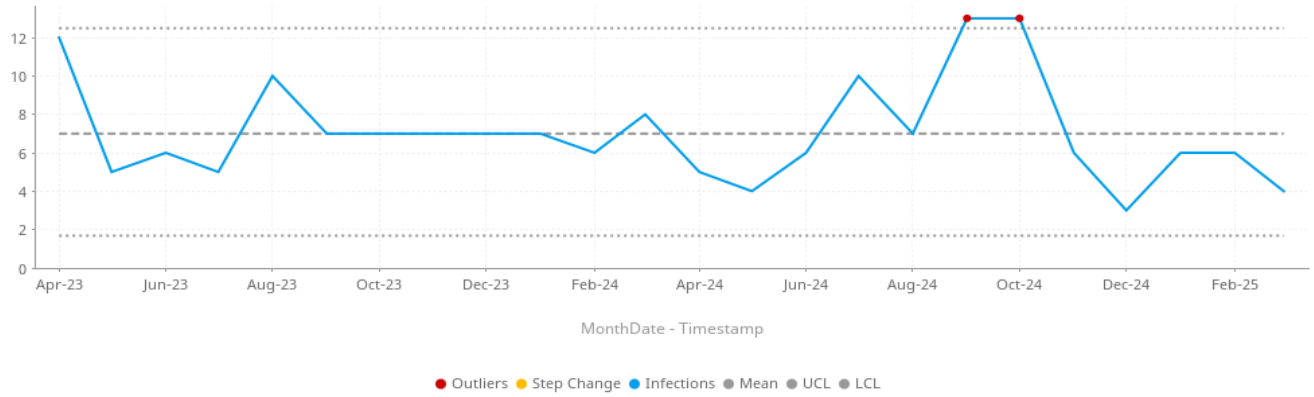
In 2024-25 we reported **85** healthcare associated cases against an **objective of 87 cases.** This is two cases under the threshold set by NHSE and three cases less than reported for 2023-24. The most common reported source was lower UTI. The IPC team have completed increased catheter audits and training. There has been a new CAUTI group launched which includes clinical staff as part of the core membership. Catheter care and UTI reduction has also formed part of the link worker study day. Catheter care and UTI education has featured in the InReach programme and will continue to form part of the IPC work stream for 2025-26.

Fig 5. E coli bacteraemia cases 2021-25

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	78	184
2022-23	87	213
2023-24	88	223
2024-25	**85**	**203**

The most common reported source was UTI, some of which were catheter related. The IPC team have completed increased catheter audits and training. There has been a new CAUTI group launched which includes clinical staff as part of the core membership. Catheter care and UTI reduction has also formed part of the link worker study day and has also featured in the InReach programme, this will continue to form part of the IPC work stream for 2025-26.

Graph 1 E-coli Bacteraemia Infections from April 2024- April 2025



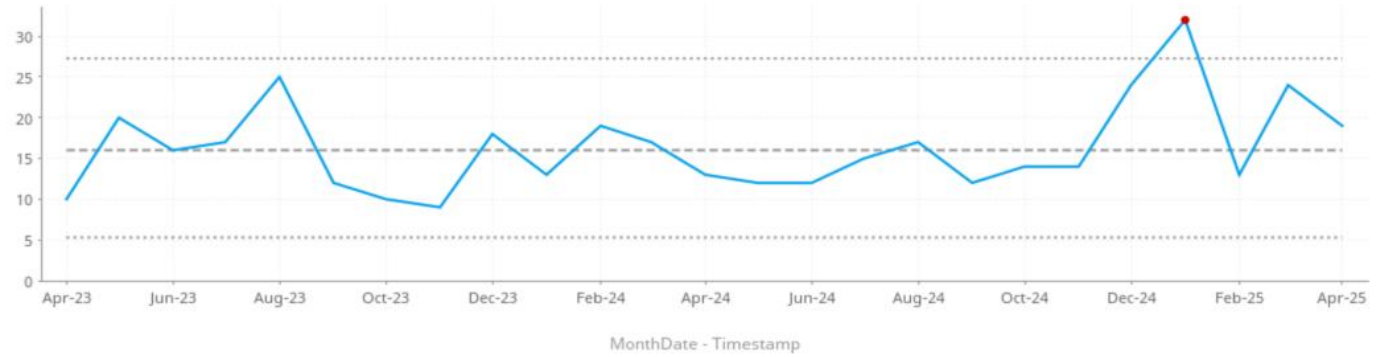
The trust have seen an increase in the number of Catheter-Associated Urinary Tract Infections (CAUTI) for 2024-25, compared to the last reporting year.

There has been work undertaken as part of a relaunched CAUTI group, as well as other initiatives such as the InReach programme and meal tray posters, to promote hydration and good catheter care, with the group also looking at alternative products to reduce catheter usage. The IPC team have launched the HOUDINI tool, with the aim of reducing the length of the time patients are catheterised. All of this with the aim of reducing catheter associated infections. The work is planned to continue into the next reporting year.

Fig 6. Catheter Associated Urinary Tract Infections 2021-2025

	2021-22	2022-23	2023-24	2024-25
Hospital onset CAUTI	265	209	186	202

Graph 2 CAUTI Infections from April 2023-April 2025



Klebsiella species bacteraemia

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

We reported **30** healthcare associated cases of Klebsiella bacteraemia in 2024-25 against **an objective of 30 cases**. Hepatobiliary and UTI remain the most common source of Klebsiella infection. The work being undertaken as part of the InReach, link worker programme and CAUTI group will contribute to a reduction in these sources of infection. In addition to this, work has been undertaken in the surgical departments to address waiting list times for procedures such as cholecystectomy.

Fig 7. Klebsiella bacteraemia cases 2021-25

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	15	44
2022-23	28	43
2023-24	31	45
2024-25	**30**	**53**

Pseudomonas bacteraemia

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

In 2024-25 we reported **17** healthcare associated cases against an **objective of 15 cases.** This is an increase of two cases from last year. Many of these cases are considered unavoidable infections. Whilst there has been a slight increase in healthcare associated cases, the community onset cases have also seen a significant increase on the previous year.

Fig 8. Pseudomonas bacteraemia cases 2021 -25

Year	*Healthcare associated cases*	*Community onset cases*
2021-22	14	12
2022-23	15	15
2023-24	15	9
2024-25	**17**	**18**

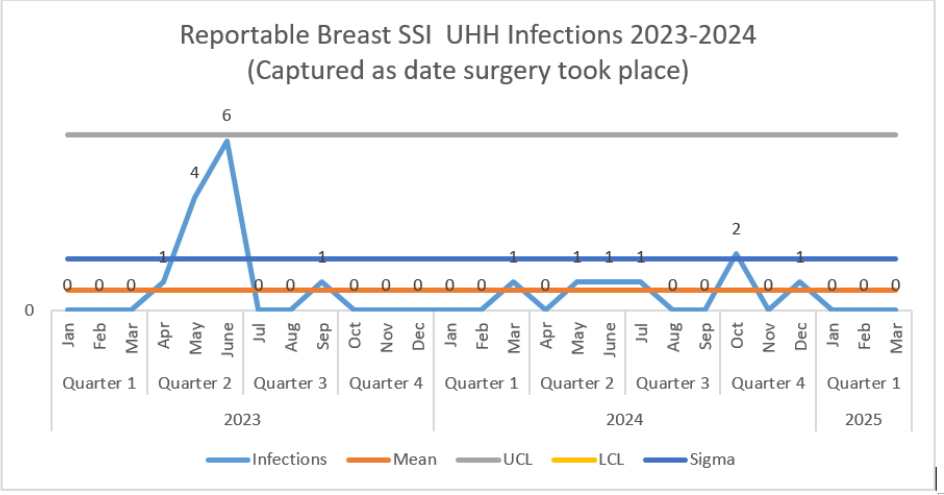
Surgical Site Infection (SSI)

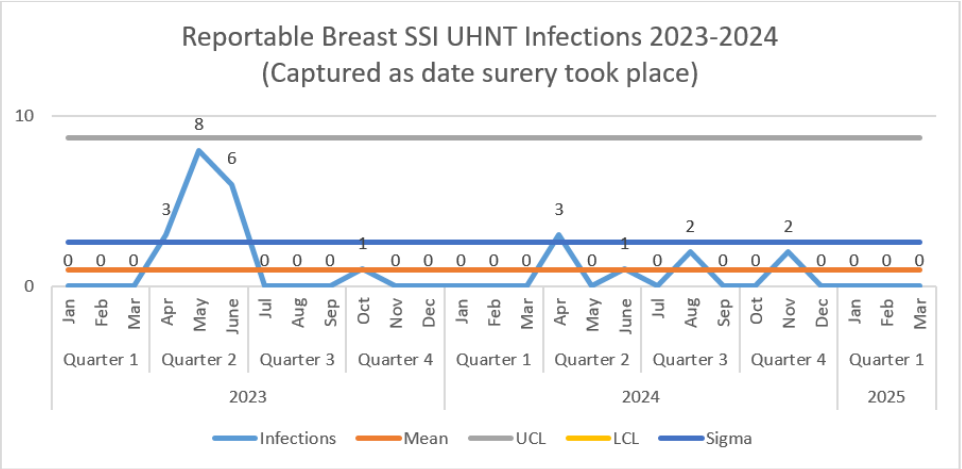
At North Tees and Hartlepool we have been part of the Surgical Site Infection (SSI) reporting since 2017, all infections are reviewed continuously across the year within surgery and orthopaedics. Within surgery we review breast, gastric, small bowel and large bowel. Within Orthopaedics we review long bone, repair of neck of femur, hip replacement, knee replacement and spinal.

SSI recording and submission is mandatory for one quarter each year, organisations are then able to complete voluntary submissions to aid learning and influence practice. It is recommended that all surgical units monitor their own SSI rates and contribute to the national surveillance of SSI in order to help inform and influence clinical practice to reduce the risk of SSI. There were a total of 189 hospitals in 2023/24 that undertook the mandatory surveillance compared to 55 who undertake voluntary surveillance continuously. The approach we undertake allows us to understand our own infections and act on any issues identified to improve practice and influence outcomes for patients. SSI's can lead to increased morbidity and mortality in patients who have received a surgical procedure. These infections can be associated with increased length of stay, further operations and a significantly increased cost. Infections of the surgical site account for approximately 16% of all hospital acquired infections (HAI).

Breast

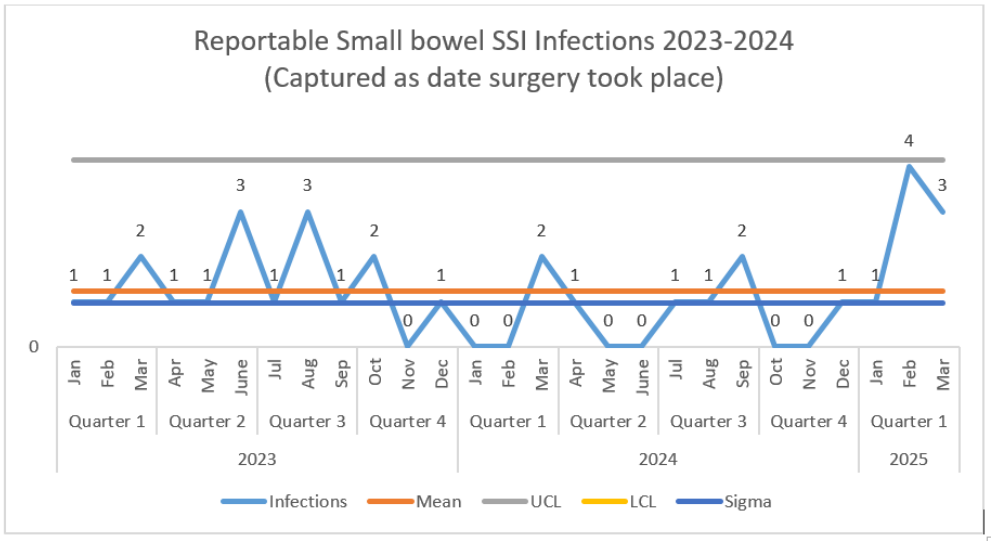
The data below shows our continuous collection of breast infections. The data demonstrates that in quarter 2 of 2023 we saw an increase of infections for which a thematic review was undertaken and a decolonization pathway was established for high risk breast cases. We have since seen a reduction in the cases at Hartlepool 12 were reported in 2023 and only 7 in 2024. At North Tees 18 were reported in 2023 with 8 reported in 2024.

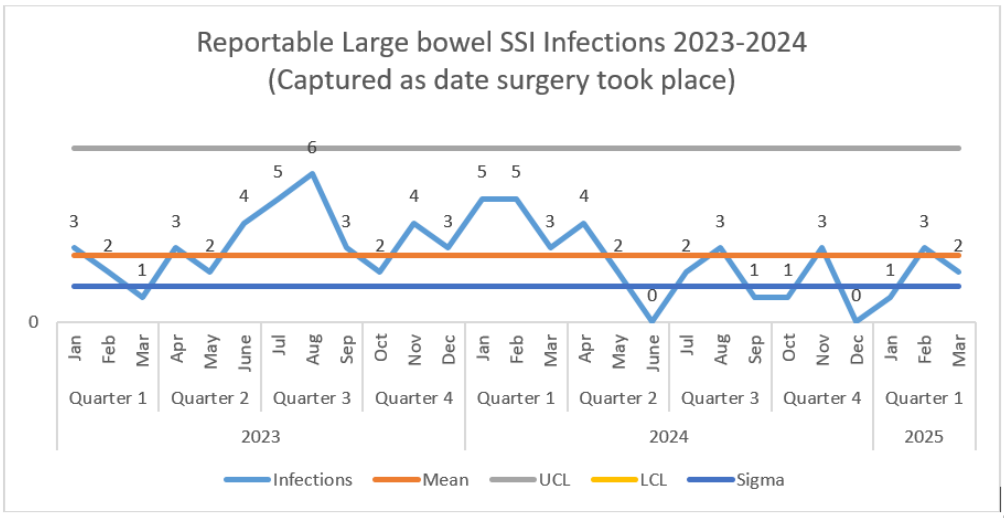




General surgery

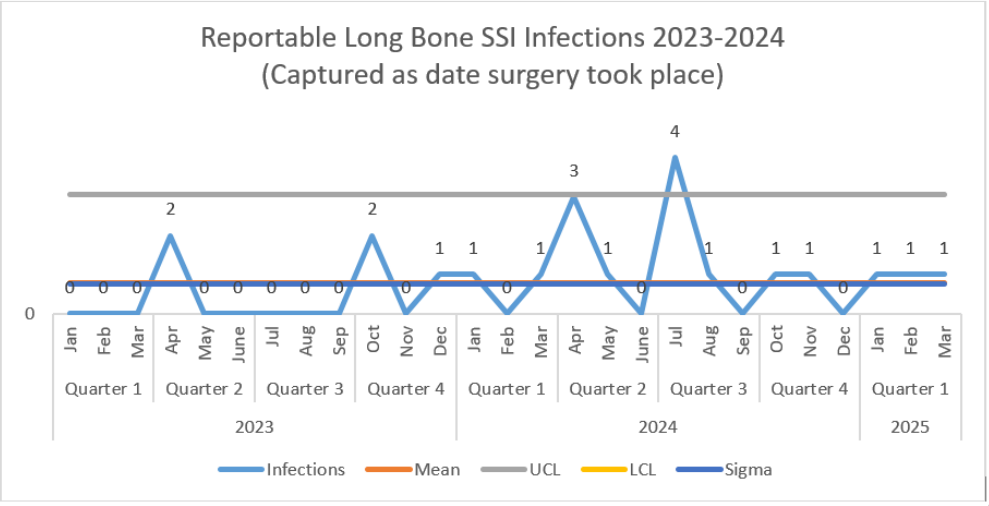
The data below shows our continuous collection of general surgery infections. For small bowel within 2023 there were 17 cases, within 2024 there were 8 cases. We have seen an increase in reporting for February 2024 however two of these relate to an unwell patient who returned to theatre twice. For large bowel there were 38 cases reported in 2023 and 29 cases reported in 2024.





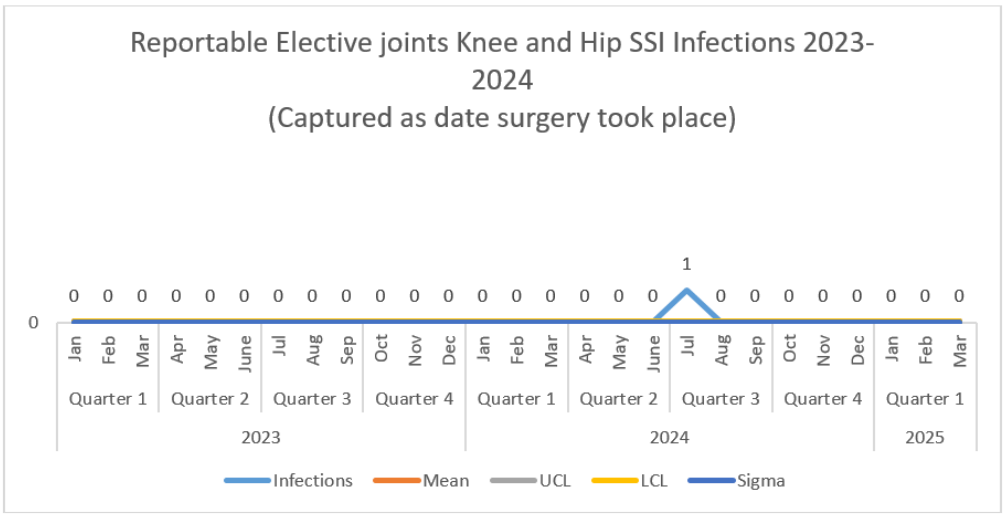
Lower limb trauma

The data below shows our continuous collection of long bone infections. The data demonstrates that in quarter 3 of 2024 we saw an increase of infections for which a thematic review was undertaken a commonality that was identified that theatre 6 within North Tees so it was agreed to bring forward the maintenance of the theatre as part of the development plans. Work has also been undertaken in relation to antibiotics and standardising the approach. We have since seen a reduction in the cases however these patients are monitored for one year due to the implants so it is too early to understand if this is a sustained reduction.



Elective Knee and Hip

The data below shows our continuous collection of elective surgery knee and hip infections. From 2023 to current we have only reported 1 infection and generally have no infections reported.



The data reporting nationally for SSI is only released up to March 2024 from this report is demonstrated that our SSI risk for the mandatory surveillance was Elective surgery 0%, long bone 0.4% and neck of femur 0%.

Influenza

In 2024-25 there was a reduction in Influenza cases with two influenza outbreaks within the trust. The percentage uptake for the flu immunisation in 2024/25 for Trust and NTH Solutions staff was 40.22% (2,556 employees). Although this was a reduction from the previous year's campaign (45.5%) this trend was seen both nationally and regionally.

In 2025-26 flu campaign, regionally, there has been a target set to increase last year's uptake by 5%. To assist with achieving this, the focus will be on peer vaccinators being identified prior to the start of the campaign to help deliver vaccinations to their colleagues, and the training sessions will be commencing early, in August. Encouraging an early and increased uptake in immunisation. Mobile hubs will be advertised so staff do not need to leave their clinical areas.

Hand hygiene

The frequency of hand hygiene audits has remained the same this year and we have continued to carry out monthly self-audit of hand hygiene for our clinical teams, with quarterly assurance audits by the IPC team. Overall the target of 95% compliance has been achieved each month. A high number of monthly audits continues to be achieved throughout 2024-25 demonstrating the commitment to hand hygiene.

Fig 10. Hand hygiene compliance April 2024 to March 2025

Month	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
%	98.91	95.20	97.94	97.53	95.20	95.36	95.57	97.80	96.83	97.52	98.82	97.73
No of audits	79	98	66	77	98	64	76	67	75	73	82	90

We continue to use opportunities such as World Hand Hygiene day to raise awareness for our staff and patients and the IPC team utilise stalls, ward walks and support from product representatives to provide education on hand hygiene and related topics.

Outbreaks

We reported 26 outbreaks in total of COVID-19, Influenza, Norovirus and Diarrhoea in 2024-25, which is a reduction of four, from the previous year. Ten of these were Diarrhoea and Vomiting and nine were confirmed as Norovirus by stool sampling. 14 COVID-19 outbreaks were reported and two Influenza outbreaks. Outbreak management has maintained patient safety and cases have been limited in numbers and have been able to be managed and closed quickly, with minimal bed closures to limit operational disruption, through effective outbreak measures being implemented. The infection control team has continued to assess risk and aims to limit bed closures in line with patient safety, working closely with the clinical teams and clinical site managers.

The trust has continued to use the 20 temporary isolation facility rooms called 'Redi-rooms', these continue to support IPC measures within clinical areas by improving the number of single room facilities. This has allowed the trust to maintain patient flow through critical periods of increased infection or outbreak, reducing the risk to others.

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

COVID-19

During 2024-25, the Trust cared for significantly less patients who were positive for COVID-19, than then previous year with 295 patients in 24-25 and 638 positive patients cared for during 2023-24, which is less than half the number of patients. 81 patients were admitted and had a positive Covid-19 result within 0-2 days of admission compared to 236 patients in 2023-24. There were 82 patients tested positive within 3-7 days of admission, a decrease of 68 patients on the previous reporting year.

74 cases were identified within 8-14 days of admission and are possibly hospital acquired. This is a decrease in cases compared to 146 cases in the previous year. 58 patients tested positive after 15 days or more of admission, compared to 106 cases in 2023-24 and are categorised as hospital acquired cases.

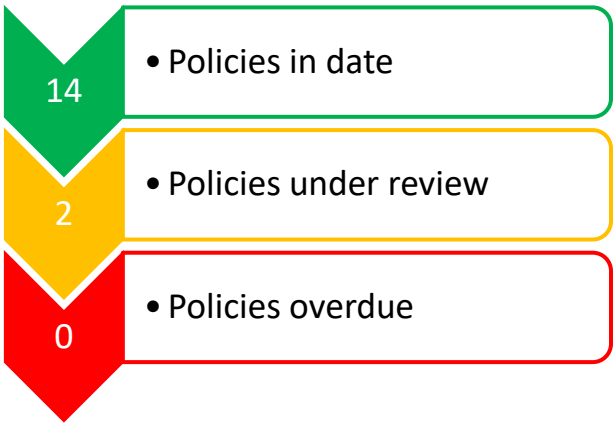
Testing remains as symptomatic testing only in line with other respiratory pathogens and therefore this decrease in cases is likely due to the reduction in the testing guidance.

The Trust continues to provide IPC support to adult care homes in Stockton and Hartlepool through a dedicated care home IPC Nurse. This is carried out through home visits, audits and specific training for care home staff to ensure they are aware of any changes in guidance and receive support in managing infected patients and outbreaks.

Policies

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

A schedule for review and revision of policies forms part of the annual IPC programme. There are 16 active policies and the status at the end of March 2025 is as below:



There has been a decrease of two polices than the previous year, due to one policy being merged with the national IPC manual policy and one policy being transferred to another care group for more appropriate management.

Audit programme

As part of the IPC annual programme, audits are planned for each year. This allows us to monitor adherence to policy and identify areas for focused work.

The catheter prevalence audit continues to be performed twice a year. Catheter prevalence in hospital inpatients ranged from 15.88% in May 2024 (81 patients), which was a 5% reduction compared to the previous year, to 21.22% in November 2024 (121 patients). The catheter-associated urinary tract infection working group meets regularly to continue the focus on training and availability of catheterisation products and alternatives for measuring urine output.

The reduction to 37.38% for the MRSA policy audit is disappointing. The MRSA Improvement Group continued to address shortfalls as part of targeted work with MRSA bloodstream infections in the earlier part of the year. Targeted training was delivered by the IPCT to care groups in formal training sessions and this has continued informally during daily visits to clinical areas.

Compliance with the MRSA screening policy demonstrated a 30% improvement compared to the previous audit. The IPCT continue to highlight patient admissions with MRSA alerts in place to clinical areas during daily ward visits and promote appropriate screening requirements.
Results of the trustwide isolation policy audit show a slight reduction in compliance compared to the previous audit. Slightly less patients requiring isolation were in single rooms, compared to the previous results, however it was noted that the number of patients included in the audit had more than doubled compared to the previous audit.

Fig 11. Audit data 2024-25

Audit	Previous Performance	2024-25 Performance
Catheter Prevalence Audit	20.66%	May 2024 15.88% November 2024 21.22%
MRSA Policy Audit	52%	37.38%
MRSA screening Policy Audit	38%	68%
Isolation Policy Audit	88.93%	86.01%

The IPCT unannounced visit annual audit programme continues. The programme includes completion of a hand hygiene facilities audit, a standard precautions audit and an environmental audit. All planned audits were completed by the IPCT during 2024/25. A new schedule is planned for 2025/26 with all inpatient areas and theatre audits completed annually and outpatient areas audited two-yearly.
In addition to the above audits, the IPCT audit programme also includes monthly hand hygiene observation audits and monthly commode audits on each ward. Results are shared with clinical areas and are presented and discussed at the Infection Control Committee meetings.

Training

All training is in line with a regionally agreed programme and is recorded on the electronic staff record (ESR). Level 1 training is for non-clinical staff and is required every 3 years. Level 2 for clinical staff is required annually.

2024-25 saw the launch of the IPC InReach programme. With the successful recruitment of an IPC support nurse, overseen by the IPC team, a program of training and education has been delivered to clinical areas, through a variety of methods. The support nurse worked on the ward, alongside the staff for a period of two weeks in each area, providing teaching and role modelling good practice for IPC whilst caring for patients and therefore being able to put the theory into practice. The programme has proven to be a very effective way of instilling knowledge and improving practices in clinical areas, with the training bespoke to each area and their current requirements in relation to IPC and ensuring the staff do not need to take time away from the clinical area to benefit from the learning.

The programme has been very well evaluated by both staff and patients and has meant that it can be continued into 2025-26. Work is being undertaken to incorporate the principles of InReach into our core business and get all of the IPC team involved.

In total 19 wards were visited during the year, with EAU visited 3 times. There have been 415 staff trained. There were pre and post visit questionnaires completed in each area, 100% of staff found the support valuable, staff reported an overall increase in IPC knowledge following the visit and rated the level of support from the IPC team as improved, with a 25% increased reported between pre and post visits.

A sample of patients were also given feedback questionnaires to complete, in which there was a 28% increase in the compliance of “scrub the hub” during cannula care and a 12% increase in patients observing staff cleaning equipment between use.

During the last year, there has also been close collaborative working between IPC and Estates, planning and design and domestic services teams, to ensure that knowledge of IPC is shared with all departments to positively impact on patient outcomes in relation to infections. There has been a bespoke training package developed with estates and has been delivered to NTH solutions estates teams and planning and design department, as well as contractors who are regularly carrying out work within the hospital. The feedback was very positive and there has been an observed improvement in practice in relation to infection control.

Antimicrobial Stewardship

Updated Guideline:
A Tees-wide Antimicrobial guideline, via the Eolas platform, has been approved and implemented across University Hospitals Tees group. This went live on the 10th March and is undergoing further review by the Consultant Microbiologists in North Tees & Hartlepool NHS Foundation Trust to both Trusts. The Antimicrobial Pharmacist role, filled as of January 2025, is actively supporting this work alongside the Microbiology and Infection Prevention and Control (IPC) teams.

Audit Overview:
A retrospective review was conducted by a trainee pharmacist to evaluate antimicrobial prescribing practices in patients who developed Clostridium difficile infections over a six-month period. Key findings include:

- The most frequently prescribed antibiotic in these cases was Co-amoxiclav
- 62% (n=48) of antibiotic prescriptions did not adhere to Trust guidelines.

Quality Improvement Activity

A quality improvement activity (QIA) on the antimicrobial prescribing was conducted on wards 24, 25, 40 and 42 by a group of resident doctors in collaboration with the antimicrobial pharmacist, focusing on chest infections and UTIs. The intervention targeted:

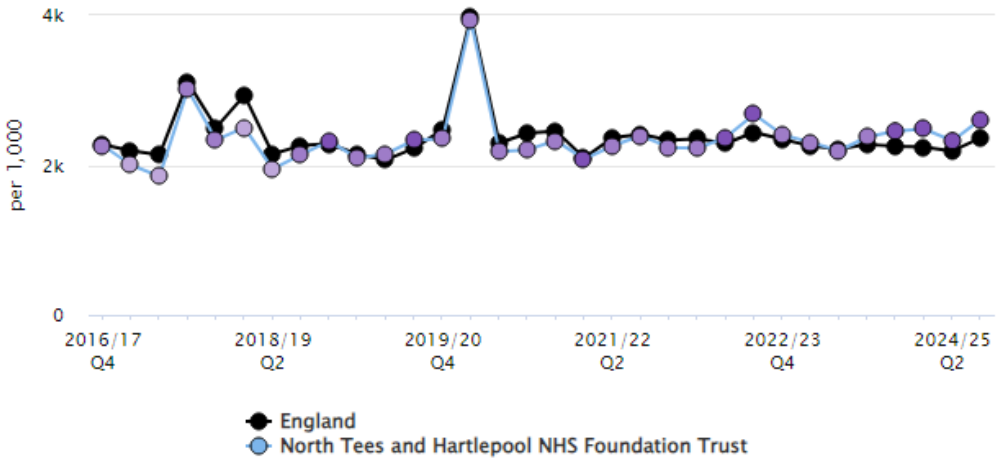
- Increasing guideline compliance
- Reducing time for IV to Oral Switch (IVOS)
- Promoting optimal antibiotic duration and documentation.

Outcome: A 40% improvement in our IVOS was observed, though duration of antibiotics remained unchanged. Results were presented to the medical team, with a follow-up QIA scheduled in August, 2025.

Prescribing Data Analysis:

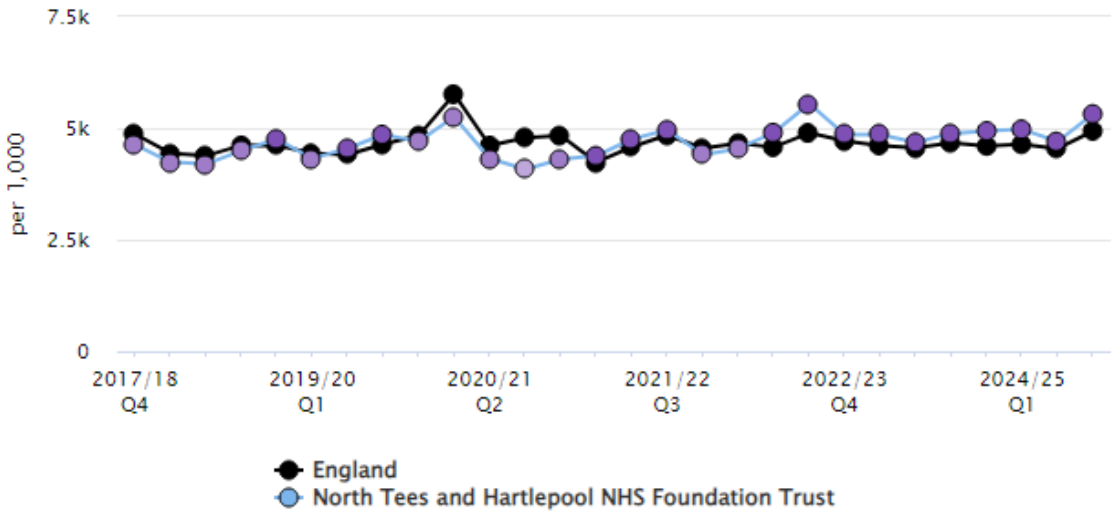
Data from PHE (fig 1) indicates our use of "Watch" and "Reserve" antimicrobials (WHO AWaRE classification) showed a marginal increase when compared to the national average, with no significant variation in trend. This highlights that more work is needed to reduce our use of "Watch" and "Reserve" antimicrobials.

Fig 1. Antibiotic prescribing from the "Watch" and "Reserve" categories of the nationally adapted WHO AWaRE index; Defined Daily Dose (DDDs) per 1000 admissions by quarter and trust



Similarly, fig 2 indicates the total antibiotic prescribing (Define Daily Dose [DDDs] per 1000 admissions) by quarter showed only a marginal increase compared to the national data, again with no significant variation.

Fig 2. Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust



Antibiotic Strategy and Trust Antibiotic Stewardship Committee

The Trust Antibiotic Strategy is currently being reviewed jointly by the Antimicrobial Pharmacist and Consultant Microbiologist. Discussions are ongoing to re-establish a Trust-wide Antibiotic Stewardship Committee.

Hospital at Home (H@H) Empirical Antibiotics Guideline Review.

The empirical antibiotics guideline for the Hospital at Home service was revised to promote appropriate antibiotic use in patients suitable for home treatment. Emphasis was placed on using WHO “Access” antibiotics to reduce broad-spectrum use and Clostridium difficile risk.

Weekly Carbapenem Rounds

Weekly carbapenem rounds aimed to reduce the use of carbapenems (Meropenem and Ertapenem) and subsequently reduce the development of Carbapenemase-producing organisms (CPO). Data from **Q4 of 2024** showed a decrease in CPO reports (3.3 per 100,000 population), compared to **Q3 2024** (3.7 per 100,000 population), which was the highest since 2020. A 41.6% decrease was noted in the North East, mostly in screening samples, although sterile site CPOs increased. This highlights the ongoing need for cautious use of Carbapenems.

Decontamination of the Environment and Equipment

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

The Sterile Services Department is responsible for reprocessing reusable invasive medical devices and flexible endoscopes. All processes are fully validated and compliant to national standards HTM 01-01, HTM 01-06, ISO 13485:2016 and UK MDR 2002 (as amended) Part 11 Regulation 14. The standards are validated by internal audit and independently by an external audit team.

The trust continues to invest in new technologies with the most recent introduction of the ION robotic bronchoscopy equipment which requires intricate and complex decontamination processes.
Disposable items are efficient and used whenever possible. No disposable items are ever re-processed.

Decontamination audits are completed annually in departments where local decontamination takes place, this for example would be where a piece of medical equipment is being decontaminated within a department outside of Centralised Sterile Services Department (CSSD). The Head of Decontamination Services and IPC Nurse carry out assurance audits and all results of such audits are reported to the Decontamination Safety Group which reports into the Trusts Infection Control Council (ICC).

The Endoscope Decontamination Units (EDU) on both sites are validated and compliant with national requirements; HTM 01-06 and also compliant to Joint Advisory Group (JAG) as part of the Endoscopy services accreditation.

The Domestic service within the organisation and other external premises are provided by 'NTH' Solutions. The department aims to provide a clean, comfortable and safe environment for patients, visitors, staff and members of the general public. NTH Solutions contribute to the Trusts efforts to prevent healthcare associated infections by providing excellent standards of cleanliness in line with the current National Standards of Healthcare Cleanliness implemented in 2023/24 which we now comply with. The National Standards of Healthcare Cleanliness recently implemented were introduced by NHS England with the main drive being to ensure transparency in terms of the cleaning undertaken and scoring achieved to assure patients, public and staff that safe standards of cleanliness have been met. The standards have now adopted the widely recognised star rating for performance, with 5 star being the highest. These star ratings are displayed at the entrance to each clinical ward & dept. and display units are currently being installed in which to display them in.
The Domestic team aim to achieve and maintain a minimum pass of 98% (5 Stars) for clinical cleaning compliance for all functional risk (FR) FR1 (very high risk) and FR2 (high risk) clinical areas in line with the standard.

Areas are monitored, depending on FR rating, either weekly or monthly, by the Quality and Standards Team. All results are discussed and shared at the Monthly Cleaning Standards group which subsequently feeds into the Trust Infection Control Council Meeting. This is attended by the Assistant Director of Operations, Head of Decontamination and the Quality and Standards Lead. The new cleaning standards has changed the way scores are determined with both Domestic and Nursing cleanliness monitored during these audits, with an amalgamated score and subsequent star rating produced and displayed providing giving our patients confidence. All audit outcomes with corrective actions are required to be reported back to ward level, via verbal report at the time of audit and then by email, any areas of concern and rectifications required are highlighted.

The Domestic Department is also responsible for completing all Terminal Cleans (TC), following a patient being discharged with a known infection. These are responded to with a plan for high level disinfection following the TC usually Hydrogen Peroxide fogging and are requested via Navenio, a digital workforce allocation tool, and then sent to the appropriate teams for completion. The implementation of this system has been a great success. The tasks added to Navenio are categorised based on urgency, with either a 60 minute or 30 minute response time to attend. On average the team responds to 95% of the urgent tasks within the agreed timings associated. As part of a greater initiative the team increased their capacity for HPV fogging to 24/7, by training all Facilities Team Leaders. This has increased fogging availability, especially out of hours and allowed a focused approach on ensuring all rooms following the discharge of a CDIFF room can be fogged.

There has been a significant increase in collaborative working with IPC, specifically in relation to training and the development of a greater understanding when it comes to the reasons behind the standards and processes that we implement. Additional audits carried out by IPC, has helped developed our teams further and highlight improvements or greater ways of working. A domestic induction training package is under development and this has been heavily supported by the IPC Team. Collaboration and development will continue, with the plan to develop the Facilities Team Leaders further by developing them into IPC Link workers.

In addition to our in-house managed mattress decontamination service, we provide a ward hygienist service, which provides the afore mentioned High level disinfection and/or Hydrogen Peroxide fogging, and a specialist deep cleaning and advisory service. The Ward Hygienist team also continue to deliver equipment deep cleaning in addition to that undertaken by users. All decontamination staff have been a vital part of the work to reduce infections never more so than during the Winter Pressure periods, with additional measures implemented as and when required. We continue to be grateful and extremely proud of their continued hard work and commitment to keeping our patients safe.

Conclusion

Reflecting on the last year, reducing the risk of infection has been our priority and remains so in the coming year. 2024-25 has seen a significant focus on training and education to provide proactive support to clinical staff for the reduction in infections. Antimicrobial stewardship and education remain two priorities for improvement in 2025-26. The upcoming year will see further progression along our journey as a joint partnership with South Tees as 'University Hospital of Tees' and the IPC teams have already seen the benefits of shared resources, education, policies and expertise to be able to provide the safest care for our population.

We have worked collaboratively with our colleagues across the North East and North Cumbria Integrated Care Board to share learning and make improvements to our infection rates regionally, ensuring that a system-wide approach is taken wherever possible.

There is a plan that the Annual Report for 2025-26 will be a combined report across Tees Hospitals in line with the future direction of the organisations.

With contributions to the report from:
Vicky Hancock, Lead Nurse IPC
Julie Dunn, IPC matron
North Tees IPC Team
Graeme Kelly, Director of Operations, NTH Solutions LLP
Chioma Anyaegbu, Specialist Pharmacist
Louise Samuel, Senior Clinical Professional, Quality, Safety and Innovation

University Hospitals Tees

Annual Infection Prevention and Control Report 2024/25 - STHFT

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 14.4

Report author: *Sharon Lance*

Executive director sponsor: *Emma Nunez, Group Chief Nurse*

Action required:
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Safe

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The NHSE Standard Contract Objectives at South Tees for 2024/2025 were all above trajectory other than Klebsiella and Pseudomonas.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Norovirus has been extremely challenging over this last winter with the Trust seeing an increase in reported outbreaks as we saw 21 clusters which met our definition of an outbreak, and they affected a total of 256 patients and 180 staff members. In comparison, during 2023/24 there were 14 clusters which met our definition of an outbreak, and they affected a total of 164 patients and 98 staff members.

During the winter months of 2024/25 we have had 5 outbreaks of influenza affecting 38 patients and 0 staff. This compares to 2 outbreaks in 2023/2024 affecting 14 patients and 0 staff.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

The IPC Team cover across all areas 7 days per week ensuring continuity of specialist advice and support is maintained. Out with of their regular working hours, the clinical areas have access to a Microbiologist on-call.

The IPC Team has a programme of audits in place undertaken on all clinical areas and outpatients' departments. The IPC Team provide assurance against consistent compliance with evidence-based practice and policies. Each audit completed creates an action plan for review and completion by the ward teams. All Environmental audits are recorded, and an electronic action plan is generated.

Where a period of increased incidence (PII) occurs, risks are identified and the IPC Team undertakes additional audits in accordance with risk requirement, this will be daily initially with an increase to weekly once an improvement and consistency in scores has been

The key aims in 2025/26 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with the Trust services. Patient safety is at the heart of IPC, and to ensure our work is sustainable the Trust promotes that every member of staff takes responsibility for IPC in order that that no person is harmed by a preventable infection.

Recommendations:

It is requested that the Group Board note the content of the South Tees Annual Report for 2024/2025 in respect of the year end HCAI position and acknowledge the actions that are being taken to address this.

The recommendation from the report is to continue with the ongoing actions, recognising that reducing the rates of infections is multi-factorial and improvements need to be sustained over a period of time to impact the data.

South Tees Hospitals
NHS Foundation Trust

2024 – 2025
Infection Prevention and Control Annual Report

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EXECUTIVE INTRODUCTION AMD SUMMARY FROM THE CHIEF NURSE AND DIRECTOR OF INFECTION PREVENTION AND CONTROL

"Dear Staff, Patients, Carers, Service Users and Partners,

Welcome to The South Tees Hospitals NHS Foundation Trust (STHFT) Infection Prevention and Control Annual Report which has been developed in collaboration with the Deputy Director for Infection Prevention and Control, the Infection Control Doctor and the Infection Prevention and Control Team.

This report summarises surveillance information on *Clostridioides difficile*-associated diarrhoea, Methicillin-resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to Glycopeptide-Resistant Enterococci (GRE), Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections for 1st April 2024 to 31st March 2025.

1. All infection prevention and control activities are monitored by The Infection Prevention Strategy Group (IPSG) which reports to the Quality Oversight Group (QOG) and the Quality Assurance Committee (QAC). This report is presented to IPSG, QOG and QAC prior to the Board of Directors.

2. The *Clostridioides difficile*-associated diarrhoea objective for 2024/2025 was to have no more than a combined total of 125 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. In 2024/2025 there have been 146 trust-apportioned cases. We have greatly exceeded the annual target. This is a 14% increase compared to 2023/24.

3. MRSA bacteraemia target is that of zero tolerance. There have been 5 Trust-assigned cases for the 2024/25 financial year, compared to 0 cases in 2023/24.

4. There was no official MSSA bacteraemia target for 2024/25. There were 80 COHA + HOHA Trust-apportioned MSSA bacteraemia cases in the current financial year. There were 49 HOHA cases in 2023/2024. Although not directly comparable numbers appear to have increased.

5. There were 619 cases of the three GNBSI organisms which are part of national surveillance, 159 of which were classed as HOHA and 87 of which were classed as COHA making a total of 246 trust-apportioned cases (172 *E. coli*, 54 *Klebsiella* species and 20 *Pseudomonas aeruginosa)*. For trust-apportioned cases this is an 11% increase compared to 2023/24. As the trust was set a target for 2024/25 of no more than 138 trust-apportioned *E. coli*, 60 *Klebsiella* species and 19 *Pseudomonas aeruginosa* we are above the combined target for the three organisms.

6. Over the last 6-7 years several patients across Teesside have been found to carry the same strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae*. In 2021/22 we had an outbreak of this infection affecting wards 31, 10, 12 and possibly GHDU affecting a total of 10 patients. We had 2 further outbreaks in 2023/24: one infant infected two others on the neonatal unit and one patient infected one other on ward

29. We have had no further linked cases since. We have introduced a widespread screening programme.

7. During the winter months, outbreaks of Norovirus infection have previously caused severe disruption both nationally and to our Trust. During 2024/25 there were 21 clusters which met the definition of an outbreak (2 or more cases with a specific infection linked in time and place) and they affected a total of 256 patients and 180 staff members. In comparison, during 2023/24 there were 14 clusters which met our definition of an outbreak, and they affected a total of 164 patients and 98 staff members.

8. During the winter months of 2024/25 we have had 5 outbreaks of influenza affecting 38 patients and 0 staff. This compares to 2 outbreaks in 2023/2024 affecting 14 patients and 0 staff.

9. An international pandemic of a novel coronavirus began in December 2019. There were 50 outbreaks in our trust during the second and third waves, which met the national/ regional definition. 464 staff members and 225 patients were infected during these outbreaks. After the third COVID-19 wave, we have had 109 outbreaks affecting 114 staff and 729 patients. All 109 of these outbreaks are now closed. Only 9 of these outbreaks occurred during 2024/2025.

10. A number of antimicrobial stewardship initiatives are in place in the trust. Due to changes in our antibiotic guidelines and patient population we have seen a sustained increase in total antibiotic use and carbapenem use in recent years.

11. There have been significant improvements in endoscope decontamination practices and traceability, over the last 8-9 years.

12. An international issue was identified in 2016 with regard to patients who have had cardiac surgery who have subsequently developed endocarditis due to *Mycobacterium chimerae*. To date no patients who have had cardiac surgery in our Trust have been found to be affected. However, we have had *Mycobacterium chimaera* isolated from several of our heater-cooler units between 2021 and 2025. We believe that the precautions we have in place should prevent any patient infections. We have had an outbreak of Serratia marcescens which began in 2019 and was closed in 2021. This re-opened in August 2023 and was closed again in December 2024.

13. The overall average of compliance with the 5 moments of hand hygiene is reported through the Trust IPC governance routes and the IPC team complete peer review audits to map against these. The average audit results across the year are as follows,
    - Self assessment = 90%
    - Peer assessment = 80%
    - Global statistics show that the average is 60%

14. Cleaning standards have been maintained on all of the trust hospital sites over 2024/25 with the majority of cleaning scores above the required threshold. Joint monitoring with the trust's Environmental Monitoring Team continues and cleaning scores are monitored through IPSG. The detail of the scores are in the report, however the average scores for the Hospitals over the year are as follows,
    - JCUH = 99%
    - Friarage – 98%
    - PCH's = 96%

15. The IPC team have continued to develop and use 'tool-box teaching' packages. This approach has enabled a more flexible approach to training and education.

16. The IPC team have a robust action plan to support the current performance and infection figures encompassing the wider collaborative teams across the Trust. The actions are multi-faceted and include various actions such as,

- Education and training – IPC Champions in clinical areas – 3 day course focussed on IPC Practices
- Thematic reviews for HCAI in line with PSIRF and shared learning
- Robust and in-depth audit and surveillance programme covering areas such as environment, equipment, practice etc.
- Intensive support programme implemented when there are areas of increased prevalence of infection to include additional support, education and learning
- Development of an ANTT working group, education package and audits to support with invasive device infections such as catheter and line care infections
- IPC and site team collaboration developed, and isolation priority supported
- Collaboration with the AMS Pharmacy team in respect of prescribing and risks of infection including training and audits
- Detailed decontamination plan to encompass areas such as cleaning, water safety, estates and ventilation
- Recruitment and retention focus to ensure a resilient and robust IPC team

Looking forward to 2025/26, the IPC team and all STHFT staff will continue to work towards the prevention of all healthcare acquired infections with a view to the Annual Report for 2025/26 to be a joint group report FOR University Hospital Tees"

Emma Nunez
Chief Nurse and Director of Infection Prevention and Control (DIPC)

Sharon Lance
Deputy Director of Infection Prevention and Control (DDIPC)

Richard Bellamy
Infection Control Doctor

IST OF ABBREVIATIONS

AER	Automated Endoscope Reprocessor
AHP	Allied Health Professional
CDI	Clostridioides difficile
CEO	Chief Executive Officer
COHA	Community Onset Healthcare Acquired
CPE	Carbapenemase Producing Enterobacteriaceae
CQC	Care Quality Commission
CSSD	Central Sterile Services Department
DIPC	Director of Infection Prevention and Control
DDIPC	Deputy Director of Infection Prevention and Control
GNBSI	Gram Negative Blood Stream Infections
HCAI	Healthcare Associated Infections
HII	High Impact Interventions
HOHA	Hospital Onset Healthcare Associated
ICB	Integrated Care Board
ICD	Infection Control Doctor
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
IPSG	Infection Prevention Strategic Group
KPI	Key Performance Indicators
LHE	Local Health Economy
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-susceptible Staphylococcus aureus
NED	Non-Executive Director
NHSE	NHS England
NICE	National Institute for Excellence
PII	Period of Increased Incidence
QAC	Quality Assurance Committee
SECSG	Safe Effective Care Strategic Group
STHFT	South Tees Hospitals NHS Foundations Trust
UKHSA	UK Health Security Agency (Previously Public Health England)
VRE / GRE	Vancomycin-resistant Enterococcus / Glycopeptide-resistant Enterococcus
WHO	World Health Organisation

SECTION 1: INTRODUCTION

The purpose of this report is to provide assurance to The South Tees Hospitals NHS Foundation Trust (STHFT) Board of Directors and the public for the reporting period 1 April 2024 - 31 March 2025 regarding the Infection Prevention and Control (IPC) activity. This includes compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (updated December 2022) (commonly known as The Hygiene Code) and regarding appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the hygiene code which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual plan which is monitored at the Trust's bimonthly Infection Prevention Strategic Group (IPSG) meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working to ensure continued compliance and continuous improvement. The Trust's is registered with the Care Quality Commission (CQC) and has declared full compliance with the ten compliance criteria as detailed in Table 1. The Deputy Director of IPC performs a regular gap analysis on this and is included within the quarterly IPC report.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

TABLE 1: The requirements of the Health and Social Care Act (2008: updated 2022)

Infection Prevention and Control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers it is essential to ensure that the safety and quality of care for our patients can be provided. At STHFT, IPC is a key priority. Our Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention

and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times. The infection prevention and control agenda faces many challenges, particularly over the last few years, including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national targets and outcomes. The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC) and her deputy, the Deputy Director of Infection Prevention and Control (DDIPC).

All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2024/25 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular, Gram-negative bloodstream infection (GNBSI), Methicillin Resistant Staphylococcus aureus (MRSA) Bacteraemia and Clostridioides difficile infection (CDI) as areas for improvement. This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2024 - 31 March 2025 by STHFT. In addition, the report aims to reassure that reducing the risk of infection through robust infection prevention and control practice is a key priority for STHFT and supports the provision of high-quality services for patients and a safe working environment for staff.

SECTION 2: WHO WE ARE, OUR DUTIES, ARRANGEMENTS AND ASSURANCE

2.1: Who are we?

As a Trust, STHFT provides health services to more than 1.5 million patients, carers and their families across the Tees Valley, North Yorkshire and beyond. These include for example five hospital sites, the James Cook University Hospital, the Friarage Hospital, East Cleveland Primary Care Hospital, Redcar Primary Care Hospital, the Friary Primary Care Hospital and community nursing services.

STHFT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

The IPC team utilises both a reactive and proactive approach with the emphasis on being visible, so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e. being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems. This also includes when answering telephone calls or visitors with queries into the office.

Looking forward, it is critical that STHFT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

Our Duties and Arrangements

Infection Prevention and Control Service:

- Director for Infection Prevention and Control (Chief Nurse)
- Deputy Director for Infection Prevention and Control
- Infection Control Doctor(s)
- Infection Prevention and Control Lead Nurse
- Decontamination Lead
- Infection Prevention and Control Lead Nurse Assistants
- Infection Prevention and Control Nurses
- Quality and Governance Facilitator
- Audit and Surveillance Support
- Infection Prevention and Control Team administration Team

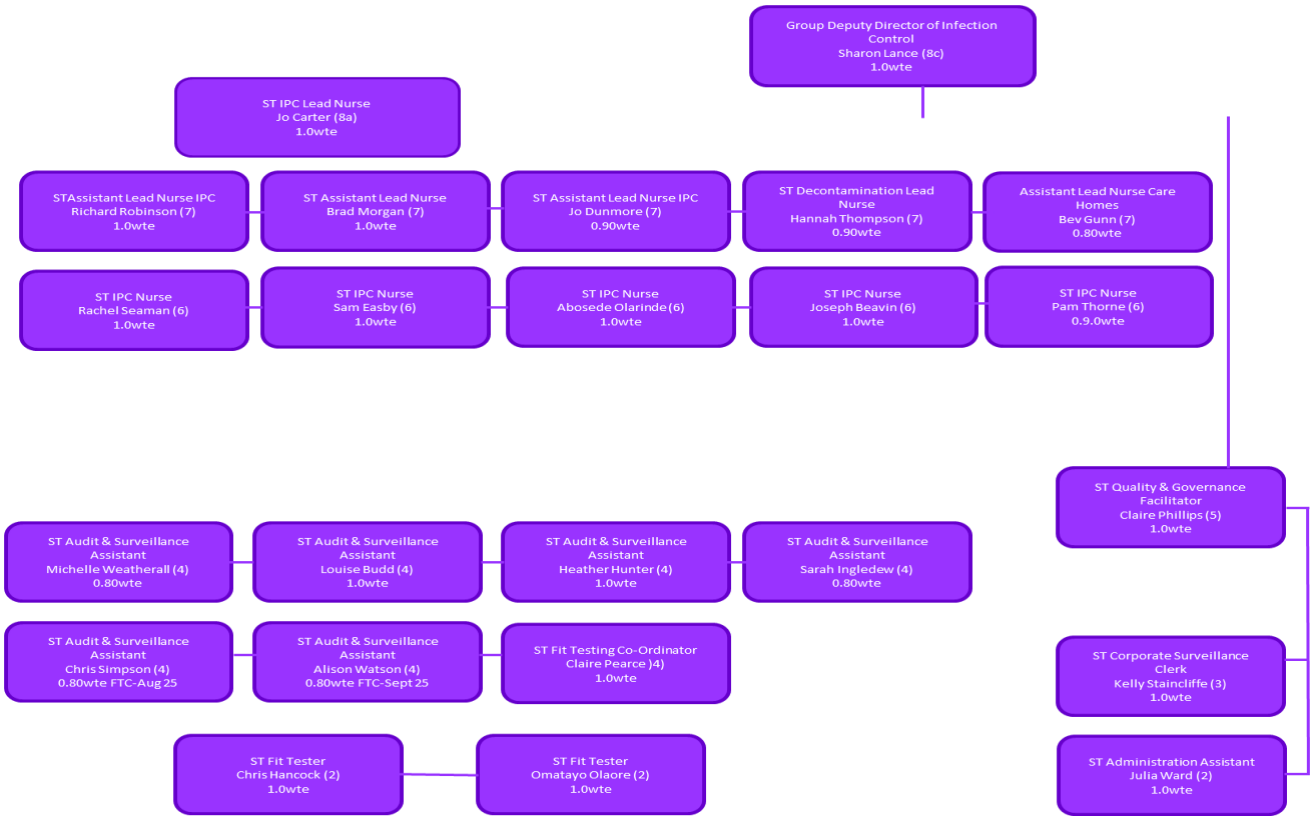


Table 2: The Infection Prevention Control Team

2.2 Director of Infection Prevention and Control – Emma Nunez (also Chief Nurse)

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008, updated 2022), otherwise known as the Hygiene Code. The DIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable Healthcare Associated Infections (HCAIs) at all levels within the organisation.

The DIPC will be the public face of IPC and will be responsible along with others for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will lead the commitment to quality and patient safety, good communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At South Tees NHS Hospitals Foundations Trust, the Chief Nurse holds the role of DIPC.

2.3 The Infection Prevention and Control Team

The IPC Team is led day to day by the DDIPC for IPC and is supported by the Infection Prevention and Control Lead Nurse alongside the Infection Prevention Nurses, Surveillance Assistants, Quality and Governance Facilitator and Team Administrators.

The IPC service is provided through a structured annual plan of work which includes expert advice, education, audit, policy development and review and service development.

The IPC Team cover across all areas of STHFT 7 days per week ensuring continuity of specialist advice and support is maintained. Out with of their regular working hours, the clinical areas have access to a Microbiologist on-call.

The IPC team develops and implements a robust annual plan of work to support in the reduction of HCAIs. This is achieved by working in collaboration with all STHFT services and staff. The IPC team perform several activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

The IPC Team host an IPC Link Practitioner Programme, with sessions arranged on a monthly basis across sites on a variety of topics related to IPC and HCAI's.

2.4 Committee Structures and Reporting Processes

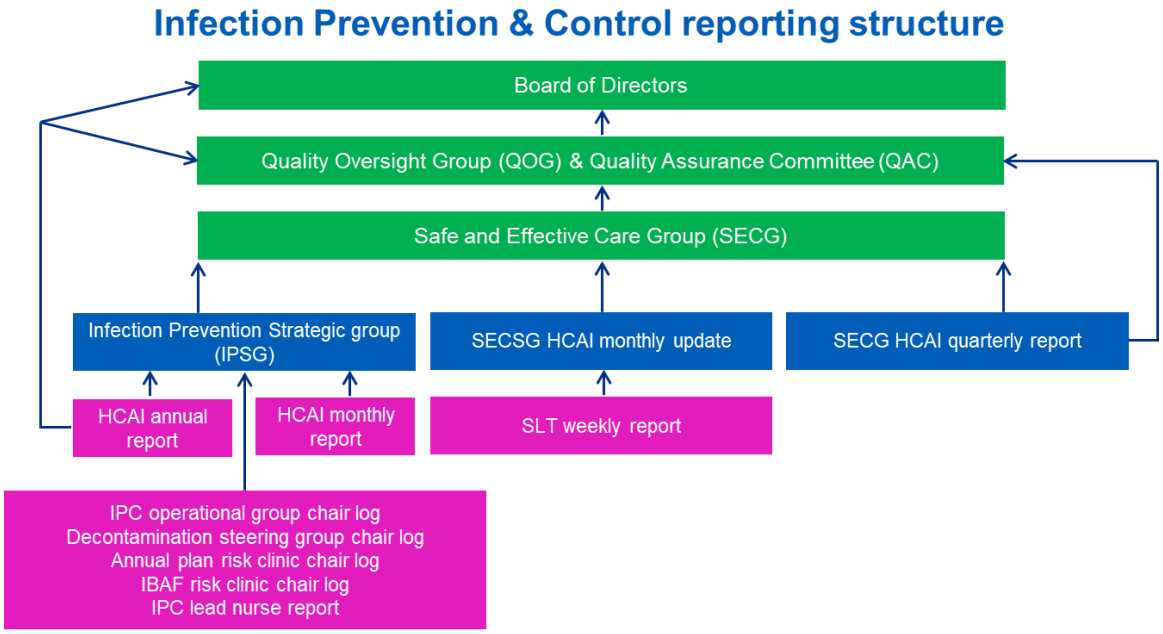


Table 3: The IPC reporting Governance Structure

2.5 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive Officer (CEO) alongside the DIPC has overall accountability for the control of infection at STHFT and any IPC matters across the trust.

STHFT's performance against National and local thresholds are included in the IPC reports that are presented through the appropriate governance systems and in the Integrated Performance Report (IPR) presented to the Trust Board.

2.6 Quality Assurance Committee (QAC)

Quarterly IPC reports including the IPC Board Assurance Frameworks and the IPC Annual plan are presented to the Quality Oversight Group (QOG) and the Quality Assurance Committee (QAC) meetings. The QAC is chaired by a Non - Executive Director (NED), it is a delegated committee of the Trust Board which meets monthly. The purpose of the QOG and QAC is to provide oversight and scrutiny of infection control standards and practices and seeking assurance that IPC Standards are being met. Due to the increasing cases of HCAI's in the Trust there has been a requirement for reporting to increase to monthly during the last 5 months of the year.

The QAC will provide assurance to the Trust Board around STHFT's arrangements for protecting and improving the quality and safety of patient-centred healthcare, thus improving the experience for all people that come into contact with the services at STHFT.

2.7 The Safe and Effective Care Strategic Group (SECSG)

Monthly / Quarterly IPC reports are presented to the Safe and Effective Care Strategic Group (SECSG) meetings. The SECSG, chaired by the Medical Director / Director of Nursing, meets monthly and is responsible for ensuring that there are processes in place for ensuring patient safety and continuous monitoring and improvement in relation to key areas including IPC, but also covers collaboratives of the trust as well as other specialties. The SECSG receives assurance from IPC that adequate and effective policies, processes and systems are in place.

This assurance is provided through a regular process of reporting and attendance at the meetings.

2.8 Infection Prevention Strategic Group (IPSG)

The membership is multi-disciplinary and includes representation from the collaboratives, estates department, antimicrobial pharmacists, and Infection Control Doctor(s) (ICD). Additional members are representatives from the ICB and Private Finance Initiative (PFI) partners. The meeting is chaired by the DIPC/DDIPC and meets bimonthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2022) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPSG Meeting is responsible for:

• Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.

• Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.

• Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.

• Ensuring, through the DIPC/DDIPC, the Chief Executive, associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.

• To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.

• To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include Health and Safety, Estates, Water Safety, Antimicrobial stewardship and Staff Health and Wellbeing via the Occupational Health (OH) department.

• Effective management of IPC related outbreaks and concerns

2.8.1 Water Safety Group

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

2.8.2 Decontamination Group

This is chaired by the Deputy Director of Estates and the group monitors, challenges, reviews, and where appropriate takes action in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, MHRA guidelines, NICE Guidance and Care quality commission. The group receives reports from Endoscopy

services, Outpatients and Specialist Surgery, Sterile Services (CSSD) and theatres with the group meeting bimonthly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Group annually. The Group reports to the IPSG Meeting.

2.8.3 Ventilation Group Meeting
The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments especially around air handling units, air extraction and capital developments.

2.8.4 DIPC, DDIPC, Consultant Microbiologist and Deputy Chief Nurse
The DDIPC and ICD meet regularly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

2.8.5 Infection Prevention and Control Link Practitioners
The aim of our IPC link practitioners is to enhance the IPC knowledge of healthcare professionals working within STHFT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link practitioners are responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues. There is also an expectation that all IPC link Practitioners attend the IPC delivered course as mentioned further in this report.

2.8.6 Associate Director Nurses, Heads of Nursing, Matrons and Ward Managers, Sisters, Charge Nurses, and Team Leaders
Associate Director Nurses, Heads of Nursing, Ward Managers, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. The Sisters, Charge Nurses, Ward Managers and Team Leaders are responsible for ensuring the link staff are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going work undertaken by the link staff is also included in reports submitted to the IPC Operational Group meeting.

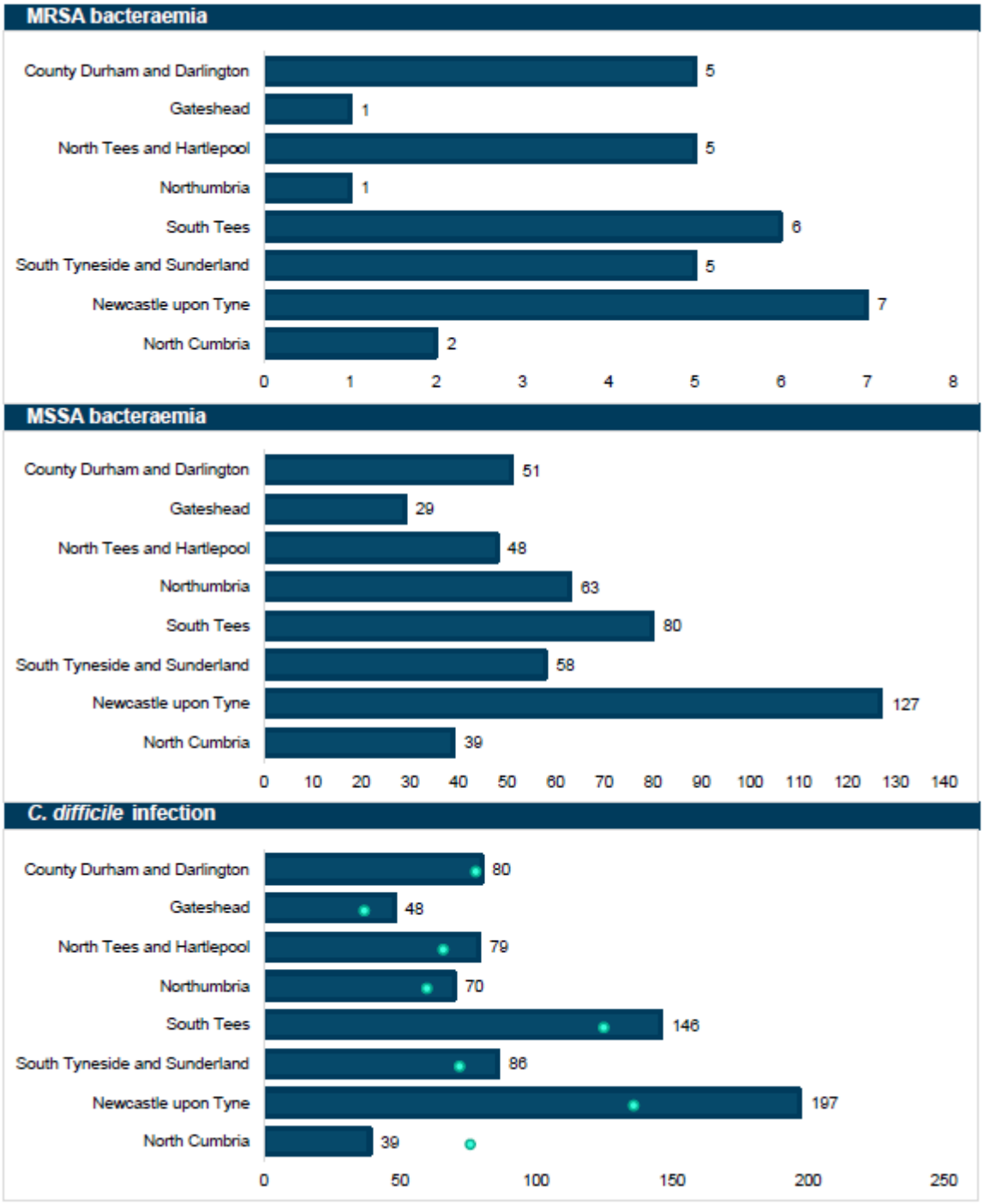
2.8.7 Learning and Development Team
Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training. The IPC Team also schedule a 3 day Advancing IPC in Clinical Practice Course several times per year. There is an expectation that all Matrons, Ward Managers, Sisters, Charge Nurses, Team Leaders and Link Practioners have attended.

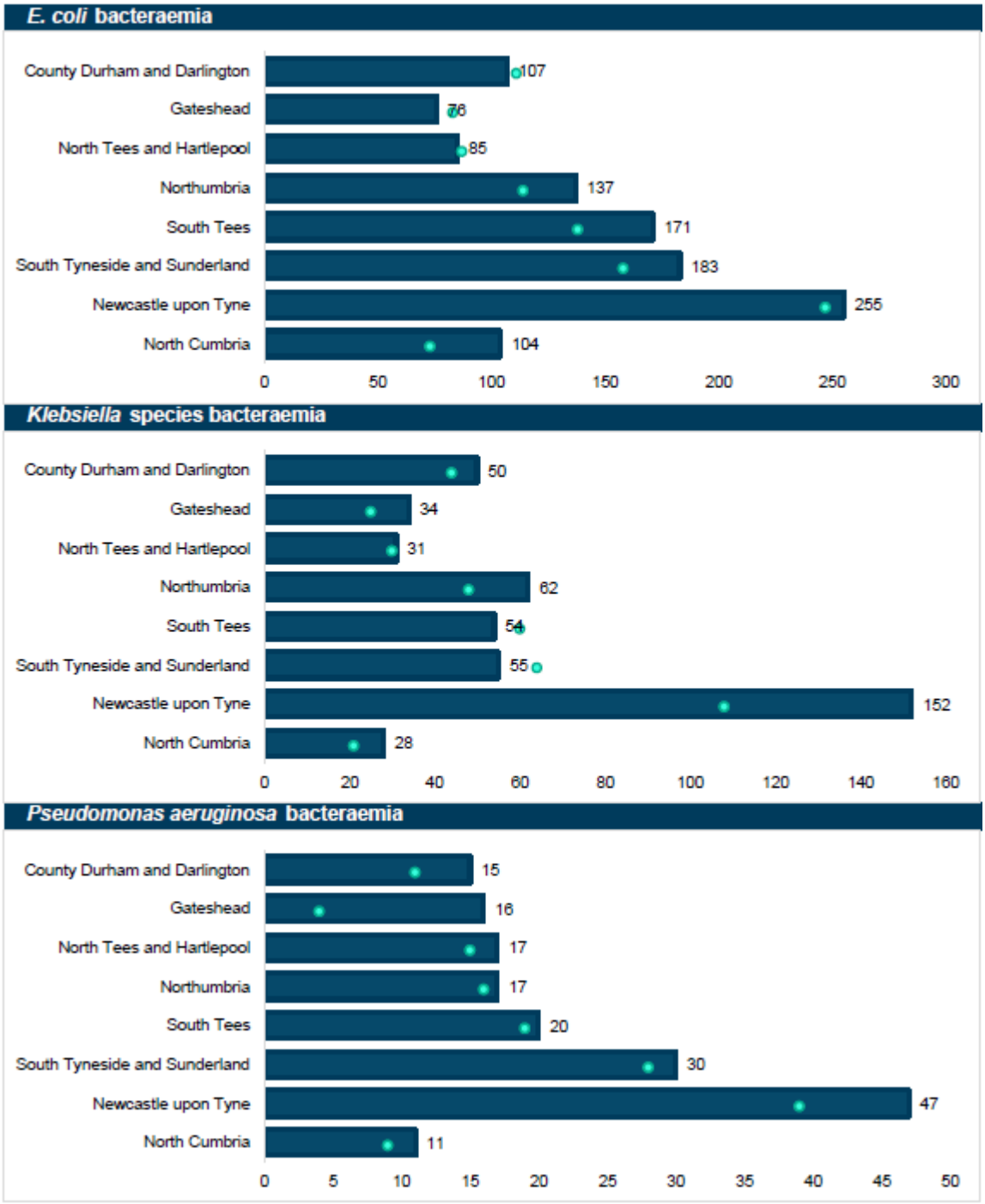
2.8.8 Roles and Responsibilities of all Staff
All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they always follow the standard IPC precautions and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and act as appropriate. All IPC policies and procedures are available on the staff intranet site.

SECTION 3: POSITION IN RELATION TO HEALTH CARE ASSOCIATE INFECTIONS

3.1 Surveillance of Healthcare Associated Infection

Surveillance is undertaken within STHFT on several alert organisms and mandatory reporting to UKHSA is undertaken via the HealthCare Associated Infection Data Capture System. Performance is monitored both internally and externally via reporting and meetings. The graphs below display the regional position to highlight South Tees from a performance perspective indicating the trajectories set against the actual number of infections reported.





3.2 Methicillin Resistant Staphylococcus aureus Blood Stream Infections (MRSA)

Staphylococcus aureus is an organism harmlessly carried on the skin by around 1 in 30 of the healthy population and remains endemic in many UK hospitals. The transmission of MRSA and the risk of MRSA infection (including MRSA Bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources of infection and treating them to reduce the risk of transmission. Guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at STHFT. In addition, STHFT have policies and processes in place to ensure isolation of patients colonised with MRSA, following the national guidance.

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality.

The Trust comply with national guidance to reduce the risk of blood stream infection and have systems in place for:

• The management and care of devices

• Antimicrobial prophylaxis

• Compliance with national guidance

Saving lives scores are undertaken by link workers on the ward areas with these refreshed in 2023/24 and a further drive completed in 2024/25 in order to cross reference locally reported scores to ensure assurance.

MRSA	Total 2023/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total 2024/25 to date	Target for 2024/25
Total cases	4	2	0	0	0	1	1	1	1	2	2	0	4	14	NA
Not trust assigned	4	2	0	0	0	0	1	1	0	2	2	0	1	9	NA
Trust assigned	0	0	0	0	0	1	0	0	1	0	0	0	3	5	**NA**

Table 4. MRSA bacteraemia cumulative totals for 2024/25

The approach to MRSA bacteraemia is that of zero tolerance. There were 14 cases of MRSA bacteraemia in 2024/25, 5 of which were classed as trust-assigned. The second case in April 2024 had a recent hospital admission so from a timing perspective, it was a COHA case. However this should not be assigned as healthcare-associated as it was due to a psoas abscess and was unrelated to healthcare. In comparison, there were 4 cases in 2023/2024, none of which were classed as Trust-assigned.

Since June 2006 every episode of MRSA bacteraemia has been investigated as a clinical incident to help identify lessons to be learnt and to guide improvements in practice. Since February 2008 the Director of Nursing/DIPC or deputy DIPC has chaired a case review panel with the appropriate clinical staff. This has enabled a number of lessons to be learnt and has helped the Trust to focus attention on avoidable causes of MRSA bacteraemia.

Following the Patient Safety Incident Response Framework (PSIRF) guidelines these have now changed to rapid learning reviews and actions from these are completed and monitored through the Collaborative forums.

In 2024/25, 14 episodes of bacteraemia were investigated. None of these patients died during the current admission. An avoidable causal factor, related to our trust, was identified for 3 patients. The causes of MRSA bacteraemia are summarised in table 5 below.

Cause	*Number of episodes (Trust-assigned cases)*	*Number where an avoidable factor was identified in our Trust*	*Number of patients who died due to MRSA or who died during the current episode of illness*
Infections in persons who inject drugs	*4(0)*	*0*	*0*
Community-acquired pneumonia	*2(0)*	*0*	*0*
Tunnelled line (Hickman) infection	*1(1)*	*1*	*0*
Infected discitis in patient receiving infliximab	*1(0)*	*0*	*0*
Infected skin pin sites for patient with Ilizarov Frame	*1(0)*	*0*	*0*
Surgical site infection	*1(1)*	*1*	*0*
Cellulitis	*1(1)*	*0*	*0*
Psoas abscess*	*1(0)*	*0*	*0*
Wound infection (chronic)	*1(1)*	*0*	*0*
Contaminant	*1(1)*	*1*	*0*
Total	*14(5)*	*3*	*0*

Table 5. Summary of causes of MRSA bacteraemia for 2024/2025.

3.3 Methicillin Sensitive Staphylococcus aureus Blood Stream Infections (MSSA)

Methicillin-sensitive Staphylococcus aureus (MSSA) is a type of bacterium which lives harmlessly on the skin and in the noses, in one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes no problems but can cause an infection when it enters into the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g., Grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) or a blood stream infection where it gets into the bloodstream.

MSSA	Total 2023/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total 2024/25 to date	Target for 2024/25
Total cases	167	17	9	12	11	15	17	23	13	12	14	16	18	177	NA
Not trust apportioned	118	9	5	8	6	10	9	12	9	6	9	7	7	97	NA
Trust apportioned	64 (49)	8 (4)	4 (3)	4 (3)	5 (3)	5 (5)	8 (6)	11 (8)	4 (2)	6 (6)	5 (5)	9 (9)	11 (7)	80 (61)	NA

Table 6. MSSA bacteraemia cumulative totals for 2024/25

Between April 2024 and March 2025 there were 177 episodes of MSSA bacteraemia, 80 of which were trust-apportioned. 61 of these cases were classified as HOHA. This compares to 49 HOHA cases in 2023/24.

There is no external target for MSSA bacteraemia. However, the trust set an internal target for a 15% reduction from the 2016/17 baseline of 41 trust-assigned MRSA and HOHA MSSA cases combined. This gives an upper threshold of 35. This has been adjusted to include COHA cases and was agreed at IPSG as 50 HOHA + COHA MSSA plus trust-assigned MRSA bacteraemia cases for 2024/2025.We have exceeded this target as we had a combined total of 85 HOHA + COHA MSSA and trust-assigned MRSA cases during 2024/25.

Since February 2008 a case review meeting should be held within the relevant clinical centre/ directorate for every Trust-apportioned MSSA bacteraemia, in line with PSIRF this has moved to a rapid learning review.

The cause of each MSSA bacteraemia is assessed by the infection control doctor and in 2024/25 the causes assigned were:

- Pneumonia: 54 cases.
- Tunnelled central venous lines including haemodialysis: 23 cases.
- Skin and soft tissue infection (including leg ulcers): 26 cases.
- Peripheral venous cannulae: 26 cases.
- Septic arthritis: 14 cases.
- Endocarditis: 6 cases.
- Infected discitis/ spinal abscess: 7 cases.
- Surgical site infection: 5 cases.
- Catheter-associated urinary tract infection: 3 cases.
- Ventilator-associated pneumonia: 1 case.
- Prosthetic joint infection: 2 cases.
- Osteomyelitis: 2 cases.
- Biliary tract infection = 1 case.
- Intra-uterine infection: 1 case.
- Epididymo-orchitis: 1 case.
- PEG site infection: 1 case.
- Contaminant = 3 cases.
- Unknown: 1 case.

In total 61 MSSA bacteraemia were related to invasive procedures in 2024/2025. This compares to 54 MSSA bacteraemia related to invasive procedures in 2023/2024. Enhanced training for Aseptic Non-Touch Technique (ANTT) continues to be implemented across the trust for all relevant staff groups to address avoidable causes related to invasive procedures.

3.4 Clostridiodes difficile (Previously referred to as Clostridium difficile) infection (CDI)

The 2021/22 *C. difficile* definitions are as follows:

- Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
- Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.
- Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Table 7. 2021/22 C. difficile definitions

C diff	Total 2023 /24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total 2024/25 to date	Target for 2024/25
Total cases	198	14	21	19	22	19	20	19	24	18	20	21	12	229	NA
Not trust apportioned	70	5	13	6	7	5	11	7	7	7	7	6	2	83	NA
Trust-apportioned	128 (83)	9 (7)	8 (5)	13 (9)	15 (10)	14 (8)	9 (8)	12 (7)	17 (14)	11 (7)	13 (11)	15 (11)	10 (9)	146 (106)	**125**
- JCUH	109	6	5	13	14	13	9	12	15	9	11	14	8	129	
-FHN	10	2	3	0	1	1	0	0	0	2	0	0	0	9	
-Redcar	3	0	0	0	0	0	0	0	1	0	0	1	1	3	
-East Cl	5	1	0	0	0	0	0	0	1	0	1	0	1	4	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	0	0	0	0	0	1	0	0	1	

Table 8. Total number of C. difficile figures for 2024/25 (numbers in brackets are HOHA cases)

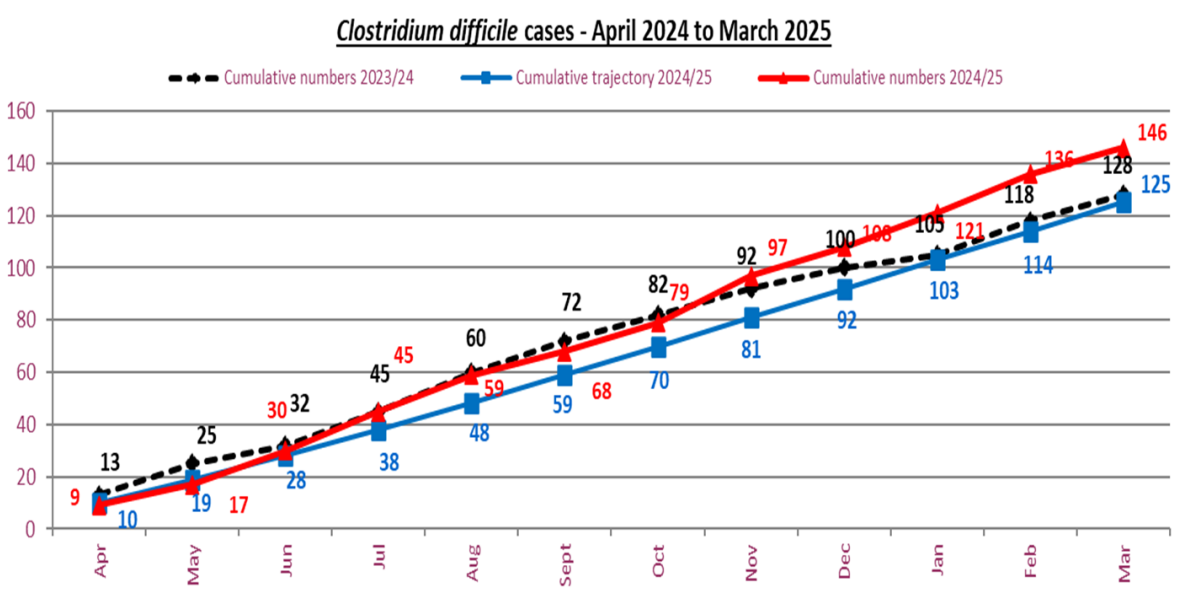
The total figure for *C. difficile* cases from April 2024 to March 2025 was 229 (see table 8). In 2023/2024 there were 198 cases so there has been a 16% increase compared to last year.

The *Clostridioides difficile*-associated diarrhoea objective for 2024/25 was to have no more than a combined total of 125 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. In 2024/25 there have been 146 trust-apportioned cases (COHA = 40; HOHA = 106) so the target has been greatly exceeded. In comparison, between April 2023 and March 2024 the Trust had 128 cases of Trust-apportioned *C. difficile* infection so there has been a 14% increase compared to last year.

As required by national *C. difficile* guidance, the Trust monitors how many of the patients who develop *C. difficile*, subsequently die within the following 30 days, regardless of cause. Since April 2009, 446/2727 patients (16%) have died during the 30-day follow-up period.

We define an outbreak of *C. difficile* as two or more linked cases (based on location, time and ribotyping if available). There were 4 outbreaks during 2024/2025 compared to 5 outbreaks during 2023/24. In April 2024 there was an outbreak affecting 2 patients on ward 11 JCUH. In May 2024 there was an outbreak affecting two patients on Ainderby ward at FHN. In the final week of October 2024 there were 3 cases on ward 7 but ribotyping showed they were not linked (so not classed as an outbreak). In November 2024 there were two cases on ward 36 shown to be linked by ribotyping. In February 2025 there were three cases on ward 34 shown to be linked by ribotyping.

All cases of *C. difficile* were discussed across the health economy using a local rapid learning review tool in line with PSIRF.
Identifying a single root cause in cases of C. difficile is challenging and is often associated with one or more influencing factors; patient factors e.g. existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or process concerns, e.g. delays in isolation.



Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
HOHA - JC11	COHA - JC31	HOHA - JC07	HOHA - JC02	HOHA - JC06	HOHA -JC26	HOHA - RZET	HOHA - JC32HD	HOHA - JC25	HOHA - JC12	HOHA - JCITU3	HOHA - RPZET
HOHA - JC04	HOHA JC34	COHA - JC37	COHA - JC36	HOHA - ITU3	HOHA - JC07	COHA - JC03	HOHA - ITU2	HOHA - JC04	HOHA-JC08	HOHA - JC34	HOHA - JC11
HOHA - ECTO	COHA - JC01	COHA - JC10	COHA-JC37	HOHA - JC09	HOHA - JC11	HOHA - JC26	HOHA - RZET	COHA - JC07	HOHA - JC34	HOHA - RPZET	HOHA - ECTO
HOHA - JC06	HOHA - JC11	HOHA - JC24HD	HOHA - JC33	HOHA - JC11	HOHA - CCT	COHA - JC02	COHA - JC38/JC14	HOHA - JC04	HOHA - JC14	HOHA - JC37	COHA - JC06
COHA - FHAIN	HOHA - FHROM	HOHA - JC37	HOHA - ITU2	COHA - JC12	HOHA - JC25	COHA - JC37	HOHA - JC34	HOHA - FHAIN	HOHA - JC36	COHA - JC07	HOHA - JC12
COHA - FHAIN	COHA - JC10	HOHA - JC07	COHA - JC02	COHA - JC08	HOHA - JIC2	HOHA - JC33	HOHA - Tocketts	HOHA - FHCDU	HOHA - ECTO	COHA - JC08	HOHA - JC33
HOHA -JC06	HOHA - FHCDU	HOHA - JC11	HOHA - JC12	COHA - JC07	HOHA - JC03	HOHA - JC07	COHA - JC01	COHA - JC10	HOHA - JC06	HOHA - JC12	HOHA - JC06
HOHA - JCCU	HOHA - FHAIND	HOHA - JIT2	HOHA - JC02	HOHA - JC31	HOHA - JC24HD	HOHA - JC07	HOHA - JC36	HOHA - JC08	COHA - JC05	HOHA - JC34	HOHA - JC04
HOHA - JC11		HOHA - JGCC	HOHA - JC11	COHA - JC34	COHA - JCVASC	HOHA - JC07	HOHA - JC08	COHA - FHAIN	HOHA - JC35	HOHA - JC09	HOHA - JC02
		HOHA - JC12	COHA - JC11	HOHA - JC08		HOHA - JC31	HOHA -JC02	HOHA - JIC3	HOHA - Victoria	COHA - JC07	HOHA - JC04
		COHA - JC10	COHA - FHAIN	COHA - JC28		COHA - JC14	HOHA - JC08	COHA - JC10	HOHA - JC07	HOHA - JC28	
		COHA - JC06	HOHA - JC02	COHA - JC14			COHA - JC02		HOHA - JC02	HOHA - JC09	
		HOHA - JC27	HOHA - JC34	HOHA - JC07			HOHA - JC31		COHA - JC37	HOHA - JC34	
			HOHA - JC14	HOHA - FHCDU			HOHA - JC36			COHA - JC24	
			HOHA - JC09				HOHA - JC24HD			HOHA - JC03	
							COHA - JC25				
							HOHA - JC12				
							HOHA - JC14				

Graph 1: Cumulative Trust-apportioned C. difficile cases 2024/25 compared to trajectory

There have been several initiatives implemented throughout the year in response to our concerns over *C. difficile* and some of these include the following,

- Use of chlorine wipes for effective cleaning of commodes in all areas including isolation rooms with no en-suite facility
- Introduction of commode tagging when unable to isolate with an en-suite room
- Implementation of a follow up phone call to patients on treatment at home or care home
- Development of 'The line of doody' and *C. difficile* awareness week
- Implementation of a sampling flow chart

- Addition of flow chart onto patient track
- Additional *C. difficile* toxin positive ward round on a Friday in addition to a Tuesday

C. difficile death certificate audit

During 2007 the Healthcare Commission published a report on an investigation into deaths which had occurred at Maidstone and Tunbridge Wells NHS Trust caused by C. difficile. In response to this, in 2007/8 we audited all deaths, from April 2005 to March 2008, at South Tees Hospitals where C. difficile was recorded on the death certificate. This was a similar method to that used by the Healthcare Commission. This audit has been repeated annually. Separate audits are now produced for JCUH and FHN.

In 2024/25, there were 2 cases included in the audit of JCUH cases and 0 cases at FHN. The death certificates recorded that for both of these patients C. *difficile* or toxic megacolon was recorded as the primary cause of death (under Ia). For 0 patients, C. difficile was recorded as a contributing/ predisposing factor in the patient's death (see table 3 below). In the infection control doctor's assessment, C. difficile was the main cause of death for 1 patient and was a contributing/ predisposing factor for 0 patients and in 1 case he would not have been able to complete the death certificate.

Section of death certificate	Number of death certificates	How this audit would have classified the death certificate
Ia (ie main cause)	2	1
Ib (predisposing factor)	0	0
Ic (predisposing factor)	0	0
II (contributory cause)	0	0
Was not or would not have been included on death certificate	0	0
Unable to complete death certificate (ie post-mortem was needed but not performed)	NA	1

Table 9. Classification of cases where C. difficile was entered on the death certificate, 2024/25

3.5 CDI investigation and rapid learning review

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (GDH positive / toxin negative).

In all cases control measures are instigated immediately. Each HOHA and COHA CDI's have a rapid learning review completed.

Lessons Learnt

Following review of all of the rapid learning reviews completed some common themes have been identified. These include; antimicrobial stewardship and appropriateness of antimicrobial

prescribing in line with Trust guidelines, Environmental Cleaning scores below an overall compliance of 95% and IPC Mandatory training compliance falling below the Trust objective of 90% compliance. All learning reviews have an action plan completed with objectives to achieve and a timeframe for completion. Many of the actions are addressed through collaborative governance meetings and through collaborative CDI action plans. Action plans and compliance are then monitored through the collaboratives.

STHFT closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridioides difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridioides difficile within a period of 28 days and associated with stay in the same ward or area, each case is reviewed to establish if they can be linked by time and place and identify any common themes. Should this occur samples are obtained and submitted to UK HSA for ribotyping. This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures and increased cleaning of the patient areas if necessary.

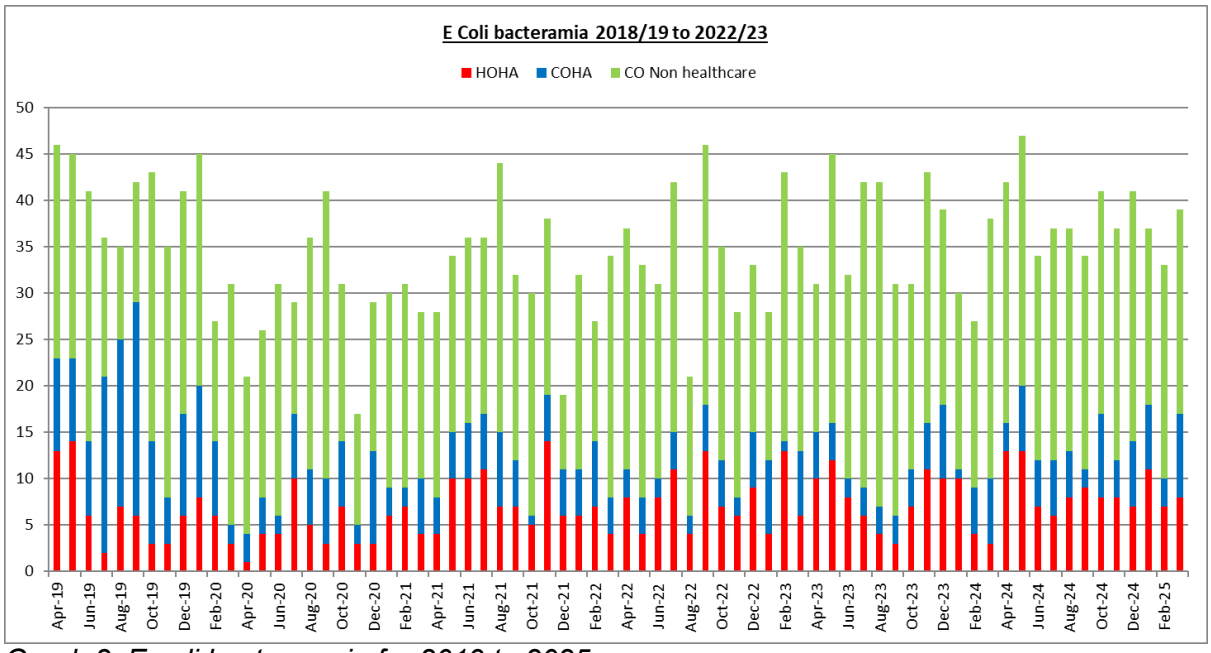
During 2024/25 the overview of the internal Deep dive continued which allows oversight and actions as a Trust but also ownership within collaboratives with their own individual action plans. The Trust has also been involved with a regional approach to CDI with the local Integrated Care Board (ICB) and also nationally with NHS England via the DDIPC.

3.6 Surveillance for other alert organisms

	Total for 23/24	Total for 24/25
Bacteraemia due to glycopeptide-resistant enterococci	6	12
Bacteraemia due to E. coli	427	459
• HOHA	87	105
• COHA	50	67
• COCA/COIA	290	287
ESBL producing coliforms	858	913
• sample taken in community	527	568
• sample taken in our trust	331	345
• bacteraemias	25	35
Bacteraemia due to Klebsiella species	143	122
• HOHA	41	38
• COHA	23	16
• COCA/COIA	79	68
Bacteraemia due to Pseudomonas aeruginosa	35	38
• HOHA	13	16
• COHA	7	4
• COCA/COIA	15	18
Other alert organisms	4	0
• Healthcare-associated invasive group A streptococcus		

Table 10. Surveillance of GNBSI and other alert organisms

Reducing gram negative blood stream infections (GNBSI) is a national priority. The trust has provisionally been set a target for 2024/25 of no more than 138 cases of HOHA + COHA *E. coli*, 60 *Klebsiella* species and 19 *Pseudomonas aeruginosa* bacteraemia cases. During 2024/25 we have had 246 healthcare-associated cases (*E. coli, 172; Klebsiella sp. 54, Pseudomonas aeruginosa 20*). This is above the target for *E. coli* and *Pseudomonas aeruginosa*. For trust-apportioned cases this is an 11% increase in the three GNBSI organisms compared to 2023/24. We are working with the Tees-wide collaborative which supports a number of initiatives within the community setting.



Graph 2. E.coli bacteraemia for 2019 to 2025

ESBL-producing coliforms are highly antibiotic-resistant Gram-negative bacteria. The majority of isolates of these organisms are from the urinary tract, but they also cause wound infections, biliary and gastrointestinal tract infections, pneumonia and bacteraemia. The majority of infections are community-acquired. ESBL producing coliforms are not included in mandatory national surveillance, however, prevalence data regarding bacteraemias enables the most effective comparison year on year. In 2024/25 there were 35 bacteraemias due to ESBL-producing coliforms compared to 25 cases in 2023/24.

Glycopeptide-resistant Enterococci are highly antibiotic-resistant Gram-positive bacteria. The majority of infections are healthcare-associated. They are included in mandatory national surveillance. In 2024/25 there were 12 bacteraemias caused by glycopeptide-resistant Enterococci, compared to 6 cases in 2023/24.

In 2012/13 we introduced monitoring for Pseudomonas aeruginosa in the water supply in critical care areas supported by active monthly surveillance. Pseudomonas aeruginosa has been detected periodically in several areas and action plans developed.

3.7 Carbapenemase Producing Enterobacteriaceae (CPE)

The Enterobacteriaceae are a large family of Gram-negative bacteria including species such as E. coli, Klebsiella species, Proteus species, and Enterobacter species. They live usually harmlessly in the guts of both humans and animals. They are opportunistic pathogens, capable of causing urinary tract infections, abdominal infections, and bloodstream infections (UK HSA 2013).

Some of these bacteria develop resistance to antibiotics through various mechanisms, one of them being the ability to produce an enzyme called Carbapenemase. The Carbapenemase enzyme makes these organisms resistant to multiple antibiotics and there are extremely limited treatment options. Antibiotic resistance is a major Public Health concern and stringent Infection Prevention and Control precautions need to be maintained to reduce the spread of these organisms. UKHSA published a toolkit in 2013 (updated 2022) to control the spread of CPE in healthcare and onwards in the community.

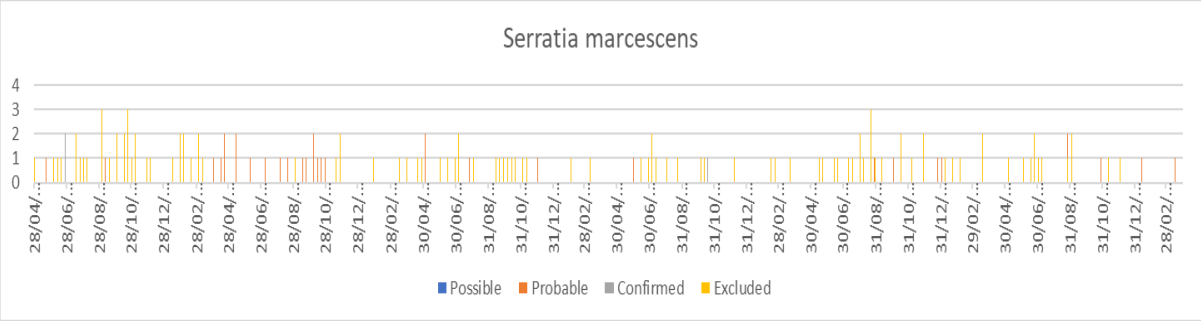
We have had an outbreak of GES-Carbapenemase-producing, multi-drug-resistant *Pseudomonas aeruginosa* over the last 11 years, originally linked to critical care and the renal dialysis unit and urology ward. In January 2025, we had one further patient who was found to be carrying a GES-Carbapenemase-producing *Pseudomonas aeruginosa* infection. This patient was in critical care in 2015 at the time of the original outbreak and likely acquired colonisation with this organism at that time. In total there have been 28 confirmed patients identified who are colonised or infected with a GES-Carbapenemase-producing strain of *Pseudomonas aeruginosa* in our trust since November 2014. We believe that cases have occurred due to patient-to-patient transmission rather than due to water-borne infection or another environmental source. We do not believe there is ongoing transmission.

A single strain of oxa-48 Carbapenemase-producing *Klebsiella pneumoniae* was first seen in acute trusts on Teesside in 2018. We continue to see cases which usually have no clear link to each other. We do not believe widespread transmission has occurred previously in our trust and we had only identified one case of transmission prior to 2021 despite extensive screening of contacts. However in October 2021 we did identify transmission of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* from one patient to 4 contacts who had been in the same bay on ward 31. Transfer of patients to other wards led to further oxa-48 carbapenemase-producing *Klebsiella pneumoniae* transmission on wards 12, 10 and possibly GHDU. In total 10 patients have acquired this organism as part of the outbreak.

Carbapenemase-producing enterobacteria screening has been reviewed in the trust and changes have been incorporated into the revised policies which were approved at IPSG on November 3rd 2021. From July 1st 2024 we extended CPE screening to all patients who have been previous inpatients at any hospital in the last 12 months. We are monitoring numbers of CPE screens performed and this indicates that implementation has been followed.

3.8 Outbreak of Serratia marcescens within the cardiothoracic surgical service

In July 2019 we found that our surveillance system for potential clusters of gram negative bacteria had identified that 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*. This outbreak was closed by the Infection Prevention Strategy Group in August 2021. There had been 5 confirmed cases, 27 probable cases and 46 excluded cases at the time the outbreak was closed. Investigations suggested a link to an environmental source. Ongoing surveillance graphs have been included in the infection control monthly report since that time (see below). The cases seemed to have fallen until July 2023, but there was then an increase. In response to this we reopened the outbreak meeting and we investigated the potential causes. Numbers reduced again and the outbreak was closed in December 2024.



Graph 3: Timeline of Serratia marcescens cases

3.9 Surveillance for other alert conditions

No cases of any of the other alert conditions included in the surveillance policy (HIC 29) have been identified since April 2006 except for invasive group A streptococci cases. We had 0 cases of healthcare-associated invasive group A streptococci in 2024/2025 but we had 4 in 2023/2024 and one each in 2022, 2019, 2017, 2013 and two cases in 2010. The recent increase is partly due to a broadening of the definition of a case of invasive infection and partly due to a national increase in group A streptococci infections.

Legionella has been detected in the water supply in several areas during the last 10 years. There have never been any cases of Legionnaires' disease acquired in our Trust.

3.10 Outbreaks of diarrhoea and vomiting

Norovirus is defined as an abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours. If this occurs the ward must gather information about the patient's affected, this infection is known to be highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or environmental contamination. In hospital this environmental risk is considerable, and outbreaks are common.

It does seem that a lot more patients and staff have been affected by outbreaks of diarrhoea and vomiting during the current winter and previous winter compared to previous years (see table 11). Prior to this the trust had not been affected by significant outbreaks of norovirus since 2012/2013. The key issues are as for *C. difficile*: cleaning, patient movements and staffing

Year	Patients affected	Staff affected
2006/7	606	151
2007/8	221	82
2008/9	187	54
2009/10	215	102
2010/11	40	30
2011/12	250	114
2012/13	383	166
2013/14	43	8
2014/15	22	18
2015/16	73	16
2016/17	17	14
2017/18	42	15
2018/19	1	12
2019/20	82	54
2020/21	11	8
2021/22	9	16
2022/23	40	52
2023/24	168	98
2024/2025	256	180

Table 11. Comparison of patients and staff affected by winter vomiting disease during outbreaks at South Tees Hospitals between 2006/7 and 2024/25

3.11 Influenza

Influenza had a much smaller impact on our trust in 2020/21 and 2021/22 than in previous years probably because of the non-pharmaceutical interventions being used to prevent the spread of COVID-19. However the cases have risen since 2022/23. We had 12 outbreaks of influenza in the winter of 2022/23, affecting 60 patients and 0 staff. We had 2 outbreaks during

the winter of 2023/2024 affecting 14 patients and 0 staff. We have had 5 outbreaks during the winter of 2024/2025 affecting 38 patients and 0 staff.

3.12 Other critical care surveillance

Isolation capacity for patients with infection continues to pose a challenge particularly on ICU2, ICU3 and Cardiothoracic ICU. Processes to mitigate risk of transmission of infection continue to be put in place including increased presence of the IPC team to support staff.

When isolation becomes challenging critical care staff work with IPC staff to ensure all risk reduction strategies are put in place. This includes appropriate use of aprons, gloves, gowns and other personal protective equipment, with the visual prompt of the PPE trolley displaying a 'STOP' sign alerting staff, who need to enter the bed space. Strict hand hygiene, equipment decontamination and any condition-specific devices (e.g. faecal collector) are put in place. For patients with infections in sputum, these measures may not be sufficient.

Between April 2024 and March 2025 we identified:

- 2 cases of MRSA acquisition of colonisation or infection while on Critical Care. There were 2 cases in 2023/24.
- 13 cases of HOHA *C. difficile* infection on Critical Care. In 2023/24 there were 13 cases.
- 16 healthcare-onset GNBSI bacteraemia (due to the 3 organisms which are part of national surveillance) have been identified 2 or more days after admission to Critical Care. In 2023/24 there were 14 cases.
- *Mycobacterium chimaera* has been isolated from several heater-cooler units in cardiothoracic surgery between 2022 and 2025. We believe that changes in the design of the equipment mean that there should not be a real risk to patients. Further precautions are also in place to further reduce any theoretical risk.

3.13 COVID-19

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as MERS and SARS. Some transmit easily from person to person, while others do not. A novel coronavirus is a new strain that has not been previously identified in humans. The virus which caused the COVID-19 pandemic was named SARS-CoV-2.

The Trust has implemented and stepped down the requirements as identified by NHS England in order to manage the additional pressures on healthcare systems.

COVID-19 Outbreaks

An outbreak is classed as two or more cases of COVID-19 which occur in the same clinical or non-clinical area within a 14-day period. During the second/ third wave we reported 50 outbreaks, and all of these have now closed. This involved 464 staff members and 225 patients. After the third COVID-19 wave, we have had 109 outbreaks affecting 114 staff and 729 patients. 9 of these outbreaks occurred during 2024/2025. All 109 of these outbreaks are now closed.

Each outbreak has an individual timeline where all information regarding these patients are collated and reviewed. Outbreak meetings are recorded and minuted, detailing all attendee discussions and findings. Outbreak meetings are arranged with both internal and external partners where necessary, and actions identified. Once outbreak areas have been identified within the trust, reviews are undertaken to find potential themes behind the outbreak occurring.

Audits are undertaken by a member of the IPC team to identify compliance and where necessary action plans are devised to prevent any further occurrences.

Clinical practice audits including hand hygiene, matron peer review and environmental audits are completed and compliance scores for each ward are collated. Where improvements are required, advice is provided by the IPC team to the wards to facilitate an improvement in their overall compliance. By reviewing areas, risks and non-compliance can be identified to limit the potential of outbreaks occurring within the trust.

3.14 Audit Programme

The STHFT IPC Team has a programme of audits in place undertaken on all clinical areas and outpatients' departments. The IPC Team provide assurance against consistent compliance with evidence-based practice and policies. Each audit completed creates an action plan for review and completion by the ward teams. All Environmental audits are recorded and an electronic action plan is generated.

Where a period of increased incidence (PII) occurs, risks are identified and the IPC Team undertakes additional audits in accordance with risk requirement, this will be daily initially with an increase to weekly once an improvement and consistency in scores has been identified.

Action plans are developed by the clinical areas, and these are managed and monitored within the collaboratives and escalated to IPSG and upwardly reported through the STHFT Governance structure.

3.15 Hand Hygiene audits

17. Hand hygiene continues to be audited across all wards and departments, on a monthly basis, this includes monthly compliance following the WHO 5 Moments of Hand Hygiene tool. The average audit results across the year are as follows,
    - Self assessment = 90%
    - Peer assessment = 80%
    - Global statistics show that the average is 60%

Patients, visitors, and staff are encouraged to challenge staff if they have any concerns about hand hygiene and in cases of repeated non-compliance, concerns are raised divisionally. This is across all staff groups including nurses, medical staff, AHP's and our PFI partners.

Raising awareness of hand hygiene and the 'Bare below the elbow' are consistently monitored throughout the year.

3.16 Link Worker Programme

The IPCT continues to provide the Infection Prevention and Control Link Nurse programme.

Link Worker meetings run every month face to face or via TEAMS to provide education support and act as an IPC resource for the link staff to maintain their enthusiasm and commitment to IPC.

The aim of these meetings is to provide updates on any new guidance / policies, an opportunity to share learning outcomes and case studies, and to enhance effective communication across STHFT. There is an ask to have at least one link worker in every department including inpatient and community areas, they are key in undertaking monthly audits of practice.

3.17 Care Quality Commission

The Care Quality Commission (CQC) are an independent regulator of health and social care in England. They ensure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage all care services to improve. Their assessment framework is made up of 5 key questions and, under each key question, a set of quality statements. The 5 key questions asked of all health and social care services is are they safe, effective, caring, responsive to people's needs and well-led.

Quality statements are the commitments that providers, commissioners and system leaders should live up to. These are known as ‘we statements’, they show what is needed to deliver high-quality, person-centred care. When they refer to 'people' they mean people who use services, their families, friends and unpaid carers.

The IPC team were heavily involved in the last CQC inspection of the Trust and were extremely proud to be part of the organisations rating which moved from requires improvement to good.

Positive findings included labelling of clinical equipment once cleaned and stored appropriately, isolation signage and policy, bare below the elbow policy and good hand hygiene practices. It was also clear that the IPC team are involved with the clinical teams to work towards both local and Trust quality programmes.

There were areas for improvement including some inconsistent use of Personal Protective Equipment (PPE) and monitoring of equipment cleaning which have been addressed and plans implemented to address.

SECTION 4: ANTIMICROBIAL STEWARDSHIP

The trust is continuing with a number of antimicrobial stewardship initiatives. The introduction of electronic prescribing has presented additional challenges in ensuring that antibiotics are prescribed for the shortest duration possible.

The regional antibiotic prescribing dashboard is shown below.

ICB Region	Trust Code	Trust Name	Total AB (DDDs/1000bed m) 2019 RX-info	Total AB (DDDs/100 0adm incl DQ) 12mth RX-info	% difference in total AB vs 2019 (DDDs/1000adm incl DQ) RX-info Target -5% by 2029	Trend AWaRe (last 12 months vs prev 12 months to Feb-25) RX-info	Total WaRe (DDDs/1000adm) 12mth to Q3 2024-25 FutureNHS	% difference in WaRe vs 2017 (DDDs/1000adm) FutureNI	MET 10% reduction target in WaRE vs 2017 (DDD/1000adm) to Q3 24-25	Trend WaRe last 12 mth vs prev to Feb-25 (Rx-info) - Target = reduce in 2025-6	Carbapenem DDD/adm rolling 12 mth to Feb	Carbapenem trend vs prev year (12mth rolling) RX-info	Trend	% Access (pre Apr-25) Feb-25 (RX-info) - Target 70%+ by 2029	Trend	2024-25 % IV AB (Jan-25) RX-info - NMOD to reduce in 2025-6	Trend	% on IV AB meeting IVOS YTD Q4 23-24 (target <40%)	% on IV AB meeting IVOS - Q3 24-25 (target <15%)	Q3/4 BCP >4hr	Q3/4 BCP <8ml+	HOHA C diff rate (12mth rolling case/100k bed days) Nov-24 UKHSA Fingertips	COHA C diff rate (12mth rolling case/100k bed days) Nov-24 UKHSA Fingertips	HA (HO+CO) C diff rate (12mth rolling case/100k bed days) Nov-24 UKHSA Fingertips	Mortality 2023-4 from infections (NHSE Infection AMR dashboar	Composite WaRe rate + reduction, BCP audit, % IV and CQUIN reduction (lower is better)
NHS NORTH EAST AN	RR7	Gateshead Health NHS Foundation	4824	5415	12.3%	11%	1455	-8.1	NOT MET	5%	9.58	48.10	71%	-1%	20%	same	22.0%	16%	67%	24%	16.80	8.20	25.00	6.5%	688.8
NHS NORTH EAST AN	RTR	South Tees Hospitals NHS Foundati	4754	5208	22.4%	9%	2148	-7.1	NOT MET	2%	83.42	-7.40	49%	4%	21%	-3%	4.0%	20%	49%	71%	30.60	10.40	41.00	6.3%	740.6
NHS NORTH EAST AN	RTF	Northumbria Healthcare NHS Foun	4287	5374	25.4%	23%	1749	-23.8	MET	22%	55.13	38.10	59%	4%	14%	-1%	9.0%	10%	3%	no submission	15.10	8.80	23.90	6.2%	712.4
NHS NORTH EAST AN	RTD	The Newcastle Upon Tyne Hospitals	4864	4867	0.1%	-8%	2150	-4.1	NOT MET	-5%	95.37	-7.30	54%	3%	23%	-2%	no submissio	25%	no submission	no submission	30.50	6.00	36.50	4.2%	783.3
NHS NORTH EAST AN	R0B	South Tyneside and Sunderland NH	5162	5731	11.0%	3%	1688	-16.1	MET	-6%	18.22	18.40	67%	-2%	15%	same	10.0%	no submissio	65%	3%	19.50	4.30	23.80	6.9%	825.3
NHS NORTH EAST AN	RXP	County Durham and Darlington NHS	6086	6000	-1.4%	-4%	2365	-27.4	NOT MET	1%	55.54	-15.10	54%	5%	21%	-5%	7.0%	12%	no submission	no submission	13.40	8.20	21.60	7.4%	934.9
NHS NORTH EAST AN	RVW	North Tees and Hartlepool NHS Fou	6091	7090	16.4%	3%	2426	-16.3	NOT MET	1%	49.89	-1.90	60%	11%	13%	-5%	13.0%	no submissio	88%	87%	32.90	10.60	43.50	5.2%	1064.2
NHS NORTH EAST AN	RNN	North Cumbria Integrated Care NHS	5784	7328	26.7%	-2%	2115	-5.3	NOT MET	-8%	43.37	-20.60	62%	2%	20%	-1%	11.4%	17%	no submission	no submission	23.80	8.90	32.70	7.1%	1183.9
																			* avg values from platform								
NHS NORTH EAST AN D NORTH		NHS NORTH EAST AND NORTH CUM	5169	5691	10.1%	3.0%	2012	-0.8	NOT MET	1.1%	59.80	-1.60	58%	2%	18%	-3%	14.0%	17%	67%	46%	23.10	7.80	30.90	6.1%	703.2
NHS HUMBER AN D NORTH YO		NHS HUMBER AND NORTH YORKSH	4646	4824	3.8%	1.7%	1673	-5.4	NOT MET	0.7%	36.80	-15.30	62%	-1%	23%	-1%	18.9%	no submissio	44%	32%	21.50	9.70	31.20	6.5%	724.9
NHS WEST YORKSHIRE INTEGRA		NHS WEST YORKSHIRE INTEGRATED	4754	5964	26.0%	2.2%	2190	-2.6	NOT MET	-1.5%	54.40	-3.10	57%	same	21%	same	17.0%	15%	26%	32%	18.90	5.40	24.30	6.1%	743.8
NHS SOUTH YORKSHIRE INTEG		NHS SOUTH YORKSHIRE INTEGRATE	5566	5489	-1.4%	0.6%	2379	-0.4	NOT MET	-0.5%	55.70	-7.70	53%	2%	20%	same	17.7%	14%	no submissio	no submission	25.20	8.60	33.80	5.6%	987.8
North East and Yorkshire		North East and Yorkshire	5065	5535	9.3%	2.1%	2074	-0.6	NOT MET	0.1%	53.20	-1.30	58%	same	20%	-1%	16.9%	17%	42%	39%	22.10	7.60	29.70	6.1%	694.5
England		England	5021	5808	15.7%	-0.4%	2282	-0.0	NOT MET	-2.4%	69.50	-2.00	55%	2%	21%	-1%	18.2%	18%	not available	not available	22.70	8.20	30.90	5.9%	902.4

Table 12 – Antimicrobial stewardship regional dashboard

The previous difficulties with submitting blood culture audit data and IV-to-oral switch antibiotic data have been addressed.

SECTION 5: CLEANING

The trust continues to monitor monthly cleaning scores through IPSG.

The James Cook Site:

Risk Category – JCUH March 2025	NSC Target	Cleaning	Estates	Nursing
FR1	98%	99.80%	99.99%	9973.00%
FR2	95%	99.48%	99.98%	99.67%
FR3	90%	99.27%	100.00%	100.00%
FR4	85%	99.35%	99.96%	99.31%
FR5	80%	98.86%	100.00%	100.00%
FR6	75%			

Table 13. Cleaning scores for James Cook site for 2024/2025

Cleaning scores have been maintained on the JCUH site. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPSG.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital:

Risk Category – FHN	NSC Target	Cleaning	Estates	Nursing
FR1	98%	99.74%	100.00%	99.92%
FR2	95%	99.63%	99.78%	100.00%
FR3	90%			
FR4	85%	97.96%	99.58%	99.81%
FR5	80%			
FR6	75%			

Risk Category	NSC Target	ECPCH	RPCH	Friary
FR1	98%		98.90%	
FR2	95%	97%	98.10%	99%
FR3	90%	98%		
FR4	85%		99.10%	
FR5	80%			
FR6	75%		94.10%	

Table 14. Cleaning scores for FHN and community sites for 2024/2025

The scores on The FHN and Community sites are an aggregated monthly score. Some clinical areas have been through a period of weekly monitoring until the cleaning score reached the required target as agreed with the service provider.

SECTION 6: PROGRESS AGAINST 2024/2025 INFECTION PREVENTION AND CONTROL PROGRAMME

The 2024/25 IPC Annual Programme consisted of a number of elements and within each one there was a nominated lead with a distinctive action plan to follow. A summary of some of these are highlighted below.

6.1 CDI – action and monitor maintenance and reduction around CDI cases through implementation of CDI recovery plan

- Audit and surveillance of CDI identifying trends and themes.
- Audit and surveillance of clinical practice around CDI in collaboration with the clinical matrons council.
- Management of diarrhoea including refreshed paperwork and training
- Education and training regarding CDI
- Rapid learning reviews developed in line with PSIRF.
- Support of a CDI Lead IPCN role
- Trust wide CDI 'Deep dive action plan', supported with collaborative owned plans and actions.

6.2 MRSA / MSSA – reduce the incidence and increase staff awareness of MRSA/MSSA infection

- Audit and surveillance of MRSA/MSSA identifying trends and themes.
- Audit and surveillance of clinical practice around MRSA/MSSA in collaboration with the clinical matron's council.
- Refresh and strengthening of Aseptic Non-Touch Technique (ANTT) processes in the Trust.
- Learning from cases developed, reviewed, and shared.
- Education and training regarding MRSA/MSSA

6.3 GNBSI – surveillance of hospital acquired GNBSI

- Refresh and strengthening of Aseptic Non-Touch Technique (ANTT) processes in the Trust.
- Focussed work on oral hygiene in critical care and high-risk areas.
- Audit and surveillance of GNBSI's identifying trends and themes.
- Audit and surveillance of clinical practice around GNBSI's in collaboration with the clinical matron's council.
- Focus on catheters and catheters associated UTI's linked to hydration.
- Education and training regarding GNBSI's.

6.4 CPE – action and monitor maintenance and reduction around CPE cases through implementation of CPE recovery plan

- Audit and surveillance of CPE identifying trends and themes.
- Audit and surveillance of clinical practice around CPE in collaboration with the clinical matron's council.
- Education and training regarding CPE
- Ongoing support of the CPE Lead for IPC
- Screening reviewed and developed in line with national guidance.
- Site team collaboration for isolation priority

6.5 Respiratory Infections – maintain safety of our staff and patients and minimise risk of cross infection

- Outbreak management process strengthened.
- Fit testing team established in the IPC team
- Surveillance of all respiratory infections and identify trends or concerns in respect of outbreaks etc.
- Support for ventilation and estates.
- Collaboration with Occupational Health regarding vaccinations

6.6 Antimicrobial Stewardship – to support with the Trusts antimicrobial strategy

- Support for AMS through collaboration with Pharmacy and through learning from HCAI cases.
- Attendance within Trust AMS working groups.
- Involvement in Regional and National initiatives around AMS

6.7 Decontamination – to support the Trust with their overarching decontamination strategy from an IPC perspective

- Audit and surveillance of areas included in identifying trends and themes around decontamination services and initiatives.
- Oversee hand hygiene updates and work across organisation.
- Support with cleanliness initiatives such as use of UV light etc.
- Support for areas such as water safety, ventilation etc. in relation to decontamination.

6.8 Education and Teaching – to implement an effective and accessible IPC Education delivery plan

- Development of education and training across the organisation
- Delivery of the 3-day IPC Advancing Care in Clinical Practice across the organisation and external as appropriate
- Review and continue IPC link practitioners programme.
- Development of the IPC team in respect of ongoing service specific training and education

6.9 Audit – development and maintenance of a robust audit delivery plan in line with Trust policies

- Development and completion of a robust IPC audit programme
- Surgical Site Infection an area of focus to carry into 2025/2026
- Ensure registration of IPC audits as applicable via the Trust team

6.10 Strategic Team Planning - To create an experienced and resilient IPC team, with sufficient establishment to be able to provide full cover to all areas of the Trust, 7 days a week. To have efficient working practices to ensure IPCN time is maximised to spend on critical support and advice functions.

- Review and refresh the IPC establishment including recruitment and retention initiatives.
- Development of a robust IPC team
- Refresh the profile and roles and responsibilities of the IPC team.
- Ensure correct alignment of IPC governance and assurance structures.

6.11 Community – provide a robust and resilient care home and social care domiciliary IPC service in collaboration with community services

Focussed work on audit, surveillance and education in the care home and domiciliary sector in relation to the following,

- ANTT
  - Catheters
  - HCAI's
  - Hydration
  - Respiratory infections

6.12 Learning from themes and trends

A large element of the IPC plan is around learning and development for the future initiatives and support for the clinical teams in relation to safe and effective patient care. All elements of the HCAI plan have a thematic review completed in line with PSIRF and this formulates the actions required and further policy development etc. some of the reviews completed from the previous year include the following,

- Delays in sampling and receipt in the laboratory
- Increased prevalence in areas – ribotyping requested to identify potential outbreaks
- Documentation – lack of recording of severity of CDI in line with national and local guidance
- Antimicrobial concerns – focus being on Co-Amoxiclav prescribing which can predispose CDI – Audit, education and training to reduce inappropriate prescribing (albeit slowly)
- Inability to isolate timely due to lack of available isolation rooms – this has improved with the IPC and site team collaboration

6.13 Achievements in 2024/2025

There have been several achievements for the IPC team across the last year and some of these include,

- Stability and resilience in the IPC team
- Attendance at conferences to speak about IPC representing the Trust
- Members of the team successfully completed the 'Dare to Lead' course
- Members of the team completed the Human Performance Practitioner Course
- Development of a robust audit and surveillance programme embedded in clinical areas
- Close working with Non-Executive Director and Executive Director
- Successful appointment of the Trust DDIPC into the University Hospital Tees Group DDIPC

SECTION 7: LOOKING FORWARD TO 2025/2026

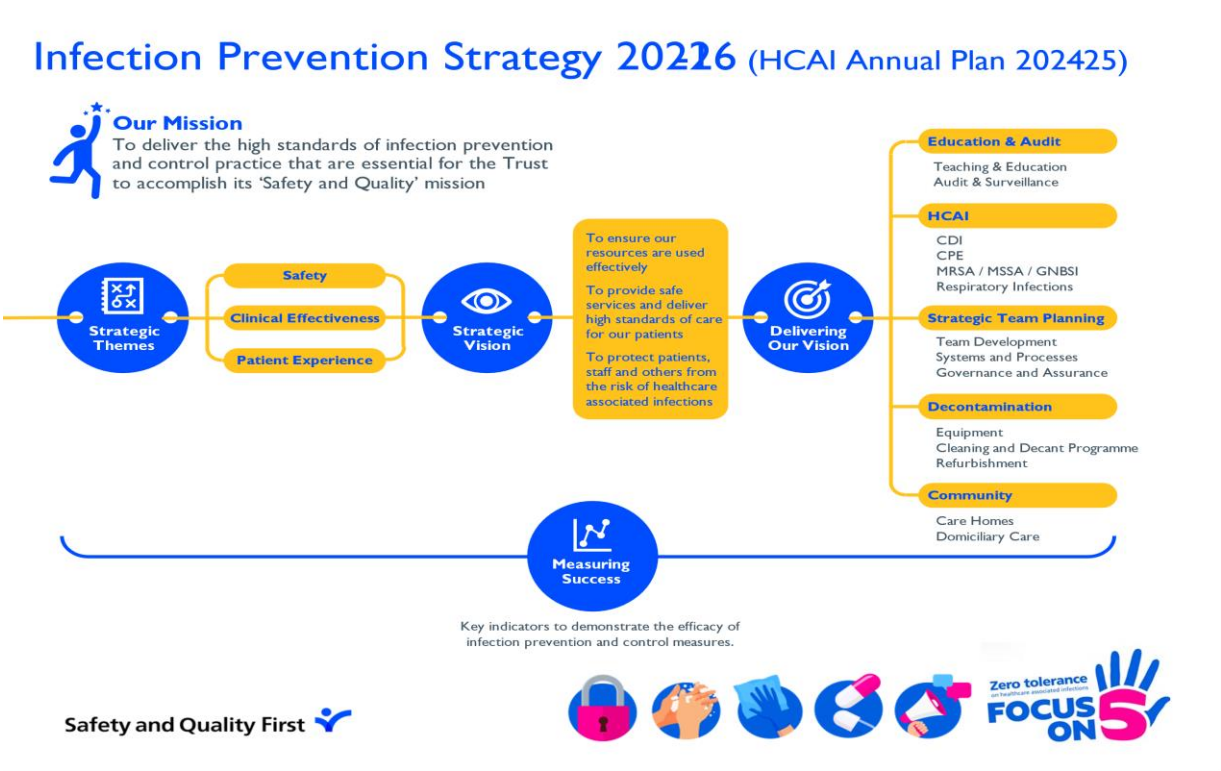
7.1 An overview of the Infection Prevention and Control Programme for 2025/2026

This section gives an oversight of the work planned to prevent and control infections in 2025/26 and to achieve external thresholds and comply with the Code of Practice on the prevention and control of infections. It is designed to reflect STHFT Strategy to deliver care that is clinically effective; care that is safe; and care that provides as positive an experience for patients as possible.

The importance of working across the wider health economy will continue into the next year and build on foundations that have already been established across the IPC and AMS agenda. This will include both regional and national strategies including local policy development and wider stakeholder events to drive the agenda forward.

The key aims in 2025/26 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with STHFT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, STHFT promotes that every member of staff takes responsibility for IPC in order that that no person is harmed by a preventable infection.

Infection Prevention and Control Strategy focus for the upcoming year are aligned to our Infection Prevention 5-year Strategy which is underpinned by our 2025 – 2026 Annual Plan



SECTION 8: CONCLUSION

The elimination of avoidable healthcare associated infections continues to be a priority for the Trust, patients and the wider public. In response, a robust annual programme of work has been implemented by the Trust over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. Although challenging, the successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the Trust. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug resistant organisms.

SECTION 9: ACKNOWLEDGEMENTS AND FURTHER INFORMATION

Thank you for reading the IPC Annual Report for 2024/25.

If you require any further information about IPC in STHFT please email the team at stees.infectioncontrol.team@nhs.net or visit our webpage at Infection control - Infection prevention and control (IPC) – South Tees Hospitals NHS Foundation Trust (xstees.nhs.uk)

This report was prepared by STHFT's IPC team:

Emma Nunez - Chief Nurse & Director of Infection Prevention and Control
Dr Richard Bellamy – Infection Control Doctor
Sharon Lance - Deputy Director of Infection Prevention and Control
Jo Carter – IPC lead Nurse
Claire Phillips – IPC Governance and Quality Facilitator
Hannah Thompson – Decontamination Lead
Richard Robinson – Assistant Lead Nurse IPC
Bradley Morgan – Assistant Lead Nurse IPC
Jo Dunmore – Assistant Lead Nurse IPC

Bev Gunn – Assistant Lead Nurse IPC – Care Homes
Pam Thorne – IPC Nurse (From June 2024)
Sam Easby – IPC Nurse
Abosede Olarinde – IPC Nurse
Rachel Seaman – IPC Nurse
Joseph Beavin (From January 2025)
Elaine Bennett - IPC Nurse, Military (Until July 2024)
Louise Budd – Audit & Surveillance Assistant
Heather Hunter – Audit & Surveillance Assistant
Sarah Ingledew – Audit & Surveillance Assistant
Michelle Weatherall - Audit & Surveillance Assistant
Christine Simpson – Audit & Training Support Assistant – Care Homes and Domiciliary Care
Alison Watson – Audit & Training Support Assistant – Care Homes and Domiciliary Care
Kelly Staincliffe – IPC Admin
Julia Ward – IPC Admin
Claire Pearce – Fit Testing Co-ordinator
Chris Hancock – Fit Tester
Omotayo Olaore – Fit Tester

In conjunction with:

Richard Cowan – Antimicrobial Pharmacist
Emma Stephenson - Health and Safety Manager
Denise Foster - Head of Contract Management and Performance (Until May 2024)
Laura Mills - Head of Contract Management and Performance (From September 2024)
Julian Verity – Head of Estates
Taylor Slee – Estates Manager

NHS
University Hospitals Tees

People Committee

27 May 2025
Connecting to: NHS UHT Group Board

Key topics discussed in the meeting:

- **Urgent Escalations**
  - Industrial Action: Resident Doctors (ballot closing 07.07.2025)
  - Voluntary Severance Scheme: Opened for corporate and non-clinical staff
  - Management and Leadership changes: Consultation
  - UK Visa & Settlement Rules 2025: Government policy paper published and expected changes may impact organisations

- **Medical Job Planning**
  - NHS England set a national target for medical job planning, whereby all NHS organisations were required to achieve a target of 95% sign-off by 31 March 2025
  - UHT current sign off rate is 32.2%
  - Trajectories set for 100% compliance by July 2025 … this is already slipping.
  - **[ACTION]** Monthly updates to people committee (June 2025)

- **Nurse Safer Staffing**
  - Assurance provided on systems for staff deployment and remedial actions.
  - Reduction is agency spend.
  - Discussion ongoing re a single talent acquisition process for nursing.

- **Annual Staff Survey**
  - Low engagement across UHT was noted
  - Committee discussed option of not undertaking a full survey on an annual basis

- **Guardian of Safe Working Report**
  - Report was noted

- **Maternity Action Plan**
  - Verbal update on progress
  - People Committee Chair to meet with Rachel Metcalf, Steph Worn (Group Director of Midwifery) and Emma Nunez (Group Chief Nurse) and agree assurance metrics

- **EDS Report**
  - Report was noted

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- **Violence & Aggression Report**
    - The report was noted
    - Chairs Logs from the Groups involved in monitoring violence and aggression be brought to future People Committee meetings

Actions:

- Medical Job Planning

Escalated items:

- Staffing impacting on quality to be shared with the Group Quality Committee.

Risks (Include ID if currently on risk register):

- None

NHS
University Hospitals Tees

People Committee

25 June 2025
Connecting to: NHS UHT Group Board

Key topics discussed in the meeting:

- **Urgent Escalations**
  - Changes to Immigration Policy and Recruitment Practise
    - Previous changes to recruitment practice indicated a possible risk (not discriminatory) and mitigations in place
    - Practice changed and organisational learning.
  - Resident (and Consultant) Doctors industrial relations risk
  - Voluntary redundancy additional £40k costs (v HM Treasury compliance)

- **BAF**
  - Updated following UHT People Plan
  - Excellent work with a comprehensive first draft
  - Living document and some wordsmithing and attainment date feedback provided.
  - **[ACTION]** BAF to be updated and reviewed at next meeting (July 2025)

- **IPR**
  - Sickness Absence: Reductions are in line with the seasonal cyclical pattern and any structural reduction appears minimal.
  - Staff Turnover: Below target and assurance provided there are no talent pools at risk,
  - Appraisals: Improvements but not delivering at pace **[ESCALATION]** Board
  - Mandatory Training: No significant improvements **[ESCALATION]** Board

- **Medical Job Planning**
  - NHS England set a national target for medical job planning, whereby all NHS organisations were required to achieve a target of 95% sign-off by 31 March 2025
  - UHT current sign off rate is 50%
  - Trajectories set for 100% compliance by July 2025 with a significant risk of non-attainment.
  - **[ESCALATION]** Board
    - **Board** – Medical Director is requested to intervene and ensure 100% compliance in July 2025 is attained.

- **Nurse Safer Staffing**
  - Assurance provided on workforce planning

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- Turnover rates in tolerance
- Reduction in agency spend noted

- **Biannual Nurse Safter Staffing Establishment Review NTH**
  - Report was noted
  - Sickness and absence rates across the nursing workforce currently exceed the Trust target of 4.0%.
  - Assurance not provided on determining establishment levels as model appears to be modelling absence based on actual v target (4%)
  - **[ACTION]** Explanation on absence rates used in modelling
  - **[ACTION]** Paper to be returned to people committee (September 2025) following third data collection

- **Absence Management Annual Report**
  - Report was noted
  - Committee questioned if this would be able to deliver structural change in absence rates and go further than 4% target?

- **Internal Recruitment Audit Report (ST)**
  - Report was noted
  - Summary of finding were explained and actions to be undertaken.
  - **[ACTION]** Risk mitigations to be actions and returned to people committee for assurance.

- **Mandatory Learning – Oversight Group**
  - Report was noted

- **Apprenticeships – Level 7 Changes**
  - The report was noted

- **Financial Oversight of Research. Learning & Leadership**
  - Committee acknowledged work done on this subject. Thank you.
  - **[ACTION]** Meeting with Derek Bell, David Redpath (Resources), Chris Day (Academic) and Mark Dias (People) to identify any additional assurance requirements.

Actions:

- BAF to be updated and reviewed at next meeting (July 2025)
- Biannual Nurse Safter Staffing Establishment Review: Explanation on absence rates used in modelling
- Biannual Nurse Safter Staffing Establishment Review: Paper to be returned to people committee (September 2025)
- Internal Recruitment Audit Report (ST): Risk mitigations to be actions and returned to people committee for assurance.

- Financial Oversight of Research. Learning & Leadership: Meeting with Derek Bell, David Redpath (Resources), Chris Day (Academic) and Mark Dias (People) to identify any additional assurance requirements.

Escalated items:

- **BOARD**
  - **Medical Job Planning:** Medical Director is requested to intervene and ensure 100% compliance in July 2025 is attained.
  - **Appraisals:** Improvements but not delivering at pace
  - **Mandatory Training:** No significant improvements

- **RESOURCE**
  - **Autism and disability training** (P24/159) to be triangulated with resource committee re additional resource and costs implications.
  - **Resident (and Consultant) Doctors industrial relations** risk triangulated with resource and risk committees
  - **Voluntary redundancy** additional £40k costs (v HM Treasury compliance) triangulated with resource committee

Risks (Include ID if currently on risk register):

- None

University Hospitals Tees

CMO Office – UHT Guardian of Safe Working – Feb to Apr 25

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 16

Report author: *CMO Office*

Executive director sponsor: *Dr Michael Stewart, Group Chief Medical Officer*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *People Committee*

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Both sites continue to report concerns relating to workload and staffing shortages

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Work continues to right size rotas and produce generic work schedules

NHS Employers announced changes to ER processes which are due to come into effect 12 September 2025

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

GOSW and CMO Office continue to work closely to ensure that we are an employer of choice for resident doctors

Recommendations:

Group Board are asked to note the content of this report.

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Group Board
3 July 2025
CMO OFFICE - UHT GUARDIAN OF SAFE WORKING (GOSW), FEB TO APR 25

1. PURPOSE OF REPORT. Provide assurances to People Committee regarding issues raised by site GOSW via their individual reports covering the period of Feb to Apr 25.

2. RECOMMENDATIONS. It is requested that the content of this report is acknowledged for assurance.

3. SUMMARY OF ISSUES RAISED, ACTIONS AND RECOMMENDATIONS

a. Workload on rotas. Both sites continue to report concerns relating to workload and staffing shortages, leading to doctors working beyond their contracted hours.

Actions
Continue longer term plan of reviewing rotas to ensure they have safe staffing levels which are costed.

4. OTHER LINKED WORKSTEAMS

a. Staff who aid resident doctor rostering. NTH and STH sites are structured differently regarding staffing models which support resident doctor rostering. NTH has a devolved approach with several roles at directorate level also having a role in rostering. STH has a more centralised approach. It is viewed that the more devolved approach is preferential. The GM to the CMO office has met with members of the People's directorate to discuss this matter. Next steps are producing a target operating model which is cognisant of the future clinical business model structure.

b. Exception Reporting (ER) Reform. NHS Employers announced changes to ER that are due to come into effect 12 Sep 25. A gap analysis regarding this reform will be produced across the Group with key stakeholders. For interest the reform involves:

- Simplifying processes for doctors and ensure compliance with new requirements
- That clinical supervisors are removed from the ER process and reports go directly to HR/Medical workforce and GOSW and the director of medical education if educational. Providing confidentiality and reducing potential conflicts of interest or detriment.
- Trusts will face new fines for non-compliance including delays in on-boarding residents onto an ER system, delays in processing reports, or sharing report details with individuals not authorised to see them.

5. CONCLUSION. The GOSWs and CMO office continue to work together to remedy issues highlighted. We continue to strive to be recognised as an employer of choice for our resident doctors.

University Hospitals Tees

NTHFT Guardian of Safe Working – Feb to Apr 25

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 16.1

Report author: *Professor Rajesh Nanda (GOSW)*

Executive director sponsor: *Dr Michael Stewart, Group Chief Medical Officer*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *People Committee*

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Three fines levied due to breaches in the maximum 13-hours shift length.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Resident doctors continue to report concerns relating to workload and staffing shortages; leading to doctors working beyond their contracted hours.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Compliance rates with code of practice and national terms and conditions.

Data and trends captured through exception reporting shared with relevant clinical rota leads to support ongoing review and action.

Recommendations:

It is requested that the content of this report is noted and acknowledged.

Group Board
3 July 2025
NORTH TEES AND HARTLEPOOL GUARDIAN OF SAFE WORKING (GOSW)
REPORT - 1 FEB 25 TO 30 APR 25

1. **PURPOSE OF REPORT**. Quarterly GOSW report for the period of 1st February 2025 to 30th April 2025, highlighting issues and trends raised by resident doctors through the exception reporting (ER) system and doctors forum. This report forms part of the reporting requirements of the national terms and conditions of service.

2. **RECOMMENDATIONS**. It is requested that the content of this report is acknowledged for assurance.

3. **DETAIL**

a. **Numbers of Doctors in Training / Locally Employed Doctors**:

Number of doctors / dentists in training (total):	251*
Of these (*) number who are LET	248
Of these (*) number who are military doctors in training (have access to ER system)	3
Number of locally employed doctors (non-consultant and SAS grades)	84
Total Resident Doctors	**335**

b. **ERs with Immediate Safety Concerns (ISC).** During this reporting period, 16 doctors (4.8%) submitted 47 exceptions. None of which were marked as an ISC.

c. **GOSW Fines**. Three fines levied within Medicine due to breaches in the maximum 13-hours shift length. Equating to a total of £152 in fines, of which £57 goes to the doctors in question and the remaining £95 to the Guardian. Increasing the Guardian's reserves to £1,786.

d. **Payment for additional hours**. Payment for additional hours worked continues to be the main outcome. Exception reporting shows an additional 59 hours worked, of which 48.5 hours paid as unplanned overtime.

Data. A summary of ERs is given in appendix one.

4. **SUMMARY OF ISSUES, ACTIONS AND RECOMMENDATIONS**

a. **Medicine rotas**. Resident doctors continue to report concerns relating to workload and staffing shortages; leading to doctors working beyond their contracted hours. During this reporting period, the majority of exceptions submitted by Medicine resident doctors related to Gastroenterology (17 out of 39) and Respiratory (9 out of 39) wards. The department continues to review their rotas based on feedback, engagement with doctors and working with STH colleagues regarding their approach.

b. **Surgery rotas**. FY1 trainees in Surgery submitted six exceptions, making 17 since August 2024. The department are reviewing to see whether this is due to the impact of additional elective activity.

c. **Out-of-hours hot food provision**. The second vending machine is now operational and located outside the Tees meeting room. However, the options available appear to be sandwiches, snacks and pot noodles rather than hot microwavable meals.

d. **Resident Doctors Forum (RDF).** Attendance significantly improved in May 2025 following a poorly attended April forum. Achieved following suggestions from resident doctors to move the meeting, and support from both the BMA and departmental rota teams.

e. **Trust Induction.** Doctors in training previously raised concerns around IT training at Trust induction. Corporate induction will become a single induction across the group with robust local inductions, which will be site specific. The medical education department will lead on unifying specific medical induction (including the use of IT systems) across the Group.

f. **Departmental Local Inductions.** Feedback from the RDF highlighted variances in the quality of departmental local inductions. The quality lead has been informed and to be discussed with departmental educational leads. Doctors have requested inclusion of available support and escalation processes when working on wards.

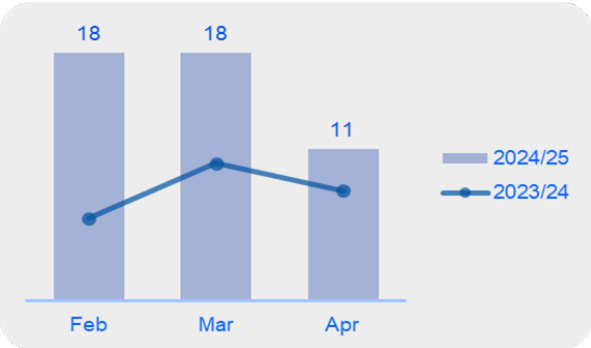
g. **FY1 Trainee Rotations**. Trainees suggested additional shadowing periods when rotating, especially when moving from a surgical area into their first medical area (or vice versa). Some already arrange these themselves with the support of the rostering teams. As local inductions do not always cover the actual day-to-day job, you learn from shadowing.

5. **CONCLUSION**. We will continue to work with all stakeholders to ensure continued compliance against code of practice and national terms and conditions. Regarding issues, such as medicine rotas, this is an area of continued focus.

Exception reporting 1st February to 30th April 2025

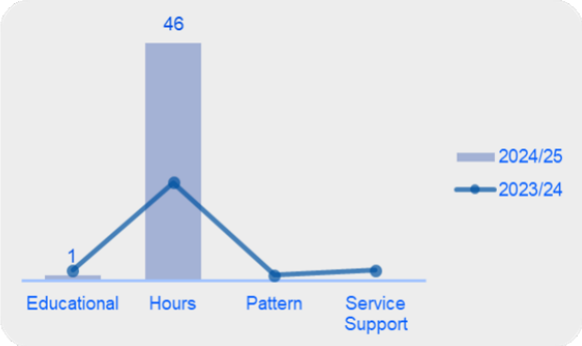
Exception Reporting

February 2025 to April 2025



47 exception reports by 16 doctors

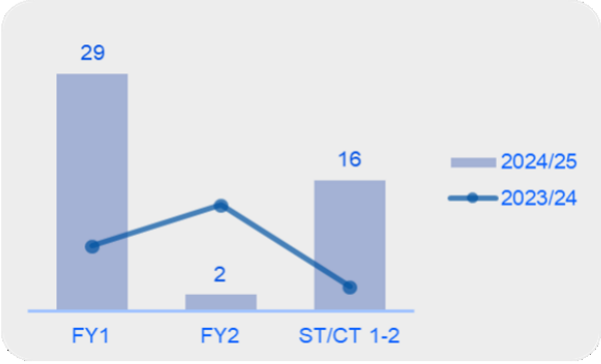
None marked as immediate safety concerns



Majority (98%) relate to hours worked

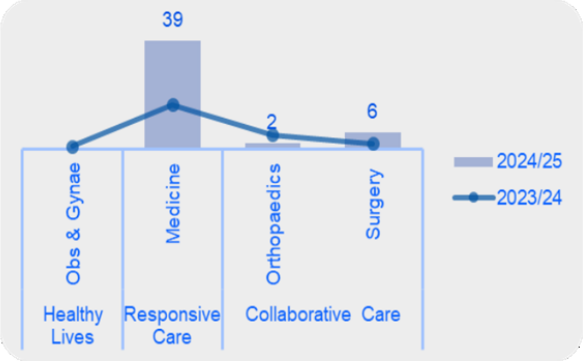
75% payment given

6% TOIL given



Majority (62%) by FY1 doctors

34% by ST/CT1-2



83% Medicine

13% Surgery

4% Orthopaedics

3 x FINES levied (£152) for working beyond the maximum 13 hours limit. Increasing the Guardians reserves to £1,786

Exception reporting 1st February to 30th April 2025 – Themes

	Educational	Hours	Pattern	Service Support	Grand Total
Medicine	1	38			39
FY1		**21**			**21**
FY2	**1**	**1**			**2**
ST/CT1-2		**16**			**16**
Orthopaedics		2			2
FY2		**2**			**2**
Surgery		6			6
FY1		**6**			**6**
Grand Total	**1**	**46**	**0**	**0**	**47**

University Hospitals Tees

STHFT Guardian of Safe Working – Feb to Apr 25

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 16.2

Report author: *Dr Catriona Lane (GOSW)*

Executive director sponsor: *Dr Michael Stewart, Group Chief Medical Officer*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *People Committee*

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Overtime levels remain high and lack of rota resilience means this is likely to remain the case in the current financial landscape.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Innovation projects to streamline some processes are being initiated. There may be some disruptions and setbacks whilst these get embedded.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The CMRT are working hard to ensure work schedule processes are streamlined and as efficient as possible to meet CoP and contractual timelines in August.

Recommendations:

It is requested that the content of this report is noted and acknowledged.

Group Board
3 July 2025
SOUTH TEES GUARDIAN OF SAFE WORKING (GOSW), FEBRUARY TO APRIL 2025

1. **PURPOSE OF REPORT**.

a. Provide an overview of the safe working patterns of all resident level doctors and dentists at South Tees Hospitals NHS foundation Trust. This report is in alignment with the 2016 junior doctor contract T&Cs and intended to provide assurance of the Trust's compliance with safe working hours and to highlight any areas and detail of concerns.

b. The report covers the period from the 1st February 2025 – 30th April 2025.

2. **RECOMMENDATIONS**. It is requested that the content of this report is acknowledged for assurance.

3. **DETAIL**

a. **Numbers of Doctors in Training / Locally Employed Doctors**:

Number of doctors / dentists in training (DiTs) (total):	541*
Of these (*) number who are military DiTs (also have access to the exception reporting system)	21
Number of locally employed doctors (non-consultant and SAS grades)	249
Total number of Resident Doctors	**790**

b. **Exception reports (ERs) with Immediate Patient Safety Concerns (IPSC)**. There were 3 ERs submitted were flagged as having IPSC. On GOSW review, 2 of which were related to resident doctors managing unwell patients with no evidence of harm. The third did not meet the threshold to count as IPSC.

c. **GOSW Fines & Finances**. There were 11 fines issued by the GOSW within this period, 6 of which for >13 hr shifts, and 5 for <11 hr rest (including 4 for the clock change in March). Fines for this reporting period total £660.22, of which £247.94 is to be paid to the affected resident doctors and £412.32 will be paid into the GoSW account. The fine amounts for the financial year April 2024 to March 2025 total £2786.65. Fines have still not actually been processed at a finance level yet but work to get this finalised is ongoing.

d. **Payment for additional hours**. A total of 109 hours of overtime is required to be paid during this period. We seek to attribute an actual cost of these overtime hours, based on specific pay spine points, with new ER software. This is an increase from the same period in 2024 which was 72.5 hours.

e. **Data**. A summary of ERs is given in appendix 1.

4. **SUMMARY OF ISSUES AND RECOMMENDATIONS**

a. **ER themes.** Themes remain very similar to previous months. Excess daytime workloads or increased workloads due to staff shortages remain the highest cause of residents staying late.

Overall, there were fewer ERs submitted, and fewer overtime hours compared to Nov 24 – Jan 25, reflecting some easing from the peak winter period. Areas of high reporting remain very similar, with General Surgery and Oncology remaining in double figures. FHN medicine has also reached a higher level this quarter. Overall the total of ERs compare to the same reporting period last year are static (125 in Feb – Apr 2024).

b. **Rota Resilience.** Rotas remain very tight and providing educational time is making this a challenge, particularly when we also provide parity to our LEDs. Delays in initiating recruitment processes creates a reliance on locums in some areas and this appears to be contributing to gaps. There is a concern that Directorates are increasingly conscious of the Trust's financial situation and due to this, a reluctance to approve locum use 'in hours', even if staffing is below the minimum. This then influences 'out of hours workload' and is contributing to the volume of overtime.

c. **CMRT – establishment**. The CMRT remained one rota coordinator short due to maternity leave for most of this period, with the CRMT manager filling this gap in addition to their own role. This gap has been filled again since April, however, workloads remain high with pressure to support directorates with day-to-day rota management as well as meeting Code of Practice (CoP) deadlines for rotas/Work schedules etc. A review of ratios of CMRT members: number of resident doctors has been completed. The next step is comparing this to how NTH are structured.

d. **Work Schedules**. Provision of work schedules in a timely manner and within the CoP and contractual obligations remains a challenge. However, work schedules for the April rotation have been issued during this reporting period with an estimated total of 90% issued within the deadline. The CMRT manager is now working closely with her team reviewing work schedules and rotas, in preparation for rotation work required for the August change over.

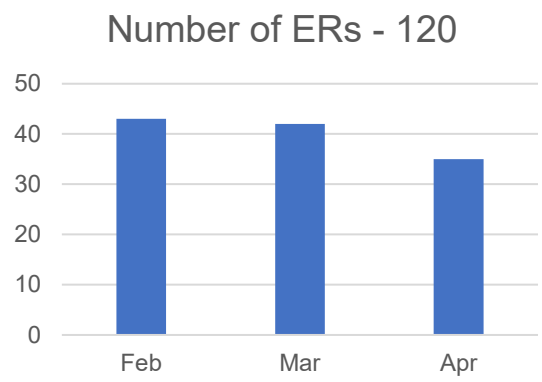
e. **Compliance software**. The trust contract with Allocate ended in February and South Tees have entered into an Innovation Contract Agreement with Pay pulse, to utilise their compliance checker for Rotas and Work Schedules. As expected, there have been some teething issues, but these are being worked through. Training sessions on the new software are being provided for the CMRT. The software will initially be used for analysis yet does have the facility to send Doctors their work schedules in advance; we are currently with the LET regarding this functionality.

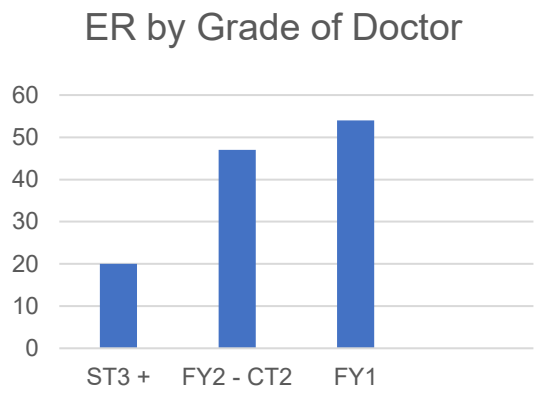
g. **ER process**. It has also been agreed that South Tees will enter into an innovation contract agreement with PayPulse, to use their Exception Reporting software to replace the accessible but labour-intensive interim solution that has been in place since Feb 24. The GoSW has been working with the team from PayPulse to get this ready for a go-live date at some point in the summer.

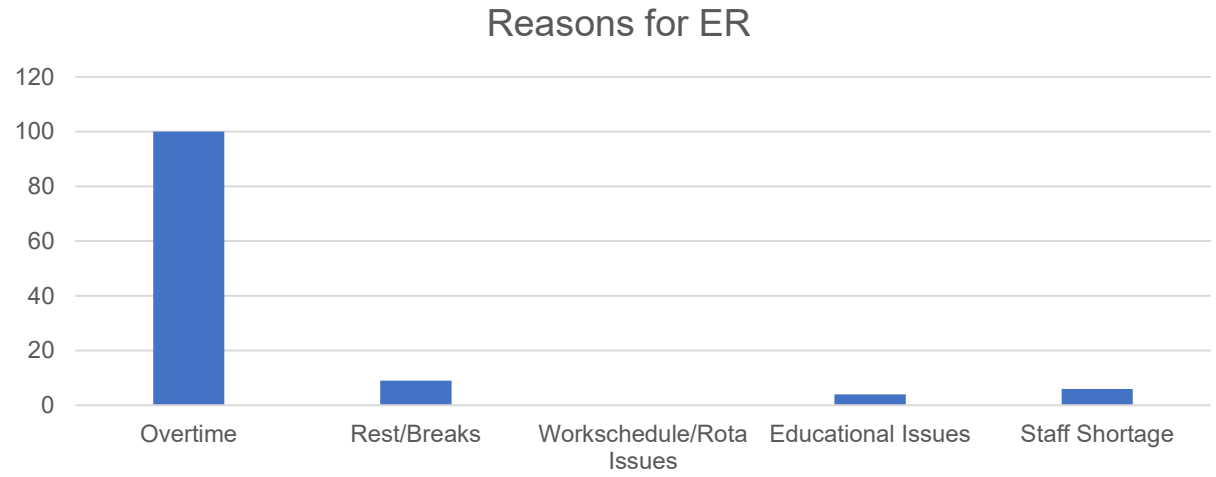
5. **CONCLUSION**. Levels of exception reporting remain comparative to the same period in 2024. Penalty breaches and the number of overtime hours however have increased significantly. Innovation contracts are in their early stages of implementation, but the hope is that they will make a big improvement in the efficiency of work related to some of the CMRT processes, and particularly the admin burden of the GoSW role.

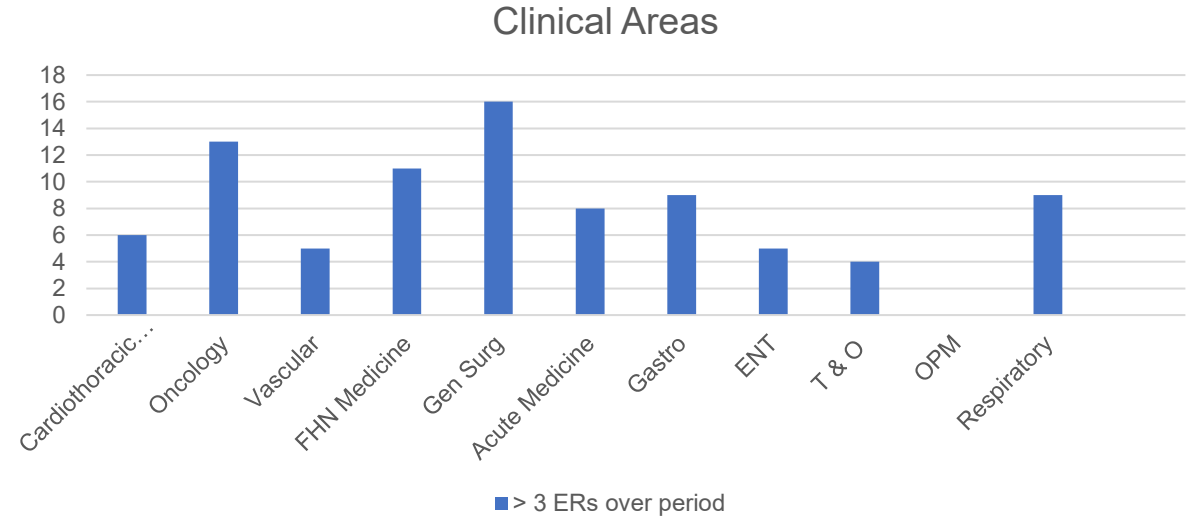
Appendix 1 to
STH GOSW
Dated May 2025

Summary of Exception Report Data









University Hospitals Tees

Nurse Safer Staffing Report - April 2025

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 17

Report author: Debi McKeown, Workforce Lead, Lindsay Garcia, Director of Nursing, South Tees, Emma Roberts, ADoN and Professional Workforce, Beth Swanson, Director of Nursing, North Tees

Executive director sponsor: *Emma Nunez, Group Chief Nurse*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *People Committee*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to

5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Failure to future proof an effective nursing workforce that anticipate shortages arising from sickness, maternity leave, planned retirements and shortfalls in all recruitment and retention plans including the forecast of a declining student nurse pipeline.

At South Tees, the ongoing development of the monthly workforce assurance meetings has provided an opportunity to explore new areas of rostering compliance and efficiencies such as an in depth look at unavailability reasons, particularly with a new focus on carers leave and study leave.

RN recruitment remains in a positive position. The existing fixed term contracts for newly qualified nurses has decreased to 10 with an ongoing plan for absorption. Those remaining are backfilling maternity leave.

The data collection and validation of the March 2025 SNCT report has been completed for presentation to Board in June 2025.

The participation in the NHSE Enhanced Care Collaborative will link strongly with the additional levels 1c and 1d within the SNCT and the Therapeutic care team and workforce lead will present this work at the regional launch in June 2025.

North Tees: HCSW vacancy is increasing month on month due to a limited number of applicants possessing the required qualification to take up the B3 posts, since the Trust moved this post from B2 to B3. This is impacting on the number of HCSW available to deliver planned nursing establishments.

There is the continued increasing reliance on the enhanced care team to provide 1:1 care to patients across several in-patient wards and departments. A review of the enhanced care service is currently underway with plans to move to cohort 3 of the NHSE Enhanced Therapeutic Observational Care (ETOC) model from Aug25.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

This report details nursing staffing levels for April 2025 for inpatient wards. The report provides assurance that arrangements are in place to provide a workforce with the right skills in the right place to provide safe, sustainable and productive staffing. Daily Safe Care Staffing meetings provide assurance that inpatient areas have been assessed, staffing levels reviewed, and staff deployed where necessary to mitigate risk to the lowest level.

This assessment is based on skill mix, patient acuity and dependency, and occupancy levels. All actions are agreed by the Safe Care Chair and escalated to Senior Nurses as

The average percentage of shifts filled against the planned nurse staffing across South Tees for April 25 has increased to 97.6%. This aligns with the reduction in sickness and turnover rates for April 25.

At North Tees the overall planned nurse fills for April 2025 are 98% which aligns with the current HCSW vacancy position and the increased need for enhanced care requirements particularly during the night. Because of this there remains a continued reliance on temporary staffing to safely staff in patient areas.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

At South Tees, registered nurse and midwives (all bands) turnover for April 25 has decreased slightly to 5.21% and HCSW turnover also decreased slightly to 7.88%.

North Tees and Hartlepool turnover for April 2025 has decreased in all roles with registered nursing turnover reducing to 5.15% and HCSW's 8.43%.

Recommendations:

Members of the Group Board are asked to: Note the content of this report and to note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout April 2025.

Group Board

3 July 2025

Nurse Safer Staffing Report

This exception report provides the Group Board with the monthly University Hospitals Tees nursing safer staffing position across all in patient areas. The report provides the People Committee with the assurance that arrangements are in place to staff services with the right skills in the right place to provide safe, sustainable and productive staffing.

1. Safer Staffing Governance

At University Hospitals Tees, Safer Staffing is maintained through twice daily safer staffing meetings (using SafeCare Live) to address any immediate safe staffing concerns (on the day) and to ensure that suitable safer staffing arrangements are in place in line with patient acuity and dependency levels. Staff redeployment is co-ordinated to ensure patient safety is prioritised and at the forefront of decision making in line with the agreed SOP's. All staffing plans are shared through OPEL meetings and SafeCare meetings.

Across the Group, all elements of safer staffing are reviewed at the site led workforce group meetings. Any unresolved concerns are escalated to the Tactical and Strategic Group and Site Leadership Team as required. Both sites undertake a look forward exercise to the week ahead, to ensure that a plan is in place to support any gaps in the nursing workforce. The monthly collaborative assurance meetings at both sites have full participation from all senior nurses including Heads of Nursing, Clinical Matrons and Service Managers to ensure all decision making is appropriate.

Monthly workforce assurance check and challenge meetings are now embedded in practice to ensure compliance with rostering and safer staffing key performance indicators.

Table 1a and Table 1b show overall planned versus actual fill across the group. Any areas showing less than 80% for registered nurses are highlighted and rationale provided as to why this has occurred.

- The following areas at South Tees, during April 2025 showed a fill rate of less than 80% due to ***patient acuity levels*** and ***staff sickness*****:**
- Days
- Ward 11 – Older Person's Medicine
- CICU – Cardio Intensive Care
- Zetland - Stroke Rehabilitation
- Maternity Centre – Friarage
- Nights
- CICU – Cardio Intensive Care
- CHDU – Cardio High Dependency
- Ward 24 HDU – Neurosurgery High Dependency
- al Ward
- cal Ward

- Maternity Centre – Friarage
- PCCU – Paediatric Critical Care
- The following areas had less than 80% fill due to a ***reduced elective programme*** during the period of reporting:

- Days and Nights
- Ward 22 – Paediatric Surgical Ward

In April 2025, the following areas at North Tees and Hartlepool showed a fill rate of less than 80%.

- Low RN fill on ward 26 due to vacancy and extended supernumerary of student nurses during this time.
- Low RN fill on ward 37 due to the phased closure of surge beds
- Low RN fill on ward 42 due to sickness and students in period of supernumerary.
- Ward 24 and 25 had an increased RN fill rate of 112-125%, due higher levels of SNCT level 2 patients with higher acuity, exceeding the planned capacity.
- ACU had an increased RN fill rate for night duty due to increased acuity and the need for RN 'twilight cover' which has now been approved within the care group.
- Ward 40 had an increased RN fill rate of 105% during nights to support the HCSW vacancies, these were agreed as backfill following daily safe staffing meetings.
- Low HCSW fill in SDU due to increased sickness levels and maternity leave.
- Low HCSW fill in elective care at night due to high acuity and redeployment of staff.
- Low HCSW fill on ward 28 and EAU due to increased vacancy.
- Wards ACU, 24, 25, 31, 32, 33, 36, 37, 40 and 42 had an increase in HCSW fill up to 110- 207% due to the increasing demands of enhanced care, particularly overnight.

All safe staffing concerns were escalated to the daily safer staffing meetings, where appropriate redeployment was carried out based on patient acuity and dependency.

Table 1a Trust Planned versus Actual fill – South Tees

		April 25
Overall Ward Fill Rate	RN/RMs (%) Average fill rate – DAYS	91.2%
	HCA (%) Average fill rate – DAYS	91.6%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	95.0%
	HCA (%) Average fill rate – NIGHTS	103.2%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**97.6%**

Table 1b Trust Planned versus Actual fill – North Tees and Hartlepool

		April 2025
Over all Ward Fill Rate	RN/RMs (%) Average fill rate – DAYS	88%

	HCSW (%) Average fill rate – DAYS	88%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	95%
	HCSW (%) Average fill rate – NIGHTS	109%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**98%**

2. Nurse Sensitive Indicators

An agreement is to be reached in relation to the future reporting content for Nurse sensitive indicators as part of the Group review.

At South Tees, staffing was not directly referenced in any concluded PSIRF reviews in April 2025.

No staffing factors were directly identified as part of any PSIRF review at North Tees and Hartlepool in April 2025.

3. Red Flags Raised through Safe Care Live

At South Tees, during April 2025, there were a total of 3 red flags raised relating to staffing. The themes identified were shortfall in RN time (1) less than 2 RN's on shift and Vital signs not assessed or recorded (1).

For red flags indicating less than 2 RN's, the Safe Care log provides a documented resolution. Therefore, no shifts had less than 2 RNs throughout April.

Reminders are sent weekly via the E-Rostering team to Clinical Matrons to review and close any resolved Red Flags.

At North Tees, we had a reduction in red flags raised relating to safe staffing during April 2025 to 5. Flags were raised by Critical Care, wards 32 and 40 in anticipation of, or confirmed 'Shortfall in RN time'. The staffing levels across all areas were reviewed at the twice daily safer staffing meetings following review of patient acuity and dependency in the areas at the time. There was one red flag raised for ward 36 in relation to missed intentional rounding due to high patient acuity, a reduction of enhanced care availability and limited security resource to support a high-risk patient.

As increased demand continues during April 2025, Ward Matrons are working clinically within teams to support safety if potential re-deployments of staff cannot be made. All red flags were closed were raised and discussed in the safe staffing meetings.

4. Datix/In-Phase Submissions

At South Tees during April 25, there were 31 Datix submissions relating to staffing. Staff are encouraged to Datix any staffing related issues as part of workforce assurance and governance. The majority of Datix submissions, highlights staff shortages in Ward 1 and Ward 4. All shortages raised were managed through the SafeCare process throughout April.

At North Tees, in April 2025 there was a reduction of in-phase reports relating to nurse staffing with 6 being submitted by the Care Groups. 5 reports were submitted due to the lack of HCSW's due to short term sickness or NHSP cancellations. AP's were redeployed where possible to mitigate gaps. 1 report was submitted by SDU due to increased activity during night duty in the ambulatory area.

All staffing concerns were appropriately escalated through Senior Clinical Matrons (CSMs) or Clinical Site Managers (CSM) at the time of the events and all In-Phase reports were discussed in the safer staffing meetings to ensure mitigation of any risk is in place.

The Nursing Workforce Team continues to work closely with the People Team and the temporary staffing providers (NHSP) to improve fill rates and maintain safe staffing.

5. Vacancy & Turnover

Across the group, the vacancy position continues to be positive. Both sites have been successful with recruitment and continue to evolve plans to support and future proof the nursing workforce. Paper to be submitted to SLT in relation to the September Newly qualified nurse cohort Collectively North and South Tees will work together to establish a central point for the collection of vacancy and retention related data.

As per the South Tees financial ledger, vacancies for April 2025, show as 4.72 WTE (RN and RM combined). The vacancy position as per the financial ledger indicates a vacancy of 121.41 WTE for HCSW's. Discrepancies exist between what is reported on the financial ledger and data extracted from e-roster. The development of a collaborative based recruitment initiative will go live June 2025.

At North Tees, the band 5 RN vacancy position remains positive across the in-patient wards and departments, for April 2025 it is 25.32wte, with forecasting to the end of June 2025 seeing this reduce to 10wte. Remaining vacancies will be filled by the next NQN cohort for September 2025. Forecasting to October 2025 supports the appointment of all students as considers natural turnover that will be accrued month on month.

At North Tees, the HCSW vacancy position across in-patient services is 45.66wte for April 2025, with a forecasted vacancy of by 33.52 wte by June 2025. Alternative proposals to manage these vacancies have been presented as part of the overall nursing workforce pipeline programme.

6. Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. This relates to the associated variance between the required care hours to safely care for patients and the actual care hours delivered by individual ward nursing workforce models. Table 2 and Table 3 show the overall average CHPPD for the group. Most recent breakdown by ward for April 2025 can be reviewed in Appendix 2.

Table 2 South Tees site

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
February 2025	9.09	8.80	-0.29
March 2025	9.11	9.16	+0.05
April 2025	9.17	9.76	+0.59

April 25 shows that 15 inpatient areas are above the required average of CHPPD provision (>1). Those that are below the required CHPPD are reflective of the current sickness and increased patient acuity. Twice daily safe care reviews plan and implement redeployment into unfilled shifts.

April 25 had an average sickness rate of 6.03 % (RN's, RM's and HCSW's combined) showing the number of staff off sick is decreasing and will aid in reducing the reliance on temporary staffing.

Due to the changing demands temporary staffing is variable, with a concerted effort made to redeploy before exploring NHSP.

A weekly look forward review and monthly Workforce Assurance meetings with each collaborative allows triangulation of data including sickness and turnover rates. The wards and departments with the largest NHSP spend relate to those areas that have been highlighted as requiring an adjustment in establishment in the biannual SNCT establishment reviews.

Table 3 North Tees site

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
February 2025	9.02	9.00	-0.02
March 2025	8.81	9.31	+0.50
April 2025	8.94	9.62	-0.67

In April 2025 the areas highlighting a higher variance level (>1) at North Tees, and thus, not delivering the required CHPPD were Respiratory, Gastroenterology, Elderly Care and Stroke wards. This is reflective of the increased acuity in Respiratory of the SNCT level 2 patients and of increased sickness and vacancy within the other departments.

All unfilled duties within rosters have been managed via the twice daily safer staffing meetings and suitable re-deployment to the areas made. The use of temporary nurse staffing continues at North Tees due to sickness levels that exceed 4% (allocated within headroom) and maternity leave that is not backfilled consistently. A full review of all wards and departments temporary staffing use, with full triangulation with sickness and turnover is reported as part of the bi-annual nurse establishment review.

Work continues with the Business Intelligence team to develop a nursing and midwifery workforce matrix to support the monthly triangulation of workforce metrics, patient quality and [illegible]ofessional judgement to ensure oversight of patient needs and the [illegible]ce.

7. Nurse Recruitment and Retention

South Tees currently has 10 newly qualified nurses on fixed term contracts. Stringent measures are in place at the weekly vacancy control panel to ensure priority placement. The over recruitment of nurses now will increase workforce resilience of the future with the known reduction of newly qualified nurses qualifying in 2027/28.

Currently North Tees is not in an over recruited RN position which will create an increasing vacancy position month on month as natural turnover occurs. This turnover will support the recruitment of the next cohort of NQN in September 2025. Recruitment centres are scheduled bi-monthly where successful candidates are currently being pooled to await a vacancy. If successful candidates sit in a pool too long there is a risk that they will withdraw and move to another Trust.

Safer Staffing workforce initiatives continue to be implemented. At both sites the monthly nursing workforce assurance meetings / Professional Workforce Assurance Council (PWAC) provide a platform to fully explore all recruitment and retention issues as well as highlighting best practice for safe and effective rostering.

8. Temporary Staffing

At South Tees, bank and agency demand for April 25 has decreased by 27% compared to April 24. Bank filled hours have also decreased by 18% when compared to April 24.

Nursing agency use continues to be minimal at South Tees. April 25 showed there was 517.33 hours of nursing agency across theatres. This is 896.31 hours less than April 24.

Bank spends decreased by £236,267.80 when compared to April 24. Agency spend decreased by £34,052.61 when compared to April 24.

The overall fill rate for bank and agency in April 25 was 88.8%. This has increased by 9.4% compared to the same period last year. The reduction in demand year on year provides a more reliable reflection of the requirements of the wards and therefore a more accurate fill rate.

At North Tees:

Agency spend YTD is £329k lower than previous year

- Agency spend is now lower than in any month last year.
- Mar-25 was high due to Cell Path outsourcing (now coded to non-pay), though some insourcing remains

Bank spend YTD is £121k higher than previous year

- At Apr-24 we were yet to see the swap from Agency to Bank
- M1 £998k is lower than most months of last year, suggesting we are back to a more normal level after the increase in Feb and Mar due to annual leave and supernumerary status

Locum spend YTD is £15k lower than previous year

- M1 spend is in line with the average from 24/25

Overtime spend YTD is £44k lower than previous year

- M1 spend is around £5k lower than the average from 24/25

9. Key Priorities

At North Tees the current key priorities are as follows:

- Continued monitoring of temporary staffing, over time use, sickness/absence & turnover
- SNCT data analysis for adult ED and adult in-patient areas.
- Bi-annual nurse establishment review to be presented to Board in July 2025
- Nursing workforce pipeline programme BC being discussed at SLT throughout Jun25
- Development of the nursing workforce matrix detailed in section 6 of this report – to move this work forward following recent delays
- Professional workforce strategy development using a Group approach
- NMAHP strategy development using a Group approach
- Enhanced Care service evaluation

At South Tees the current key priorities are as follows:

- Continuation of monthly collaborative assurance rounds to review all staffing issues with the inclusion of reporting on use if carers leave and study leave
- Paper to SLT in June 2025 for newly qualified nurse cohort including SNA's and RNDA's for September 2025
- Centralised recruitment of collaborative based Care Support Workers to commence June 2025
- Completion of SNCT report for submission June 2025
- Further review of workforce assurance dashboard in collaboration with CIP and BIU
- Further development of the Group Developing Workforce Safeguards portfolio and aligned policies

10. RECOMMENDATIONS

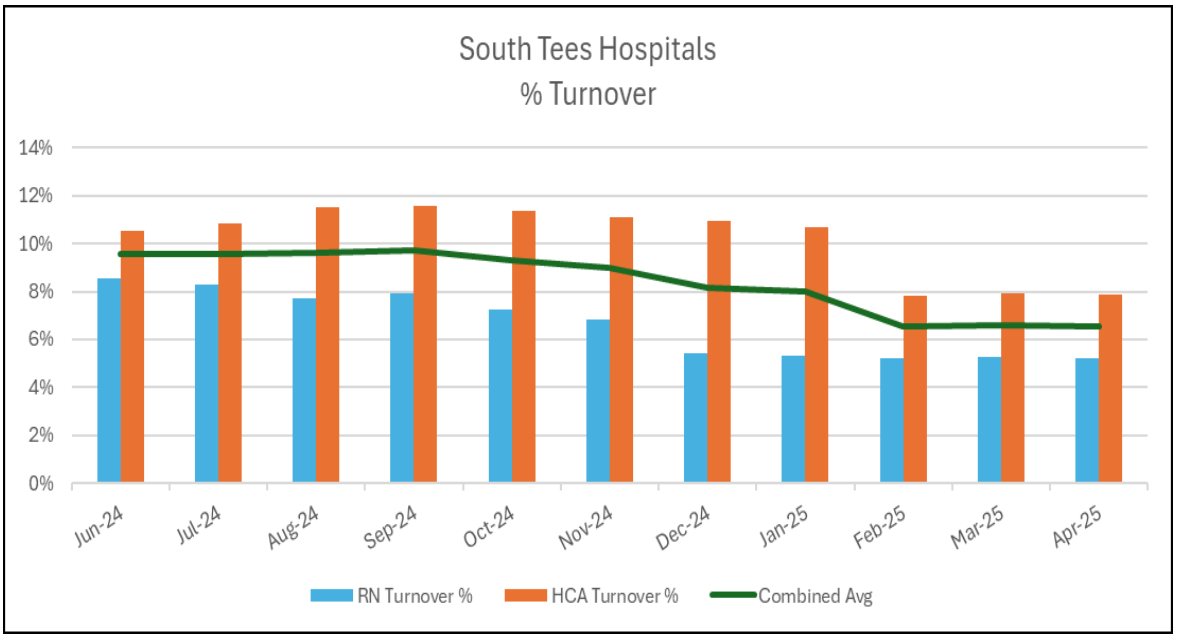
The Board is asked to read the content of this report and to note the progress made across both sites in relation to developing and retaining the nursing workforce.

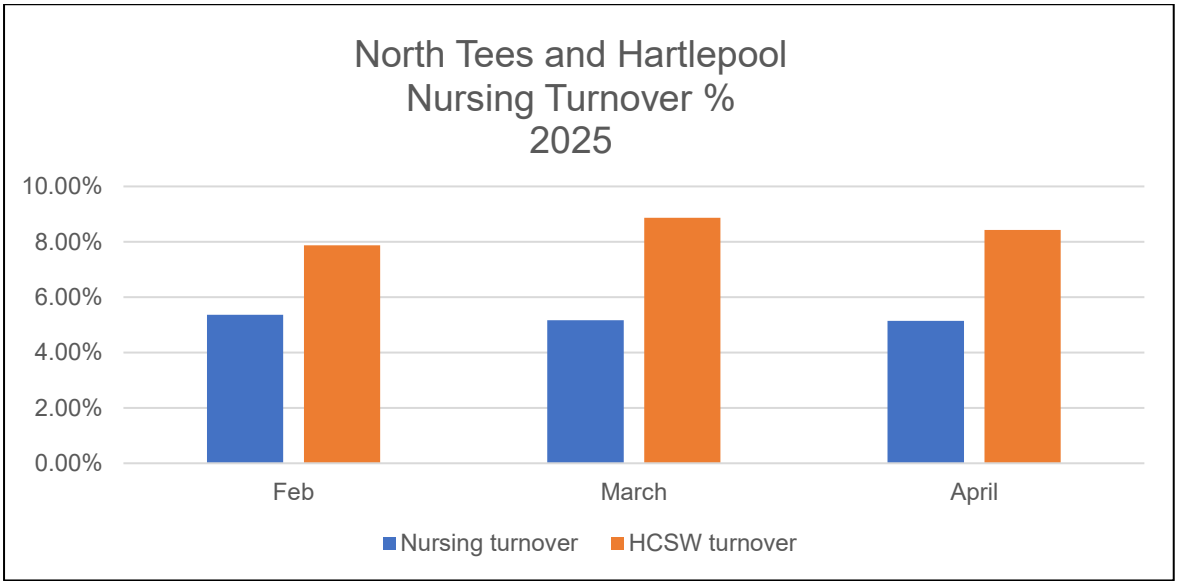
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

The Board are asked to acknowledge the development of this report in the coming months to ensure that the two current reporting methods across both site teams continue to align. This will provide the continued assurance that arrangements are in place to staff services with the right skills in in the right place to provide safe, sustainable and productive staffing

Appendix 1

Nursing Turnover





Appendix 2

HPPD Breakdown by Ward (March 2025):

Caring Better Together

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ward 1	9.10	8.54	-0.55
Ward 31	7.24	5.91	-1.33
Ward 2	10.66	8.55	-2.10
Ward 3	10.83	15.15	4.32
Ward 4	6.10	7.87	1.77
Ward 5	15.22	11.19	-4.03
Ward 6	8.44	7.49	-0.95
Ward 7	22.73	29.63	6.90
Ward 8	17.15	23.89	6.74
Ward 9	8.07	7.52	-0.55
Ward 10	6.50	14.43	7.93
Ward 11	8.69	6.60	-2.09
Ward 12	8.95	4.08	-4.87
Ward 14	6.35	5.34	-1.01
Ward 24	8.71	8.56	-0.15
Ward 25	12.35	11.12	-1.23
Ward 26	7.64	8.13	0.49
Ward 27	11.16	26.61	15.45
Ward 28	10.29	8.00	-2.29
Ward 29	8.86	6.16	-2.70
Cardio MB	5.38	5.40	0.02
Ward 32	6.41	6.86	0.45
Ward 33	9.33	9.36	0.03
Ward 34	7.26	6.10	-1.16
Ward 35	6.77	6.07	-0.70
Ward 36	12.30	12.84	0.54
Ward 37 - AMU	8.41	6.60	-1.81
Spinal Injuries	16.02	23.38	7.36
CCU	6.71	6.21	-0.50
Critical Care	7.98	7.09	-0.90

CICU JCUH	5.30	4.85	-0.44
Cardio HDU	9.57	6.80	-2.77
Ward 24 HDU	8.08	6.47	-1.61
CDU FHN	6.52	6.35	-0.17
Ainderby FHN	9.37	6.52	-2.84
Romanby FHN	6.54	5.12	-1.43
Gara FHN	10.36	8.39	-1.97
Rutson FHN	8.09	9.76	1.67
Friary	8.67	5.85	-2.82
Zetland Ward	9.51	6.56	-2.95
Tocketts Ward	8.62	6.68	-1.94
Ward 21	5.33	5.06	-0.27
Ward 22	5.92	5.08	-0.84
Neonatal Unit (NNU)	6.08	5.60	-0.48
Paediatric Critical Care (PCCU)	9.55	7.31	-2.24
Grand Total (Average)	**9.11**	**9.16**	**0.05**

North Tees Site - CHPPD by ward for April 2025

Unit Previous month	Required CHPPD	Actual CHPPD	CHPPD Variance
Acute Cardiology Unit	7.02	5.95	1.06
Critical Care North Tees	21.01	27.16	-6.16
Elective Care Unit	6.45	18.13	-11.68
Emergency AMB	7.24	9.77	-2.53
Neonatal Unit	10.93	22.72	-11.79
Paediatrics	10.03	10.81	-0.78
SDU	10.38	10.33	0.05
Ward 24 (Respiratory)	8.95	7.30	1.65
Ward 24 RSU (Respiratory)	13.54	10.55	2.98
Ward 25 (Respiratory)	8.94	6.49	2.45
Ward 25 RSU (Respiratory)	11.90	10.46	1.44
[redacted]ogy)	7.21	5.33	1.88

Ward 27 (Gastroenterology)	6.97	6.12	0.85
Ward 28 (Surgery)	6.24	6.25	-0.02
Ward 31 (Surgical Observation Unit)	8.60	8.72	-0.13
Ward 32 (Fragility Fracture)	7.96	7.00	0.96
Ward 33 (Orthopaedic & Spinal)	6.62	6.38	0.24
Ward 36	8.66	6.98	1.67
Ward 37	6.04	8.82	-2.78
Ward 38	6.45	5.50	0.95
Ward 40 (Acute Elderly)	8.85	7.04	1.81
Ward 41 (Stroke Unit)	7.84	6.39	1.45
Ward 42 (Elderly Rehabilitation)	7.89	6.95	0.95
Average	**8.94**	**9.62**	-0.67

Resources Committee

28 May 2025
Connecting to: Group Board

Key topics discussed in the meeting:

Finance Position
The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.5m ICS deficit support for STH).
The financial position for Month 1 2025/26 is a deficit of £3.1m for the Group, which is an adverse variance of £0.6m against the year-to-date plan.
NHSE have advised of changes to the deficit support regime for 2025/26, with regional assurance of plan delivery required to prevent funding being withheld. NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

Corporate reductions
The Committee received a report regarding the additional 2025/26 planning requirement on providers to put in place plans to reduce the growth in Corporate costs by 50%. This required a Board approved submission by the 30th May which required the submission of a plan to meet the NHSE target to reduce growth in Corporate Costs since 2018/19 by 50%. The Committee discussed the benchmarking data and the issues and anomalies which were identified and approved the submission of the completed ‘comply or explain’ template, including the proposed exceptions to the reduction target.

WTE
Month 1 shows a net overall decrease of 199.04 WTE worked across the Group, compared to the previous month. WTEs worked in month are 27.83 WTE higher than the average of the previous financial year and are 2,568.01 WTE (19.9%) higher than the average deployed during 2019/20 (pre-Covid).

The committee received a presentation on the non-clinical WTE reduction plan and agreed to receive a deep dive looking at the whole programme of WTE at its next meeting.

Digital

Working with an external partner, an indicative plan for the EPR Business Case has been

produced. An EPR Programme Board is being established which will be jointly chaired by Mike Stuart and Emma Nunez.

Plans to 'flatten' the network architecture across UHT are still on schedule for go-live date on 21 May 2025. In practice, this means users will be provided with seamless connectivity to clinical systems and file share on either site. Users should also experience faster performance when connecting to systems.

Productivity
A number of reports on productivity were received which identified that across UHT, further improvement in productivity is required to meet agreed activity and performance plans within the available resources. Lower quartile performance in some metrics identifies where improvements are needed and where there are opportunities to learn.

IPR
The committee were alerted to a number of metrics which it considered including for NTHFT, the 4-hour A&E standard this reflects that performance did not meet the agreed plan, however it was upper quartile nationally and achieved the national recovery target and one metric has been regraded to 'Alert', from Advise which is the 12-Hour A&E Breaches increased between September 2024 and March 2025. However, the 2% standard was met in March 2025 and performance is in upper quartile nationally. Performance is expected to improve from April as the combination of winter demand pressures, IPC and estates constraints has subsided.

For STHFT, two performance metrics remain as 'Alert' assurance which were Cancelled Operations Not Rebooked in 28 Days and RTT Incomplete Pathways.

Actions:

- Further work needed on whole time equivalent – deep dive

Outstanding from last period

- Terms of reference updates
- Vice Chair of Committee needs to be appointed
- Review of externally funded posts – is funded still in place for entire 25/26 and plan to remove costs if not
- Review of business cases – are we seeing benefits – if not what is the plan to remove the additional roles
- Definition of cost saving / cost avoidance

Escalated items:

- WTE – further assurance required
- Corporate reductions signed off on behalf of the Board for submission to NHSE

Risks (Include ID if currently on risk register):

- No new Risks identified

Resources Committee

25 June 2025
Connecting to: Group Board

Key topics discussed in the meeting:

Finance Position

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH. This includes non-recurrent deficit support provided by NHSE to systems with an agreed deficit plan, to deliver break-even for the 2025/26 financial year. NENC ICB received an allocation of £33.3m (reduced from £49.9m in 2024/25), which has been allocated to deficit trusts including an allocation of £11.5m for STH. The planned deficit excluding non-recurrent deficit support funding is £20.6m.

At the end of Month 2 2025/26 the Group is reporting an adverse variance of £0.57m with a variance of £318k relating to NTH and £256k relating to STH).

WTE

The committee had a deep dive discussion on the following areas

- Agency and Bank staff
- CMO scheme
- Reduction in non clinical WTE
- Voluntary severance scheme
- Sickness reduction
- Closure of STH day Nursery

Important to note that month 2 shows first decrease in WTE, with a net overall decrease of 99.41 WTE worked across the Group, compared to the previous month, with an increase in WTE worked by substantive staff offset with reductions in both Bank and Agency. WTEs worked in month were 71.57 WTE lower than the average of the previous financial year. However, this remains 2,468.60 WTE (19.1%) higher than the average deployed during 2019/20 (pre-Covid).

Committee highlighted concerns with the continued increase in WTE at the North Tees LLP – this needs further investigation and action to address.

The committee had robust presentations and discussions on all of these areas focusing on the actions needed to deliver the targets. CMO schemes remain an area of concern with little assurance that the correct actions have been identified or where they have that they can be deliver against (job planning for example)

The committee challenged the 1% reduction in sickness with concern that this wasn't ambitious enough, this requires further discussion at board level

National Cost Collection
The committee was provided with a pre submission report which was approved, and CFO was given delegated authority to submit as per timeframes

Actions:

- Further work needed on whole time equivalent – actions to be agreed
- LLP WTE increase investigation and action
- CMO WTE
- Ambition on sickness target and budgeting

Outstanding from last period

- Terms of reference updates
- Vice Chair of Committee needs to be appointed
- Review of externally funded posts – is funded still in place for entire 25/26 and plan to remove costs if not
- Review of business cases – are we seeing benefits – if not what is the plan to remove the additional roles
- Definition of cost saving / cost avoidance

Escalated items:

- Strive Options Paper to be considered by Board
- Voluntary severance scheme – emerging risk associated with treasury approval
- WTE
    - Concern on action and Timelines associated with the CMO – job planning not in line with Targets and actions unclear.
    - Committee not assured around actions / timelines that would be consistent with in year savings as anticipated.

Risks (Include ID if currently on risk register):

- No new Risks identified

Caring
Better
Together

Month 2 2025-26 Finance Report

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: *19*

Report author: *Chris Hand, Group Chief Finance Officer*

Executive director sponsor: *Chris Hand, Group Chief Finance Officer*

Action required: *Assurance*

Delegation status: *Jointly delegated item to Group Board*

Previously presented to: *Group Resources Committee*

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to the Board Assurance Framework Finance domain

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.5m ICS deficit support for STH).

The financial position for Month 2 2025/26 is a deficit of £3.2m for the Group, which is an adverse variance of £0.6m against the year-to-date plan.

NHSE have advised of changes to the deficit support regime for 2025/26, with regional assurance of plan-delivery required to prevent funding being withheld. NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

The plans for the Group include a number of risks and assumptions, which will need to be closely monitored over the course of the financial year through the Resources Committee.

Month 2 shows a net overall decrease of 99.41 WTE worked across the Group, compared to the previous month. WTEs worked in month are 71.57 WTE less than the average of the previous financial year; however this is 2,468.60 WTE (19.1%) higher than the average deployed during 2019/20 (pre-Covid).

Positive progress has been made in the development and de-risking of the CIP programme since plan submission. However, at the end of the reporting period £6.4m of the CIP programme remains defined as Opportunity. Over £26m of the programme remains as High Risk. Across the Group, overall year-to-date CIP delivery is £8.9m (85% of target).

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The Resources Committee will receive monthly assurance reports on the financial performance throughout the year.

External assurance on the year-end financial position is received from the Group's external auditors.

Recommendations:

Members of the Group Board are asked to:

- Note the financial position for Month 2 2025/26.

Group Board
3 July 2025

Month 2 2024/25 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 2 of 2024/25.

2. BACKGROUND

For 2025/26, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single Integrated Care System (ICS). Both North Tees and Hartlepool NHS Foundation Trust (NTH) and South Tees Hospitals NHS Foundation Trust (STH) and are aligned to the North Cumbria (NENC) Integrated Care System (ICS).

The Group financial plans for NTH and STH for the 2025/26 financial year are consistent with the overall ICS plan re-submission on 30th April. The Trust's plans were developed based on a number of assumptions, which were reviewed throughout the planning period by the executive team, Resources Committees and meetings of the Trust Board.

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH.

This includes non-recurrent deficit support provided by NHSE to systems with an agreed deficit plan, to deliver break-even for the 2025/26 financial year. NENC ICB received an allocation of £33.3m (reduced from £49.9m in 2024/25), which has been allocated to deficit trusts including an allocation of £11.5m for STH. The planned deficit excluding non-recurrent deficit support funding is £20.6m.

NTH and STH are required to plan and report to NHSE on a consolidated group basis, including the financial position of each of the trust's subsidiary companies. The financial performance in this report therefore includes the consolidated positions of Optimus Health Ltd and North Tees & Hartlepool Solutions LLP for NTH and South Tees Healthcare Management Ltd for STH.

The plans for the Group include a number of risks and assumptions, that will need to be closely monitored and mitigated over the course of the financial year through the Resources Committee.

3. MONTH 2 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 2 2025/26, shown by trust:

	NTH			STH			GROUP		
STATEMENT OF COMPREHENSIVE INCOME	**Plan £000**	**Actual £000**	**Variance £000**	**Plan £000**	**Actual £000**	**Variance £000**	**Plan £000**	**Actual £000**	**Variance £000**
Operating income from patient care activities	70,560	71,156	596	155,938	156,079	141	**226,498**	**227,235**	**737**
Other operating income	5,772	6,175	403	11,609	8,853	(2,756)	**17,381**	**15,028**	**(2,353)**
Employee expenses	(51,178)	(52,813)	(1,635)	(100,742)	(99,886)	856	**(151,920)**	**(152,699)**	**(779)**
Operating expenses excluding employee expenses	(24,266)	(25,192)	(926)	(64,216)	(65,010)	(794)	**(88,482)**	**(90,202)**	**(1,720)**
OPERATING SURPLUS/(DEFICIT)	**888**	**(674)**	**(1,562)**	**2,589**	**37**	**(2,552)**	**3,477**	**(637)**	**(4,114)**
FINANCE COSTS									
Finance income	376	696	320	502	678	176	**878**	**1,374**	**496**
Finance expense	(116)	(91)	25	(3,606)	(3,605)	1	**(3,722)**	**(3,696)**	**26**
PDC dividends payable/refundable	(534)	(534)	0	0		0	**(534)**	**(534)**	**0**
NET FINANCE COSTS	**(274)**	**71**	**345**	**(3,104)**	**(2,927)**	**177**	**(3,378)**	**(2,856)**	**522**
Other gains/(losses) including disposal of assets	0	830	830	0	1	1	**0**	**831**	**831**
Corporation tax expense	(16)	(6)	10	(2)		2	**(18)**	**(6)**	**12**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**598**	**221**	**(377)**	**(517)**	**(2,889)**	**(2,372)**	**81**	**(2,668)**	**(2,749)**
Add back all I&E impairments/(reversals)	0	59	59	0	0	0	**0**	**59**	**59**
Remove capital donations/grants I&E impact	0	0	0	(1,276)	840	2,116	**(1,276)**	**840**	**2,116**
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0		0	**0**	**0**	**0**
Remove PFI revenue costs on an IFRS 16 basis	0	0	0	10,757	10,372	(385)	**10,757**	**10,372**	**(385)**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(12,175)	(11,790)	385	**(12,175)**	**(11,790)**	**385**
Adjusted financial performance surplus/(deficit)	**598**	**280**	**(318)**	**(3,211)**	**(3,467)**	**(256)**	**(2,613)**	**(3,187)**	**(574)**
Less Non-Recurrent Deficit Funding	0		0	(1,926)	(1,926)	0	**(1,926)**	**(1,926)**	**0**
Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding	**598**	**280**	**(318)**	**(5,137)**	**(5,393)**	**(256)**	**(4,539)**	**(5,113)**	**(574)**

At the end of Month 2 2025/26 the Group is reporting an adverse variance of £0.57m (with a variance of £318k relating to NTH and £256k relating to STH).

The main drivers of the **NTH Month 2 position** are:

- Clinical Income is ahead of plan by £0.6m, mostly relating to elective income.
- Other operating income (excluding donated asset income) is £0.4m ahead of plan, mainly relating to education assumed income.
- Interest receivable is ahead of plan by £0.3m, reflecting current interest rates and cash balances.
- Gain on disposal of £0.8m.
- Non-Pay is behind plan of £0.9m due to increases in supplies and services, and drugs linked to higher activity levels, alongside slippage on CIP delivery.
- Pay is £1.6m behind plan due to increased demand for Enhanced Care, weekend working linked to activity and slippage on CIP delivery.
- The position includes slippage on delivery of CIP savings £0.7m.

The main drivers of the **STH Month 2 position** are:

- Clinical Income is slightly ahead of plan by £0.1m, with draft ERF delivery in line with the 2025//26 activity plan.
- The Other operating income variance mainly relates to the Salix grant income which is removed from the Trusts reported control total position.
- Pay is £0.9m underspent and relates to an underspend on bank staff of £0.4m and substantive staff of £0.7m, part offset by an adverse variance on agency expenditure.
- Non-Pay overspends on medical and surgical equipment and drugs amount to £0.8m and includes non-delivery of CIP.
- Interest receivable is ahead of plan by £0.2m, reflecting higher than plan cash balances.
- The position includes undelivered CIP of £1.0m.

Agency and Bank Expenditure

Reductions in temporary staffing and premium pay costs are a national priority set by NHSE.

The 2025/26 planning guidance included requirements to reduce agency spend by at least 30% from the prior year and to reduce bank spend by at least 10%.

The tables below show the position on agency and bank expenditure for the Group to the end of Month 2, comparing the year-to-date expenditure with the same period in the previous financial year (adjusted for inflation).

Across the Group, **YTD agency** expenditure was £1,207k. This was £343k higher than plan, largely relating to Consultant agency which was £211k over at STH and at £156k over at NTH.

However, total agency expenditure was £573k (32%) less than the agency expenditure incurred at the same point in the previous year (adjusted for inflation).

Across the Group, **YTD bank** expenditure was £4.8m. This was £195k less than plan, largely relating to Nursing Bank at STH which was under by £234k.

Total bank expenditure was £589k (11%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	146	25	-121	607	-582	-96%
AHP and S&T	51	97	46	43	54	128%
Other Clinical	0	0	0	0	0	-
Consultants	157	313	156	376	-63	-17%
Career/staff grades	0	0	0	13	-13	-100%
Trainee grades	0	10	10	0	10	-
Non Clinical	0	4	4	17	-13	-77%
TOTAL	**354**	**449**	**95**	**1,056**	**-607**	**-57%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	803	844	41	819	25	3%
AHP and S&T	109	99	-10	116	-17	-15%
Other Clinical	792	985	193	815	170	21%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	128	103	-25	145	-42	-29%
TOTAL	**1,832**	**2,031**	**199**	**1,895**	**136**	**7%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	32	20	-12	50	-30	-60%
AHP and S&T	38	68	30	142	-74	-52%
Other Clinical	6	0	-6	0	0	-
Consultants	425	636	211	531	105	20%
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	9	34	25	1	33	2335%
TOTAL	**510**	**758**	**248**	**725**	**33**	**5%**

BANK YTD	STH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,479	1,245	-234	1,628	-383	-24%
AHP and S&T	35	23	-12	20	3	18%
Other Clinical	1,257	1,141	-116	1,485	-344	-23%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	282	263	-19	226	37	16%
Non Clinical	145	132	-13	171	-39	-23%
TOTAL	**3,198**	**2,804**	**-394**	**3,530**	**-726**	**-21%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	178	45	-133	657	-612	-93%
AHP and S&T	89	165	76	185	-20	-11%
Other Clinical	6	0	-6	0	0	-
Consultants	582	949	367	906	43	5%
Career/staff grades	0	0	0	13	-13	-100%
Trainee grades	0	10	10	0	10	-
Non Clinical	9	38	29	19	19	102%
TOTAL	**864**	**1,207**	**343**	**1,780**	**-573**	**-32%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	2,282	2,089	-193	2,447	-358	-15%
AHP and S&T	144	122	-22	135	-13	-10%
Other Clinical	2,049	2,126	77	2,300	-174	-8%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	282	263	-19	226	37	16%
Non Clinical	273	235	-38	316	-81	-26%
TOTAL	**5,030**	**4,835**	**-195**	**5,424**	**-589**	**-11%**

Workforce

Growth in workforce remains an area of significant national and regional scrutiny, linked to the reductions in productivity and growth in non-clinical roles that has been noted across the NHS.

The table below shows the WTE actual worked in Month 2 (split between Substantive, Bank, and Agency staff) compared to each of:

- the average monthly WTE worked in 2019/20 (the pre-Covid baseline),
- the average monthly WTE worked in 2023/24,
- the average monthly WTE worked in 2024/25 (the previous financial year); and
- the previous month.
- the same month in the previous financial year

WTE worked data has been used (taken directly from the General Ledger), to ensure consistency between different reporting periods and to provide the best correlation to the actual pay costs incurred.

WTE Worked	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	Mth 1 25/26	Mth 2 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from M2 24/25
	NTH									
Agency	20.38	63.89	35.17	15.19	18.59	3.40	-1.79	-45.30	-16.58	-33.67
Bank	186.45	234.11	247.00	235.92	249.09	13.17	62.64	14.98	2.09	21.57
Substantive	4,659.47	5,130.23	5,325.94	5,321.47	5,288.04	-33.43	628.57	157.81	-37.90	0.33
Sub Total	**4,866.30**	**5,428.23**	**5,608.11**	**5,572.58**	**5,555.72**	**-16.86**	**689.42**	**127.49**	**-52.39**	**-11.77**
	STH									
Agency	25.51	34.62	18.73	15.35	13.82	-1.53	-11.69	-20.80	-4.91	-7.71
Bank	198.01	393.05	347.40	280.34	278.92	-1.42	80.91	-114.13	-68.48	-125.80
Substantive	7,836.68	9,235.07	9,492.43	9,626.24	9,546.64	-79.60	1,709.96	311.57	54.21	90.59
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,921.93**	**9,839.38**	**-82.55**	**1,779.18**	**176.64**	**-19.18**	**-42.92**
	UHT GROUP									
Agency	45.89	98.51	53.90	30.54	32.41	1.87	-13.48	-66.10	-21.49	-41.38
Bank	384.46	627.16	594.40	516.26	528.01	11.75	143.55	-99.14	-66.39	-104.23
Substantive	12,496.15	14,365.30	14,818.37	14,947.71	14,834.68	-113.03	2,338.53	469.38	16.31	90.92
Grand Total	**12,926.50**	**15,090.97**	**15,466.68**	**15,494.51**	**15,395.10**	**-99.41**	**2,468.60**	**304.13**	**-71.57**	**-54.69**

Month 2 shows a net overall decrease of 99.41 WTE worked across the Group, compared to the previous month, with an increase in WTE worked by substantive staff offset with reductions in both Bank and Agency.

WTEs worked in month were 71.57 WTE lower than the average of the previous financial year. However, this remains 2,468.60 WTE (19.1%) higher than the average deployed during 2019/20 (pre-Covid).

The table below provides an analysis of WTE worked data split by staff grouping:

WTE Worked	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	Mth 1 25/26	Mth 2 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from 24/25 avg
	NTH									
Nursing & Midwifery	1,381.12	1,607.51	1,682.30	1,707.14	1,700.56	-6.58	319.44	93.05	18.26	20.45
Medical & Dental	535.14	555.47	585.95	604.00	599.78	-4.22	64.64	44.31	13.83	22.39
AHP, Sci., Ther.&Tech.	540.32	588.28	603.99	567.81	558.28	-9.53	17.96	-30.00	-45.71	-40.43
HCAs & Support Staff	949.52	1,051.64	1,050.01	1,014.26	1,030.79	16.53	81.27	-20.85	-19.22	-7.09
Non Clinical	1,460.20	1,625.34	1,685.87	1,679.37	1,666.31	-13.06	206.11	40.97	-19.56	-7.09
Sub Total	**4,866.30**	**5,428.24**	**5,608.11**	**5,572.58**	**5,555.72**	**-16.86**	**689.42**	**127.48**	**-52.39**	**-11.77**
	STH									
Nursing & Midwifery	2,506.06	2,958.13	3,095.50	3,136.66	3,143.74	7.08	637.68	185.61	48.24	36.05
Medical & Dental	1,242.76	1,318.94	1,376.28	1,408.50	1,390.04	-18.46	147.28	71.10	13.76	38.11
AHP, Sci., Ther.&Tech.	1,225.20	1,484.76	1,570.58	1,572.08	1,574.76	2.68	349.56	90.00	4.18	21.58
HCAs & Support Staff	1,424.35	1,755.65	1,672.69	1,642.25	1,610.20	-32.05	185.85	-145.45	-62.49	-113.75
Non Clinical	1,661.83	2,145.27	2,143.50	2,162.44	2,120.64	-41.80	458.81	-24.63	-22.86	-24.91
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,921.93**	**9,839.38**	**-82.55**	**1,779.18**	**176.64**	**-19.18**	**-42.92**
	UHT GROUP									
Nursing & Midwifery	3,887.18	4,565.64	4,777.80	4,843.80	4,844.30	0.50	957.13	278.66	66.50	56.50
Medical & Dental	1,777.90	1,874.41	1,962.23	2,012.50	1,989.82	-22.68	211.92	115.41	27.59	60.50
AHP, Sci., Ther.&Tech.	1,765.52	2,073.04	2,174.57	2,139.89	2,133.04	-6.85	367.52	60.00	-41.53	-18.85
HCAs & Support Staff	2,373.87	2,807.29	2,722.71	2,656.51	2,640.99	-15.52	267.12	-166.30	-81.71	-120.84
Non Clinical	3,122.03	3,770.61	3,829.37	3,841.81	3,786.95	-54.86	664.92	16.34	-42.42	-32.00
Sub Total	**12,926.50**	**15,090.98**	**15,466.68**	**15,494.51**	**15,395.10**	**-99.41**	**2,468.60**	**304.12**	**-71.57**	**-54.69**

Efficiency

The plan assumes delivery of an overall efficiency target for the Group of £73.1m. The table below shows the current planning position against the target:

	NTH				STH				GROUP			
2025/26 Total Plan	Plan £000	Forecast £000	(Gap) / Surplus £000	% Delivery	Plan £000	Forecast £000	(Gap) / Surplus £000	% Delivery	Plan £000	Forecast £000	(Gap) / Surplus £000	% Delivery
Fully Developed	8,756	16,541	7,785	189%	2,187	12,338	10,151	564%	10,943	28,879	17,936	264%
Plans in Progress	2,961	5,181	2,220	175%	42,070	32,652	-9,418	78%	45,031	37,833	-7,198	84%
Opportunity	4,839	2,850	-1,989	59%	4,241	3,508	-733	83%	9,080	6,358	-2,722	70%
Unidentified	8,017	0	-8,017	0%	0	0	0	-	8,017	0	-8,017	0%
Total	**24,573**	**24,572**	**-1**	**100%**	**48,498**	**48,498**	**0**	**100%**	**73,071**	**73,070**	**-1**	**100%**
High Risk	12,860	5,161	-7,699	40%	24,305	21,383	-2,922	88%	37,165	26,544	-10,621	71%
Medium risk	2,426	4,289	1,863	177%	13,401	13,389	-12	100%	15,827	17,678	1,851	112%
Low Risk	9,287	15,123	5,836	163%	10,791	13,726	2,935	127%	20,078	28,849	8,771	144%
Total	**24,573**	**24,573**	**0**	**100%**	**48,498**	**48,498**	**0**	**100%**	**73,071**	**73,071**	**0**	**100%**

Since Final Plan submission in March there has been positive movement in development of schemes and de-risking of the programme, as schemes are progressed to completion of full PID and QEIA documentation. At the end of the reporting period none of the CIP programme remains Unidentified, however £6.4m remains defined as Opportunity. Over £26m of the programme remains as High Risk (which is a reduction of £10.6m since plan submission).

Progression of all schemes to full PID completion must be a priority to ensure continued de-risking of the programme and to maximise in year delivery. This will be a key are of focus for the Financial Recovery Oversight Group and trust CIP meetings.

The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 2 Delivery	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**
Pay	2,435	1,063	-1,372	44%	1,964	1,221	-743	62%	4,399	2,284	-2,115	52%
Non Pay	1,270	950	-320	75%	3,891	3,921	30	101%	5,161	4,871	-290	94%
Income	227	1,262	1,035	556%	757	506	-251	67%	984	1,768	784	180%
Total	**3,932**	**3,275**	**-657**	**83%**	**6,612**	**5,648**	**-964**	**85%**	**10,544**	**8,923**	**-1,621**	**85%**
Recurrent	2,244	1,471	-773	66%	4,860	2,410	-2,450	50%	7,104	3,881	-3,223	55%
Non-recurrent	1,688	1,805	117	107%	1,752	3,238	1,486	185%	3,440	5,043	1,603	147%
Total	**3,932**	**3,276**	**-656**	**83%**	**6,612**	**5,648**	**-964**	**85%**	**10,544**	**8,924**	**-1,620**	**85%**

Across the Group, overall year-to-date delivery is £8.9m (85% of target). However, delivery of recurrent savings is behind plan at the end of Month 2, and constitutes 43% of YTD delivery.

Work continues through the Site leadership teams to identify and deliver efficiency savings to meet the targets, with escalation meetings held with Care Groups and Collaboratives, and oversight from the UHT FROG meeting, chaired by the Managing Director.

Capital

The Group's gross capital expenditure plan for the 2025/26 financial year totals £66.8m.

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2025/26 amounts to £37.8m, including ICS approved Constitutional Standards/Estates Safety schemes (that are funded through additional national PDC). For the 2025/26 financial year there are no separate CDEL allocations for IFRS16 right of use assets, and this capital expenditure must be managed within overall system allocations.

The capital programme also includes external support, in the form of Public Dividend Capital (PDC) of £6.5m, including support for RAAC eradication work and replacement of Linacs. The plan includes further de-carbonisation works, which is supported with further Salix grant funding of £13.9m across the Group. The plan also includes

expected PFI lifecycle costs of £8.0m (the cost of which sits outside the ICS CDEL limit).

The Group's capital expenditure to the end of Month 2 amounted to £4.4m, as detailed in the table below.

	NTH				STH				Group			
	Plan	YTD Plan	YTD Actual	Variance	Plan	YTD Plan	YTD Actual	Variance	Plan	YTD Plan	YTD Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Equipment	6,066	84	349	265	8,012	86	669	583	**14,078**	**170**	**1,018**	**848**
Digital	5,117	1,551	0	-1,551	2,080	134	799	665	**7,197**	**1,685**	**799**	**-886**
Estates	10,211	0	1,058	1,058	3,844	240	15	-225	**14,055**	**240**	**1,073**	**833**
PFI	0	0	0	0	8,163	1,328	1,327	-1	**8,163**	**1,328**	**1,327**	**-1**
Decarbonisation	1	0	0	0	13,928	2,322	176	-2,146	**13,929**	**2,322**	**176**	**-2,146**
RAAC	1,300	0	0	0	2,900	0	3	3	**4,200**	**0**	**3**	**3**
IFRS 16	876	-173	0	173	4,313	0	0	0	**5,189**	**-173**	**0**	**173**
Total Gross Capital	**23,571**	**1,462**	**1,407**	**-55**	**43,240**	**4,110**	**2,989**	**-1,121**	**66,811**	**5,572**	**4,396**	**-1,176**
Funding Source												
CDEL	14,512	1,378	12	-1,366	11,820	460	1,483	1,023	**26,332**	**1,838**	**1,495**	**-343**
Salix	0	0	0	0	13,928	2,322	176	-2,146	**13,928**	**2,322**	**176**	**-2,146**
Donated	504	84	337	253	0	0	0	0	**504**	**84**	**337**	**253**
PFI	0	0	0	0	7,963	1,328	1,327	-1	**7,963**	**1,328**	**1,327**	**-1**
PDC ICS	7,255	0	1,058	1,058	4,275	0	0	0	**11,530**	**0**	**1,058**	**1,058**
PDC Other	1,300	0	0	0	5,254	0	3	3	**6,554**	**0**	**3**	**3**
Total	**23,571**	**1,462**	**1,407**	**-55**	**43,240**	**4,110**	**2,989**	**-1,121**	**66,811**	**5,572**	**4,396**	**-1,176**

This is £1.2m slippage against the phasing of the 2025/26 year-to-date plan, largely relating to Salix grant funded schemes.

Liquidity

The cash balance at the end of Month 2 stood at £136.9m for the Group (with £53.4m relating to NTH and £83.5m relating to STH). The current cash forecast balances are £51.3m for NTH and £6.4m for STH.

NHSE have advised of changes to the deficit support regime for 2025/26, with regional assurance of plan delivery required to prevent funding being withheld. NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

This additional uncertainty means that continued close monitoring of cash will be essential throughout the course of the financial year.

The continued strong cash balances have supported good compliance with the Better Payment Practice Code for both trusts, as shown in the tables below:

NTH	YTD Number	YTD Value £000
Total bills paid in the year	12,135	38,635
Total bills paid within target	11,930	37,810
Percentage of bills paid within target	**98.3%**	**97.9%**

STH	YTD Number	YTD Value £000
Total bills paid in the year	17,679	104,745
Total bills paid within target	17,332	98,805
Percentage of bills paid within target	**98.0%**	**94.3%**

GROUP	YTD Number	YTD Value £000
Total bills paid in the year	29,814	143,380
Total bills paid within target	29,262	136,615
Percentage of bills paid within target	**98.1%**	**95.3%**

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 2:

	NTH £000	STH £000
Non-current assets		
Intangible assets	1,591	8,389
On-SoFP IFRIC 12 assets	0	143,840
Other property, plant and equipment (excludes leases)	147,900	168,578
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	18,571	35,344
Receivables: due from NHS and DHSC group bodies	607	912
Receivables: due from non-NHS/DHSC Group bodies	1,264	2,836
Credit Loss Allowances	0	(2,760)
Total non-current assets	**169,933**	**357,139**
Current assets		
Inventories	6,942	15,609
Receivables: due from NHS and DHSC group bodies	2,726	21,603
Receivables: due from non-NHS/DHSC Group bodies	24,910	20,079
Credit Loss Allowances	(3,481)	(957)
Other Assets	0	3,558
Cash and cash equivalents: GBS/NLF	51,824	81,644
Cash and cash equivalents: commercial/in hand/other	1,597	1,832
Total current assets	**84,518**	**143,368**
Current liabilities		
Trade and other payables: capital	(513)	(19,294)
Trade and other payables: non-capital	(58,197)	(155,209)
Borrowings	(5,886)	(21,111)
Other financial liabilities	(658)	0
Provisions	(2,614)	(1,220)
Other liabilities: deferred income including contract liabilities	(6,263)	0
Total current liabilities	**(74,131)**	**(196,834)**
Total assets less current liabilities	**180,320**	**303,673**
Non-current liabilities		
Borrowings	(31,900)	(262,988)
Provisions	(1,601)	(1,368)
Total non-current liabilities	**(33,501)**	**(264,356)**
Total net assets employed	**146,819**	**39,317**
Financed by		
Public dividend capital	196,047	470,377
Revaluation reserve	12,937	32,808
Other reserves	0	26,476
Income and expenditure reserve	(62,165)	(490,344)
Total taxpayers' and others' equity	**146,819**	**39,317**

4. RECOMMENDATIONS

Members of the Group Board are asked to:

- Note the financial position for Month 2 2025/26

University Hospitals Tees

Integrated Performance Report (IPR) – reporting to 30 April 2025

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 20

Report author: *Lucy Tulloch, Deputy Director Strategy & Planning and Lynsey Atkins, Associate Director Planning, Performance & Improvement*

Executive director sponsor: *Neil Atkinson, Group Managing Director*

Action required :
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Board Committees*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Performance and Compliance

Key discussion points and matters to be escalated from the meeting

The UHT Integrated Performance Report (IPR) provides, within one document, a consistent presentation of key metrics for each trust, and an aggregate UHT view. The narrative highlights performance trends and where applicable the actions in hand to address variance from plan. The alert, advise and assure framework is used to provide a clear line of sight on metric performance. Whilst underpinned by a larger number of measures and other evidence used to govern, manage and improve our services, these can be viewed as the sentinel metrics for the performance of the organisations.

The current IPR for data reporting month of April 2025 is presented for information and discussion on the items stated in the following alert, advise and assure sections.

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The IPR uses statistical process control, and expert judgment, to identify performance exceptions / consistent under-performance against plan, to alert to the Board and Committees.

For NTHFT, the following five performance metrics remain as 'Alert' assurance.

- Still birth rate
- Breast feeding at first feed
- Readmission rate
- 4-hour A&E standard
- Sickness Absence (%)

In addition, for NTHFT three metrics have been regraded to 'Alert':

- SAFE: *Klebsiella, Pseudomonas* and *E.coli* infections are more than 20% higher than trajectory for the start of the new financial year. *E.coli* had been regraded from 'Assure' and the others regraded from 'Advise'.

For STHFT, the following six performance metrics remain as 'Alert' assurance:

- *E. coli* infections
- Breast feeding at first feed
- Cancelled Operations Not Rebooked in 28 Days
- Cancer Faster Diagnosis
- Sickness Absence (%)
- Mandatory Training (%)

In addition, for STHFT three metrics across two CQC domains have been regraded to 'Alert', from Advise:

- SAFE: *C. difficile* and *Pseudomonas* infections regraded from Advise due to cases above trajectory in April 2025.
- RESPONSIVE: Diagnostic 6 Week standard regraded from Advise, as the previous trajectory has stalled.

Healthcare acquired infections (HCAI) triggering Alert are based on one month's data, April 2025, so a small number of cases above trajectory can trigger the Alert threshold of 20% above plan (plans can be in low single figures). This helps to explain the additional HCAI metrics triggering Alert this month. The IPR references the actions in hand to reduce infection cases, specific to each infection and to continuously improve infection prevention and control generally. These include behavioural interventions, antimicrobial stewardship, education, cleaning and fogging.

The **still birth rate** for NTHFT alerts due to an increasing trend (there is no target or trajectory). It is being examined in relation to peer benchmarks, to understand whether there is cause for concern and / or further action needed.

Breast feeding at first feed is a metric that has been consistently below peer median benchmark for NTHFT; and after a period of improvement has a declining rate for STHFT. This is reflective of population-level demographics and trends. However, recognising the value of breast feeding in health outcomes for the best start in life as a public health priority, both sites are working towards breast-feeding initiative accreditation, which includes staff training, support to parents and infant feeding plans.

Readmission rates (an unplanned readmission within thirty days of an admission) are being explored through focused clinical audit across UHT, to understand the reasons for the higher rates alerted for NTHFT.

In the case of **4-hour A&E standard**, the IPR analysis alerts that the more challenging agreed operational plan for 4-hour standard held by NTHFT was not met, although the national recovery standard of 78% is consistently exceeded for NTHFT as one of the top performing trusts nationally. The lower performance for STHFT remains Advise, as the agreed lower recovery trajectory is within the range of variation of monthly performance.

Cancelled operations not rebooked within 28-days is consistently Alert for STHFT. The ambition is to reduce this to zero. A spike in elective surgery cancellations over the winter period, combined with the need to prioritise patients clinically, meant that higher numbers of patients did not receive their surgery on an alternative date within 28 days. There is renewed focus on this and pilots underway at STHFT to learn how best to avoid these breaches.

Cancer faster diagnosis standard is Alert for STHFT due to a recent trend of declining compliance with referral-to-diagnosis in 28 days. STHFT focus is on further improving compliance in urology and gastro-intestinal tumour groups. Recent changes in prostate diagnostic pathway are being monitored with early evidence of improvement in process steps from April 2025.

Diagnostic 6-week standard is regraded to Alert for STHFT as the improvement trend seen in recent months stalled. Whilst compliance in the major imaging modalities is high, some small and more specialist diagnostic services face capacity and demand challenges which increasingly impact on the overall compliance. Modality specific action plans are in place.

Sickness absence has consistently been graded Alert for both Trusts. Allocation of resources to a dedicated absence team to support consistent and compliant management of absence is expected to make a positive impact.

Mandatory training is consistently graded Alert for STHFT. The current focus is to ensure consistent alignment of Training Needs Analysis to roles across UHT. Work is underway to implement the national mandatory training policy, to ensure standardised reporting across UHT and to improve compliance across all face-to-face topics.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

The Board and Committees are advised of areas of performance where there is ongoing focus to improve performance and/or assurance.

For NTHFT, the following 23 performance metrics remain as 'Advise' assurance:

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- MRSA infections
- *C. difficile* infections
- PPH >= 1500ml (%)
- 3rd/4th Degree Tear (%)
- A&E Handovers – Within 60 mins (%)
- Cancer Faster Diagnosis
- Cancer 31 Day Standard
- Cancer 62 Day Standard
- Diagnostic 6 Week Standard
- RTT Incomplete Pathways
- Cancelled Operations Not Rebooked in 28 Days
- Community UCR 2 Hour response rate
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

In addition, for NTHFT the following three metrics from the responsive domain have been regraded this month, as 'Advise'. Note that 12-Hour A&E Breaches and RTT 52 Week Waiters show an improved level of assurance, moving from Alert to Advise. RTT time to first appointment % metric is new for financial year 2025/26 and is categorised for the first time.

- RESPONSIVE: **12-Hour A&E Breaches** regraded from Alert to Advise as performance recovered after winter pressures, with typically very low numbers of breaches.

- RESPONSIVE: **RTT time to first appointment %** within 18 weeks (new metric included for 25/26)

- RESPONSIVE: **RTT 52 Week Waiters** regraded from Alert to Advise, as plan is within the range of monthly performance variation, and met in April.

For STHFT, the following 19 performance metrics remain as 'Advise' assurance:

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- C. difficile infections
- Still birth rate
- PPH >= 1500ml (%)
- 3rd/4th Degree Tear (%)
- Summary Hospital-Level Mortality Indicator
- Readmission rate
- A&E Handovers – Within 60 mins (%)
- 4-Hour A&E Standard (%)
- 12-Hour A&E Breaches (%)
- RTT 52 Week Waiters (%)
- A&E Experience (%)
- Maternity Experience (%)
- Feedback Acknowledged in 3 Days (%)
- Annual Appraisal (%)
- Cumulative YTD Financial Position (£Millions)

In addition, for STHFT the following eight metrics across three domains have been regraded this month, as 'Advise'. Note that five (MRSA infections, Cancer 31 Day Standard, Cancer 62 Day Standard, RTT incomplete pathways and Complaints Closed Within Target %) show an improved level of assurance, moving from Alert to Advise.

Two metrics (*Klebsiella* infections and Inpatient Experience %) have been regraded from 'Assure', reflecting the new year targets and trajectories.

RTT time to first appointment % metric is new for financial year 2025/26 and is categorised for the first time.

- SAFE: **MRSA infections** regraded from Alert due to no new cases recorded in April 2025. ***Klebsiella* infections** regraded from Assure as cases at the start of 2025/6 were equal to target.

- RESPONSIVE: **Cancer 31 Day Standard** and **Cancer 62 Day Standard** regraded from Alert, agreed recovery plans for 25/26 are now within the range of monthly performance variation.

- RESPONSIVE: **RTT incomplete pathways** regraded from Alert as the new recovery trajectory for 25/26 is within variation, and was met in April, and **RTT time to first appointment %** within 18 weeks (new metric included for 25/26).

- CARING: **Inpatient Experience (%)** regraded from Assure, as the higher target for 25/26 is not consistently met.

- CARING: **Complaints Closed Within Target (%)** regraded from Alert, plan is now within the range of monthly performance variation.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The IPR uses statistical process control to provide positive assurance on performance, where standards are consistently met.

g four performance metrics remain as 'Assure':

- *E. coli* infections
- Summary Hospital-Level Mortality Indicator
- Staff Turnover
- Annual Appraisal (%)

There were two metrics that were newly graded as 'Assure' this month:

- SAFE: **MSSA infections** (new metric included for 25/26)
- CARING: **Feedback Acknowledged in 3 Days (%)** regraded from Advise as consistently compliant with the 100% target.

For STHFT, the following three performance metrics remain as 'Assure':

- Staff Turnover
- Outpatient Experience (%)
- Community Experience (%)

In addition, for STHFT two further metrics has been graded this month, as 'Assure':

- SAFE: **MSSA infections** (new metric included for 25/26)
- RESPONSIVE: **Community UCR 2 Hour Response Rate (%)** regraded from Advise, as performance is assuredly above target, after a period of compliant but deteriorating performance when staff were utilised flexibly to support the community services response to winter pressures.

Recommendations:

The Group Board are asked to:

- Receive the Integrated Performance Report for reporting period April 2025.
- Note that separate agenda items into the Committees, as set out in the annual cycles of business, will provide further detailed reporting and assurance.
- Note the performance standards on which assurance is provided; those advised for ongoing monitoring and improvement; and those alerted as exceptions or consistent under-performance against plan; and the improvement actions being taken.

NHS
University Hospitals Tees

Integrated Performance Report (IPR)

Reporting month: April 2025

Caring Better Together

Overview

The IPR reports on the key indicators and standards by which Trusts' performance is monitored. They are underpinned by a broader range of metrics and evidence for clinical governance and operational management.

- **SAFE:** For consistency of focus in reducing healthcare acquired infections across UHT, 24/25 trajectories are rolled forward as 25/26 NHS Standard Contract Objectives have not yet been formally published. Maternity metrics and trajectories are being reviewed to align with national audit and peer group benchmarks.
- **EFFECTIVE:** Standardised mortality is 'as expected' for both Trusts. Readmissions rates differ between the two Trusts and relative to the national average. Clinical audit has been initiated to understand whether this variation is appropriate for the pathways of care, with oversight and monitoring via the Audit & Clinical Effectiveness Council.
- **RESPONSIVE:** NTHFT has strong performance in urgent and emergency care, with an improvement programme underway at STHFT. Performance in core ED metrics has returned to expected variation following the dissipation of winter pressures. Community services are integral, maximising use of urgent community response teams, 'hospital at home' and the frailty service to identify patients whose needs are best served in a community setting including their own home.
- Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. Whilst focus has been on ensuring the very longest waiters receive their treatment, there is not consistent improvement/achievement across the core metrics. Productivity improvements such as driving up theatre utilisation to create more capacity for patients awaiting surgery, waiting list validation and cancer pathway action plans are tools being used to address challenges. STHFT receive additional performance scrutiny and support for improvement in cancer treatment waiting times from within the NHS England performance management regime.
- **CARING:** The IPR demonstrates that both Trusts are generally performing well in patient feedback surveys. At STHFT managing complaints to a timely closure is being addressed with senior leadership support.
- **WELL LED:** The improvement of working lives, staff retention and attendance is a focus for the People Directorate. The national People Promise will be implemented as part of the Group People Plan. A detailed absence plan and focus on whole time equivalent reduction (e.g. non-essential bank and agency work, scrutiny of recruitment requests) will support the Group's obligation to deliver the agreed financial position.

Regulation & Compliance

Regulated by CareQuality Commission

North Tees & Hartlepool Hospitals NHS Foundation Trust has an overall rating of Requires Improvement.
Since the 2022 inspection CQC recommendations have been addressed and action plan completed.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Sept 2022	Requires improvement ↓ Sept 2022	Good → ← Sept 2022	Good → ← Sept 2022	Requires improvement ↓ Sept 2022	Requires improvement ↓ Sept 2022

South Tees Hospitals NHS Foundation Trust has an overall rating of Good. Since the 2023 CQC inspection 11 Must Do and 15 Should Do actions have been completed. The remaining 2 Must Do and 5 Should Do actions are in progress. Each action has a robust plan that is reviewed monthly by the CQC Compliance Group. Recent progress includes increased assurance around Resuscitation and Safeguarding training in ED and a trajectory developed which will ensure all staff are 100% compliant by May 2025.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023

CQC assessment ratings per hospital site and service can be found on the CQC website.

Caring Better Together

Provider Performance Summary

	Urgent & Emergency Care					Elective care											Cancer			
Provider	A&E 4 hour standard	12 hour delay from DTA	% A&E Type 1 Attendances >12hrs from arrival	Ambulance handovers 30-60 mins	Ambulance handovers 60+ mins	RTT - 18 week standard	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 24/25 v 23/24	1st OP - YTD growth 24/25 v 23/24	Total elective - YTD growth 24/25 v 23/24	Diagnostic activity 24/25 v 23/24	Diagnostic 6 week waits	Cancer 62 day	Cancer 62 day backlog	Cancer treatments (first and subsequent)	Cancer 28 day FD
Data period	Apr-25	Apr-25	Apr-25	Apr-25	Apr-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Mar-25	Apr-25	Mar-25	Mar-25
Target	95%	Zero				92%	24/25 Plan	24/25 Plan	Zero	Zero	24/25 Plan					<=5%	85%	Mar 24 Plan		75%
North Tees & Hartlepool NHSFT	83.3%	10	2.2%	101	1	75.5%	173	0	0	0	20,571	106%	104%	102%	90%	3.3%	67.0%	128	195	79.5%
South Tees Hospitals NHSFT	77.0%	13	4.4%	455	54	60.3%	1,541	43	2	0	56,877	110%	105%	108%	107%	12.6%	61.2%	169	661	71.1%
NENC ICS Provider level *(including IS providers)*	77.7%	631	4.8%	2,723	707	70.1%	4,599	178	24	2	372,869	105%	105%	104%	107%	9.6%	71.0%	825	3,504	78.5%
North East & Yorkshire	75.4%		6.4%			65.5%										16.6%	70.7%			78.2%
National	74.8%		9.9%			59.8%										18.4%	71.4%			78.9%

Urgent and emergency care metrics continue to show good performance for NTHFT in April compared to national benchmarks. 4-hour performance remains a strategic risk for STHFT with actions reviewed weekly by the operational team. Reducing ambulance handover delays and the longest department waits are a priority, whilst further improving patient experience by developing alternatives to ED pathways.

Elective care metrics show an RTT 18-week standard at NTHFT that is above the national average. NTHFT focus is on ensuring patients wait no longer than 52 weeks whilst STHFT services are working to eliminate waits above 65 weeks. Both Trusts are committed to improving RTT compliance by 5% in 25/26, Achievement of this standard is a strategic risk for both Trusts, with actions focusing increasing outpatient productivity.

Cancer 62-day standard is a strategic risk for both Trusts. NTHFT met the 28-day faster diagnosis standard in March 2025, a key enabling metric within cancer pathways. STHFT has been in tiering support with NHS England for the 62-day standard since February 2025. Actions and progress are discussed fortnightly. These focused on reducing delays in specific tumour pathways, whilst investment in cancer navigators in focus specialties helps to ensure individual cases are proactively pursued through the diagnostic and treatment steps.

North Tees & Hartlepool assurance summary

No change in assurance — ALERT — New ALERT indicator

- Still birth rate
- Breast feeding at first feed
- Readmission rate
- 4-hour A&E standard
- Sickness Absence (%)

Klebsiella and ***Pseudomonas*** **infections** regraded from Advise, due to cases above trajectory in April 2025.

E. coli **infections** regraded from Assure due to cases above trajectory in April 2025.

No change in assurance — ADVISE — New ADVISE indicator

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- MRSA infections
- *C. difficile* infections
- PPH >= 1500ml (%)
- 3rd/4th Degree Tear (%)
- A&E Handovers – Within 60 mins (%)
- Cancer Faster Diagnosis
- Cancer 31 Day Standard
- Cancer 62 Day Standard
- Diagnostic 6 Week Standard
- RTT Incomplete Pathways
- Cancelled Operations Not Rebooked in 28 Days
- Community UCR 2 Hour Response Rate
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

12-Hour A&E Breaches regraded from Alert as performance recovered after winter pressures.

RTT time to first appointment % within 18 weeks (new metric included for 25/26)

RTT 52 Week Waiters regraded from Alert, as plan is within the range of monthly performance variation, and met in April.

No change in assurance — ASSURE — New ASSURE indicator

- Summary Hospital-Level Mortality Indicator
- A&E Experience (%)
- Staff Turnover
- Annual Appraisal (%)

MSSA infections (new metric included for 25/26)

Feedback Acknowledged in 3 Days (%) regraded from Advise as consistently compliant.

Caring Better Together

South Tees Hospitals assurance summary

No change in assurance — ALERT — New ALERT indicator

- *E. coli* infections
- Breast feeding at first feed
- Cancelled Operations Not Rebooked in 28 Days
- Cancer Faster Diagnosis
- Sickness Absence (%)
- Mandatory Training (%)

C. difficile and ***Pseudomonas*** **infections** regraded from Advise due to cases above trajectory in April 2025.

Diagnostic 6 Week (%) regraded from Advise, as the previous improvement trajectory has stalled.

No change in assurance — ADVISE — New ADVISE indicator

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- *C. difficile* infections
- Still birth rate
- PPH >= 1500ml (%)
- 3rd/4th Degree Tear (%)
- Summary Hospital-Level Mortality Indicator
- Readmissions rate
- A&E Handovers – Within 60 mins (%)
- 4-Hour A&E Standard (%)
- 12-Hour A&E Breaches (%)
- RTT 52 Week Waiters (%)
- A&E Experience (%)
- Maternity Experience (%)
- Feedback Acknowledged in 3 Days (%)
- Annual Appraisal (%)
- Cumulative YTD Financial Position (£Millions)

MRSA infections regraded from Alert due to no new cases recorded in April 2025. ***Klebsiella*** **infections** regraded from Assure as cases at the start of 2025/6 were equal to target.

Cancer 31 Day Standard and **Cancer 62 Day Standard** regraded from Alert, agreed recovery plans for 25/26 are now within the range of monthly performance variation.

RTT Incomplete Pathways regraded from Alert, and **RTT time to first appointment** % within 18 weeks (new metric included for 25/26).

Inpatient Experience (%) regraded from Assure, as the higher target for 25/26 is not consistently met.

Complaints Closed Within Target (%) regraded from Alert, plan is now within the range of monthly performance variation.

No change in assurance — ASSURE — New ASSURE indicator

- Staff Turnover
- Outpatient Experience (%)
- Community Experience(%)

MSSA infections (new metric included for 25/26)

Community UCR 2 Hour Response Rate (%) regraded from Advise, as performance is assuredly above target.

Caring Better Together

Index of metrics

SAFE DOMAIN
Responsibility: Quality Assurance Committee

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
Falls with Harm per 1000 Bed Days
C. difficile infections
MRSA infections
E. Coli infections
MSSA infections
Klebsiella infections
Pseudomonas infections
Babies Born
Still Births Rate (Rolling 12 months, per 1000 Births)
Breast Feeding at First Feed (%)
PPH >= 1500ml (%)
3rd/4th Degree Tear (%)

EFFECTIVE DOMAIN
Responsibility: Quality Assurance Committee

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)

RESPONSIVE DOMAIN
Responsibility: Resources Committee

Handovers – Within 60 mins (%)
4-Hour A&E Standard (%)
12-Hour A&E Breaches (%)
Community UCR 2 Hour Response Rate (%)
Cancelled Operations Not Rebooked in 28 Days
Cancer Faster Diagnosis Standard (%)
Cancer 31 Day Standard (%)
Cancer 62 Day Standard (%)
Diagnostic 6 Weeks Standard (%)
RTT Incomplete Pathways (%)
RTT 52 Week Waiters Rate (%)
RTT Time to First Appointment (%)

CARING DOMAIN
Responsibility: Quality Assurance Committee

A&E Experience (%)
Inpatient Experience (%)
Maternity Experience (%)
Outpatient Experience (%)
Community Experience (%)
Feedback Acknowledged in 3 Days (%)
Complaints Closed Within Target (%)

WELL LED DOMAIN
Responsibility: People Committee, *Resources Committee (Finance only)

Sickness Absence (%)
Staff Turnover (%)
Annual Appraisal (%)
Mandatory Training (%)
*Cumulative YTD Financial Position (£Millions)

SAFE DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

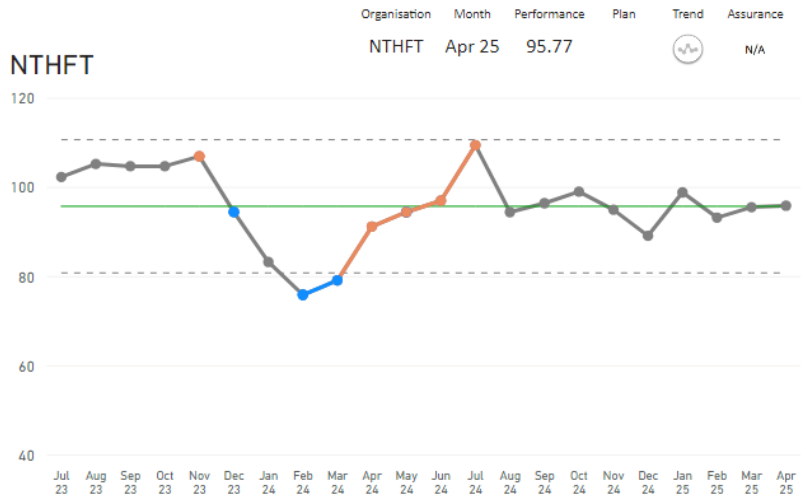
The Patient Safety Incident Response Framework has been implemented across UHT since January 2024. Thematic review is used to identify trends and opportunities for learning; an example of this is the work being undertaken in relation to the provision of hot drinks and liquid foods for frail patients following an analysis of incidents leading to harm. The learning from this is being shared across UHT.

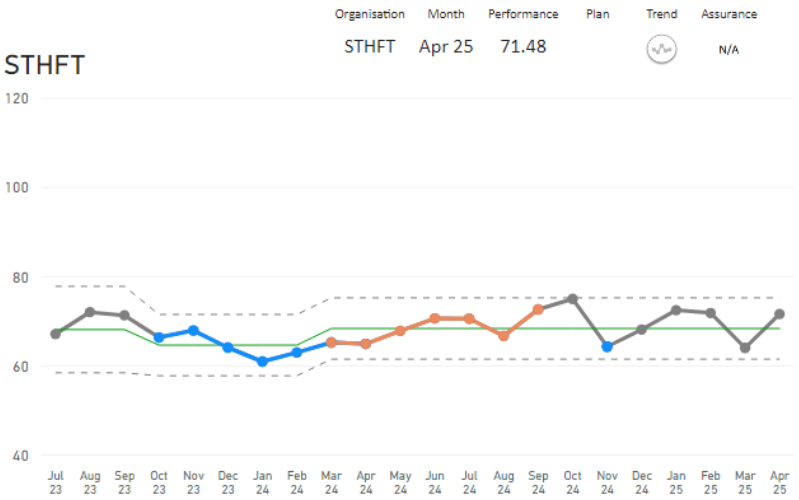
Healthcare-acquired infections continue to be closely tracked by the Infection Prevention Committee. A recent review identified three key areas we need to embed more firmly into day-to-day practice and these continue to be the focus. First, improving hydrogen peroxide 'fogging' at NTHFT following updating the policy and further clarity continues to be sought regarding cleaning responsibilities around equipment. Second, strengthening antimicrobial stewardship (AMS) through consistent use of shared guidelines online, pharmacy ward rounds and ongoing training for junior doctors. The multi-disciplinary team for AMS and *C. difficile* infection at NTHFT has been reviewed and will be reintroduced. Third, a full reset of professional standards consistently across UHT – including dress code, bare below the elbows and professional behaviour – is backed by the executive team. The focus is on embedding these actions into routine practice.

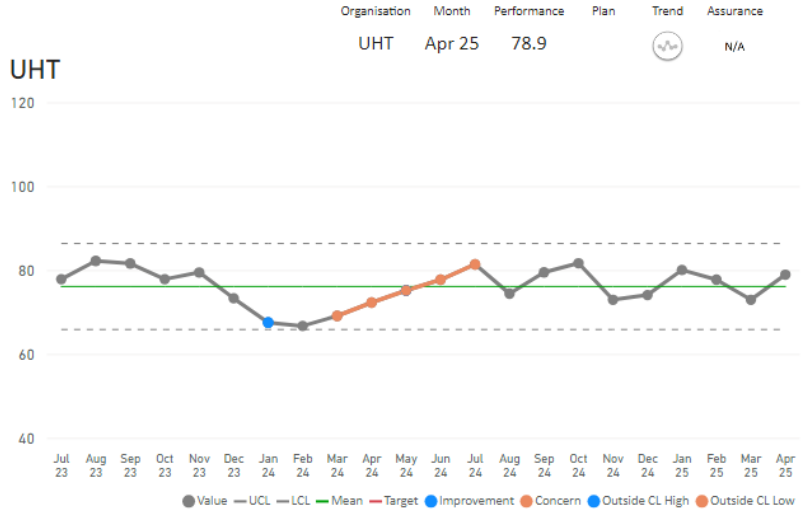
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Incidents Per 1000 Bed Days		94.34	96.91	109.35	94.32	96.33	98.92	94.86	89.01	98.76	93.1	95.44	95.77
Patient Safety Incident Investigations		0	3	2	3	1	3	2	0	1	0	1	0
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.14	0.15	0	0.22	0.28	0.07	0.27	0.14	0.19	0.37	0.27	0
C-Difficile	5	10	7	10	6	3	9	2	1	5	6	7	6
MRSA	0	0	0	0	1	1	1	1	1	0	0	0	0
E-Coli	6	4	6	10	7	13	13	5	3	6	6	4	8
MSSA	5	3	3	2	2	5	6	4	6	9	2	1	3
Klebsiella	2	2	2	2	5	3	4	2	2	1	0	5	4
Pseudomonas	1	3	1	0	2	0	2	2	2	2	0	2	4

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Incidents Per 1000 Bed Days		67.71	70.5	70.44	66.58	72.5	74.86	64.18	68.01	72.34	71.71	63.89	71.48
Patient Safety Incident Investigations		1	2	1	1	0	1	0	1	0	0	0	1
Never Events	0	0	1	0	1	0	2	1	1	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.13	0.14	0.08	0.06	0.03	0.11	0.14	0.16	0.08	0.17	0.19	0.25
C-Difficile	10	8	12	15	13	9	11	17	11	13	15	10	13
MRSA	0	0	0	0	1	0	0	1	0	0	0	3	0
E-Coli	11	20	12	12	13	11	17	12	14	18	10	17	16
MSSA	8	4	4	5	5	8	11	4	6	5	9	11	3
Klebsiella	4	1	5	9	4	6	8	1	3	5	4	2	4
Pseudomonas	1	3	0	3	2	1	3	1	0	1	1	3	3

SAFE Incidents Per 1000 Bed Days





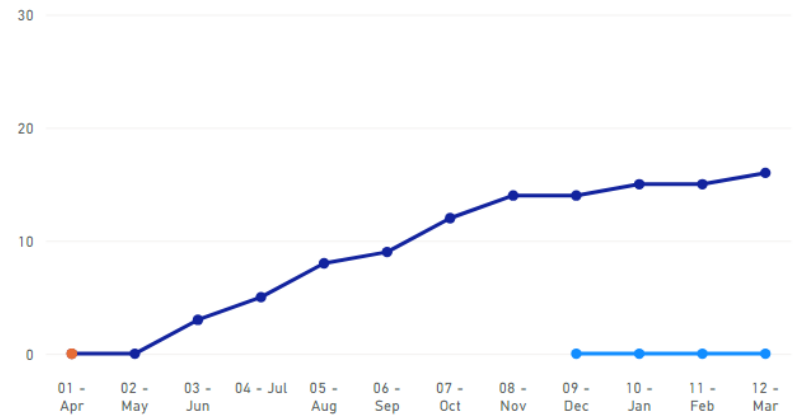


Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Enables benchmarking.
Data quality: Assured. Each incident is validated.
Trend: No trend
Assurance: n/a
Action taken: A review is being undertaken by patient safety teams to understand the differences in incident reporting numbers between sites. As NRLS data is no longer available for regional comparison, the ICB have been contacted to support some regional benchmarking for additional context, during Q1 25/26.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Patient Safety Incident Investigations (YTD)

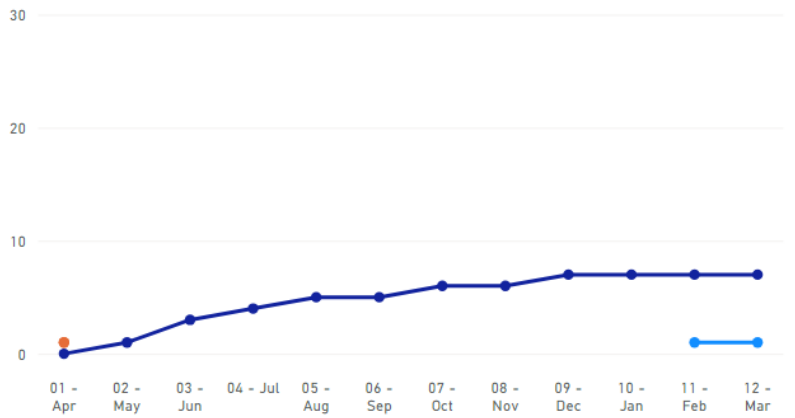
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	0		N/A	N/A



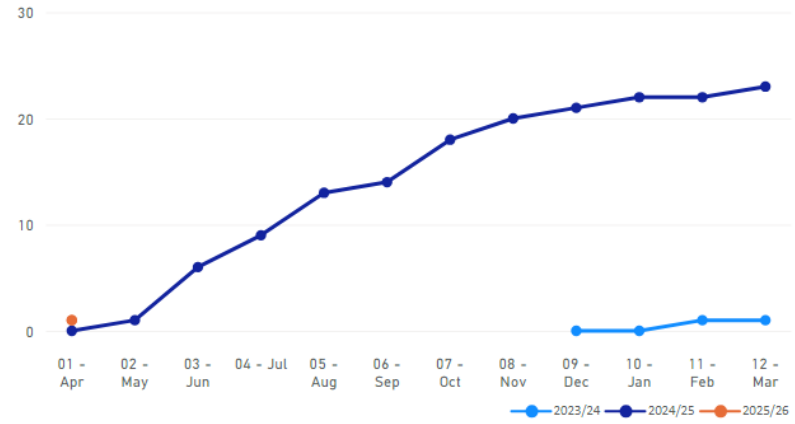
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	1		N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	1		N/A	N/A

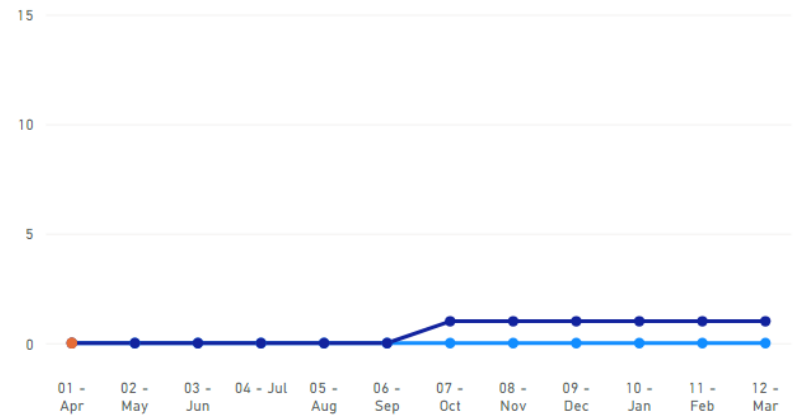


Metric: PSIIs initiated, cumulative annually from April.
Plan: n/a. An open reporting culture is encouraged.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT 0 PSIIs YTD. STHFT: 1 PSIIs YTD.
Assurance: n/a
Action taken: Incidents are reviewed at weekly site LRPs, to determine how they are investigated under PSIRF. There was one PSII registered at STHFT in April 2025. An independent evaluation of PSIRF across the Group has commenced and will be concluded in June 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Never Events (YTD)

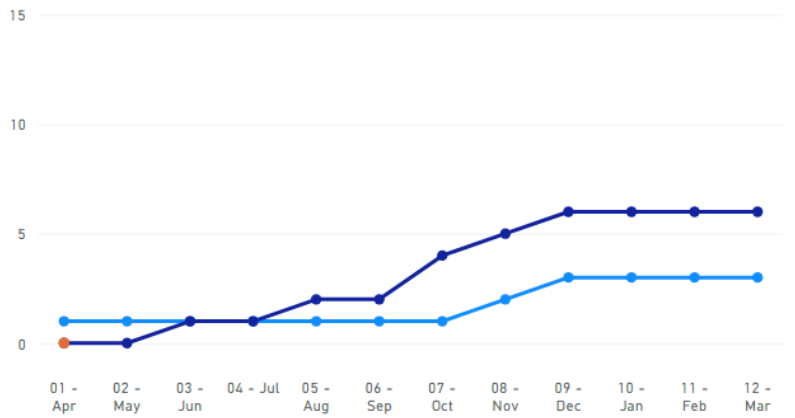
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	0	0	N/A	N/A



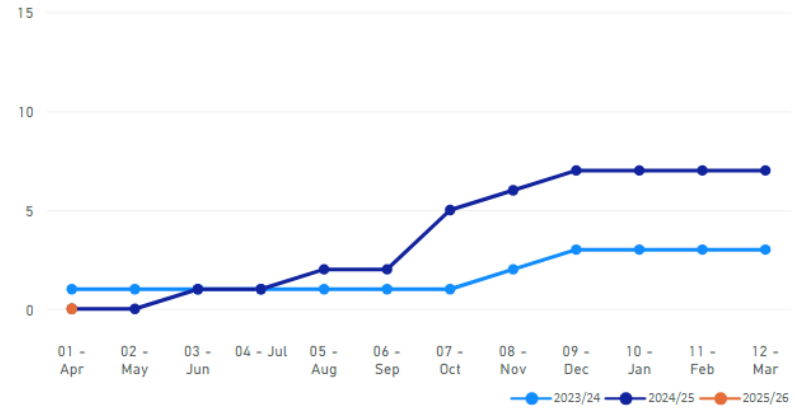
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	0	0	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	0		N/A	N/A

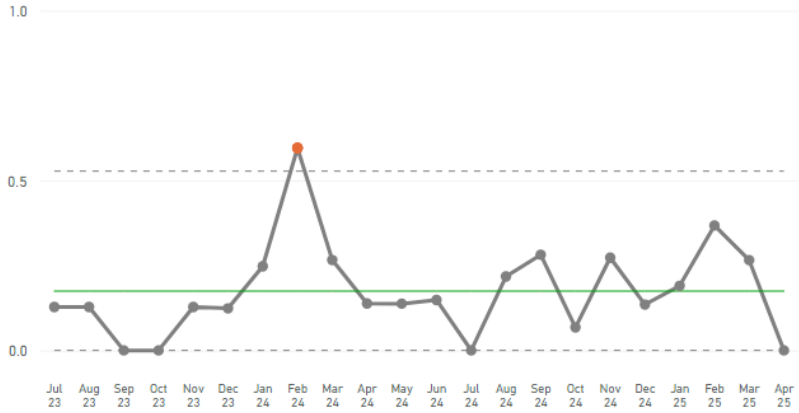


Metric: Never Events (a defined list of serious preventable errors), cumulative annually from April.
Plan: Zero.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 0 Never Event YTD. STHFT: 0 Never Events YTD.
Assurance: Advise. No new events for 6 months NTHFT and 4 months STHFT.
Action taken: No new events – n/a.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Falls With Harm Rate (Per 1000 Bed Days)

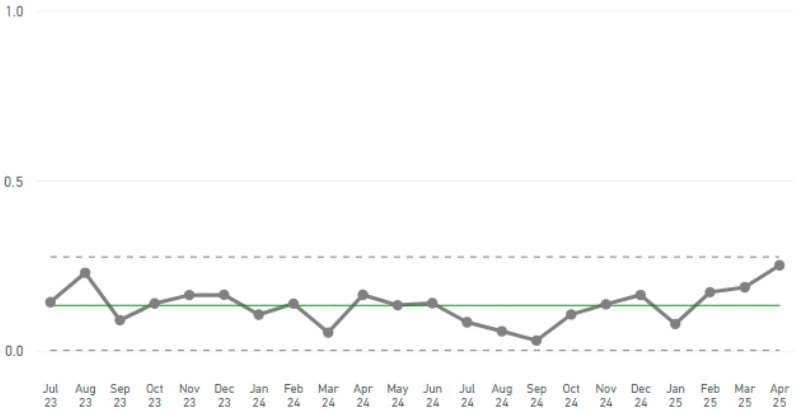
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	0			N/A



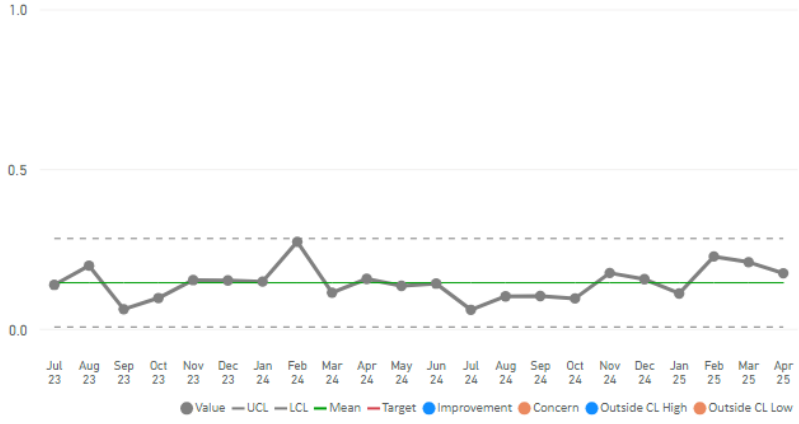
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	0.25			N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	0.17			N/A

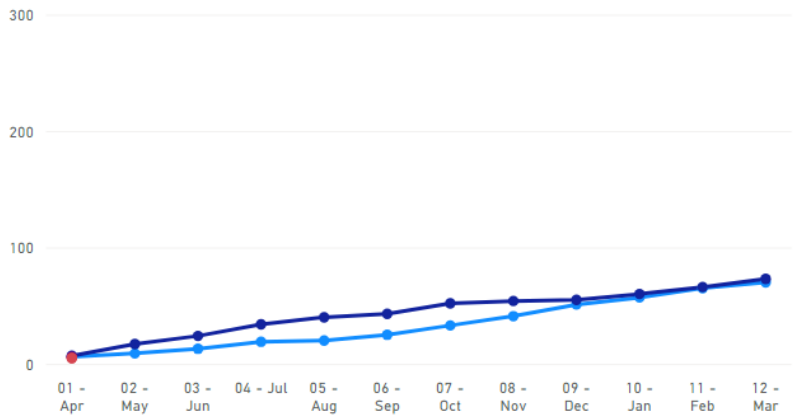


Metric: Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
Plan: n/a
Rationale: NHS Quality Accounts regulatory indicator. National Audit of Inpatient Falls.
Data quality: Assured. Each incident is validated.
Trend: No trend.
Assurance: n/a
Action taken: The focus is on thematic learning from falls, targeted interventions and bringing together a single UHT approach.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE C-Difficile (YTD)

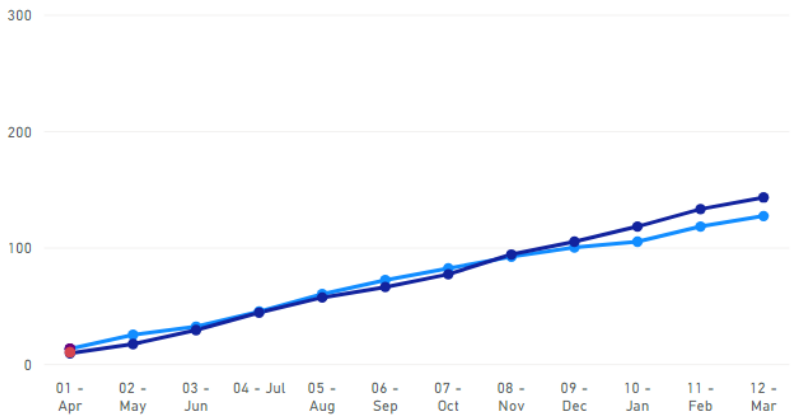
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	6	5	N/A	N/A



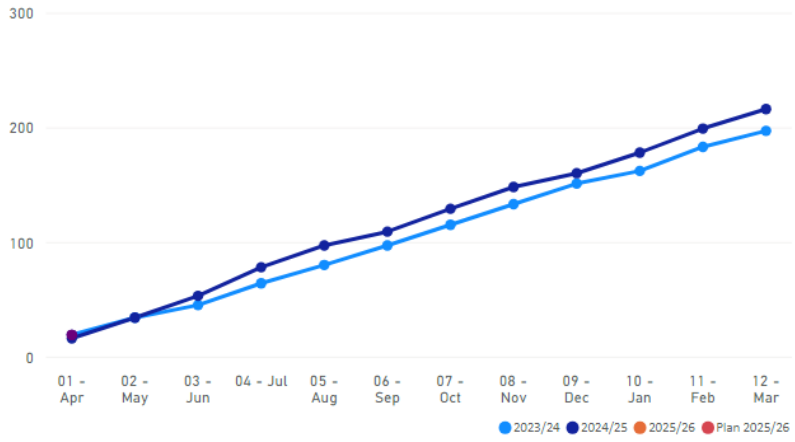
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	13	10	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	19		N/A	N/A

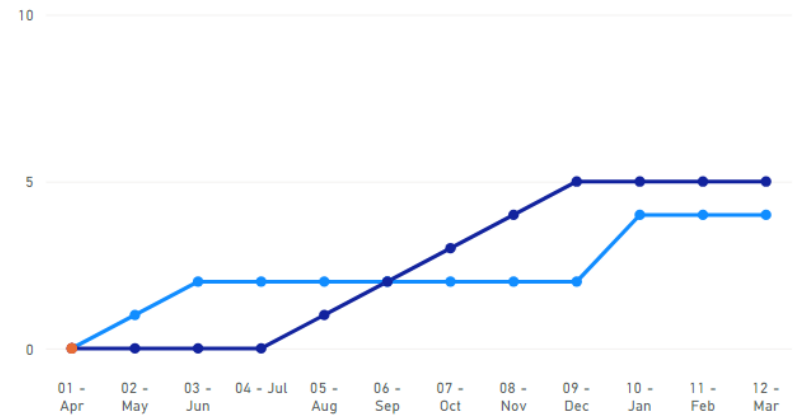


Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: Still to be confirmed
Rationale: NHS Contract and Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 new cases in April, trajectory of 5.
STHFT: 13 new cases in April, trajectory of 10.
Assurance: NTHFT: Advise, 1 case above trajectory YTD.
STHFT: Alert, 3 cases above trajectory YTD.
Action taken: Both Trusts have detailed action plans. Increase in compliance with HPV fogging at North Tees continues aligned to robust reporting planned.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MRSA (YTD)

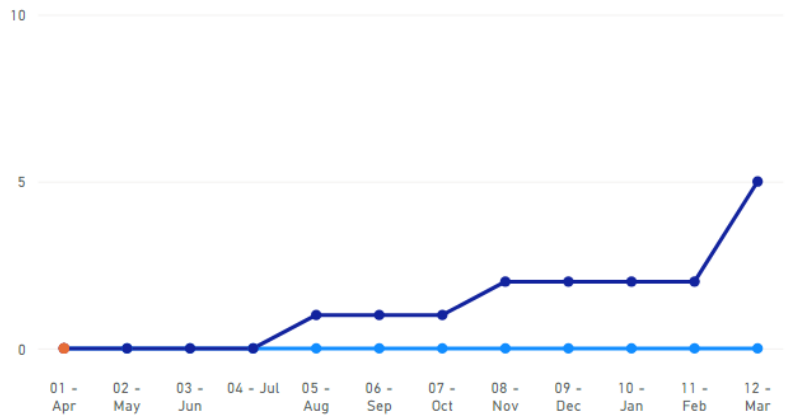
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	0	0	N/A	N/A



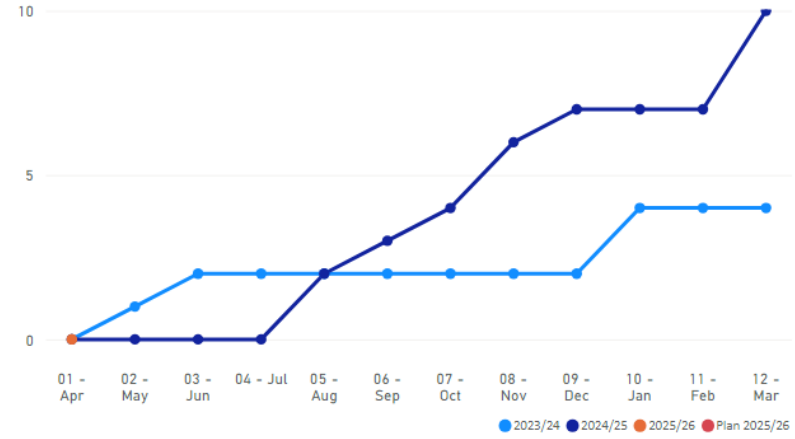
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	0	0	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	0		N/A	N/A

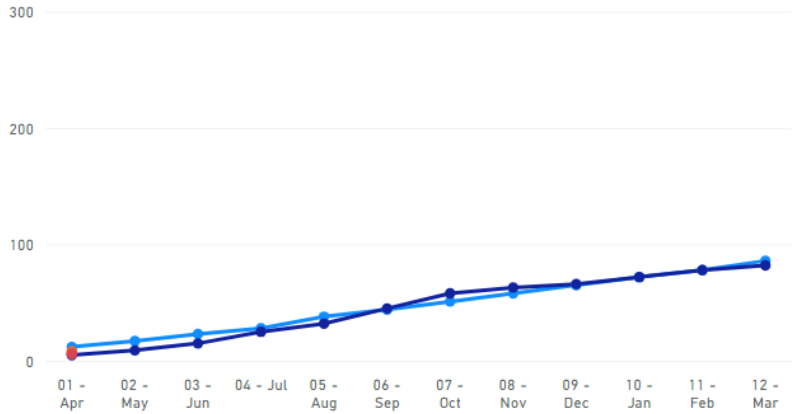


Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases in April 2025. STHFT: No new cases in April 2025.
Assurance: NTHFT: Advise, 0 cases YTD. STHFT: Advise, 0 cases YTD. Zero tolerance plan difficult to achieve.
Action taken: Policy adherence audit and education continues across all areas.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE E-Coli (YTD)

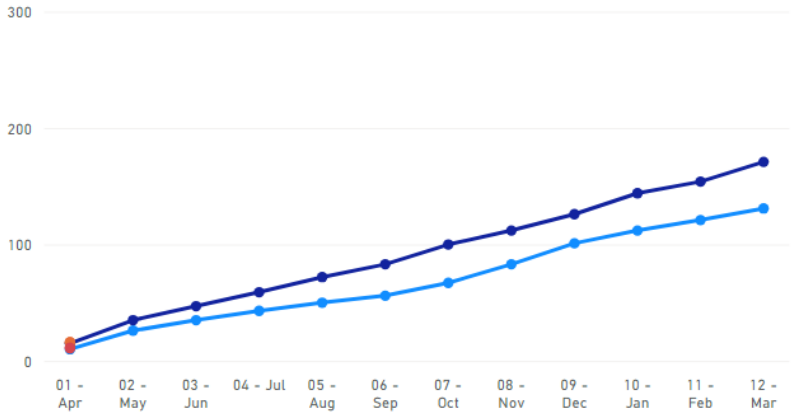
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	8	6	N/A	N/A



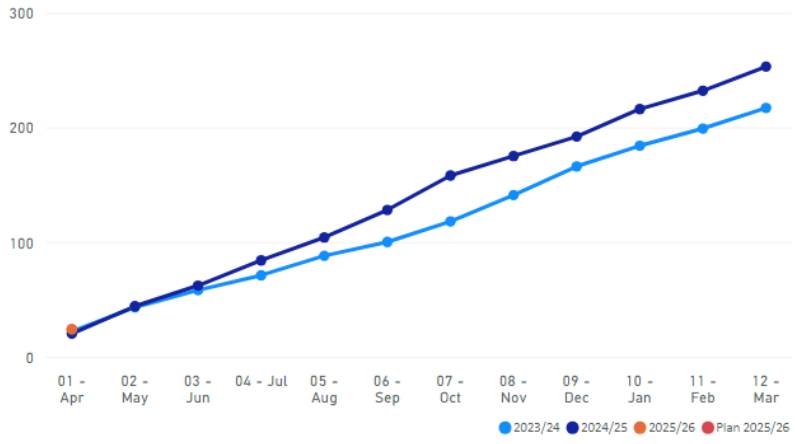
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	16	11	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	24		N/A	N/A

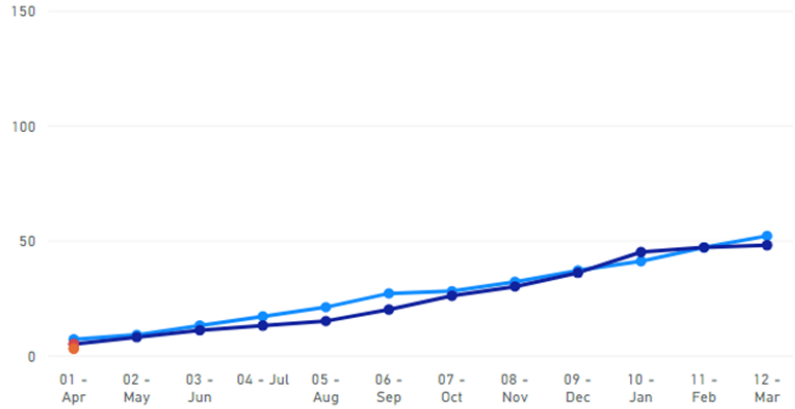


Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: Still to be confirmed
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: Number of cases tracking above trajectory. STHFT: Number of cases tracking higher than trajectory.
Assurance: NTHFT: Alert, 8 cases in April against trajectory of 6. STHFT: Alert, 16 cases in April against trajectory of 11.
Action taken: Focus remains on invasive devices and VIP audits completed across all sites, re-audit planned. T&F group established at STHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MSSA (YTD)

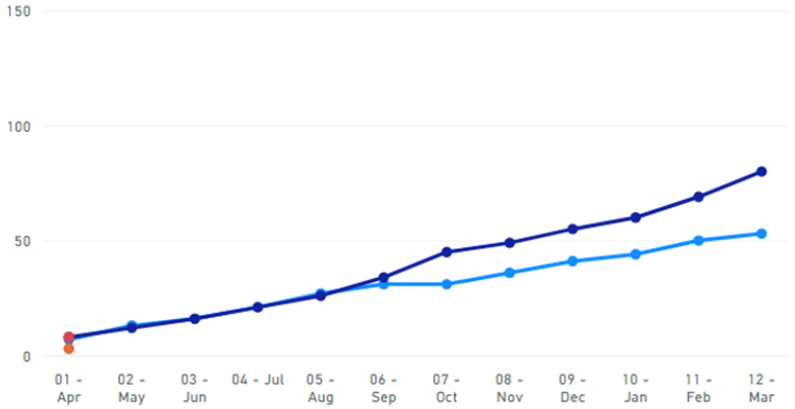
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	3	5	N/A	N/A



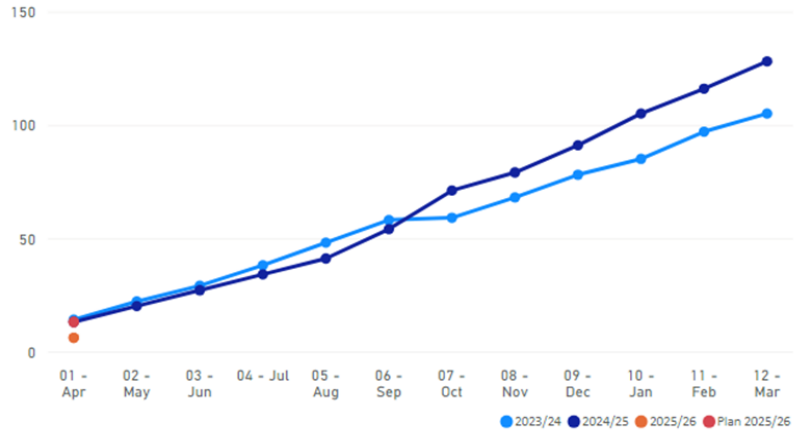
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	3	8	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	6	13	N/A	N/A

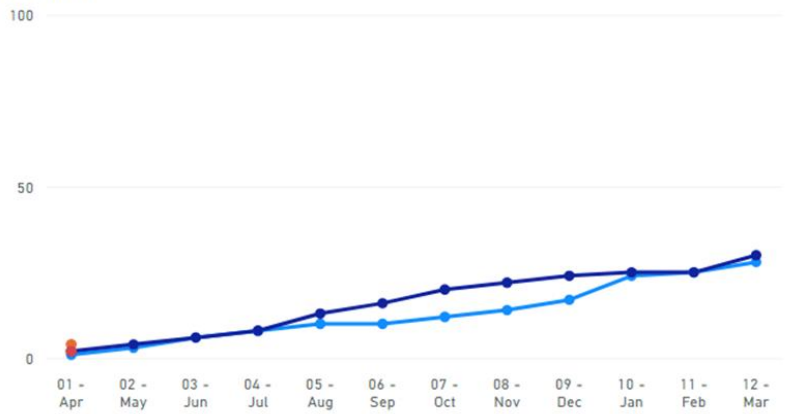


Metric: Healthcare associated cases of MSSA annually from April.
Plan: No NHS standard contract trajectory set: Plan for 1 case fewer than 2024/25.
Rationale: In line with other NHS Contract indicators.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 3 new cases in April. STHFT: 3 new cases in April.
Assurance: NTHFT: Assure, fewer than trajectory YTD. STHFT: Assure, 3 cases, fewer than trajectory YTD.
Action taken: Supported by the work of the invasive devices groups including audit and education.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Klebsiella (YTD)

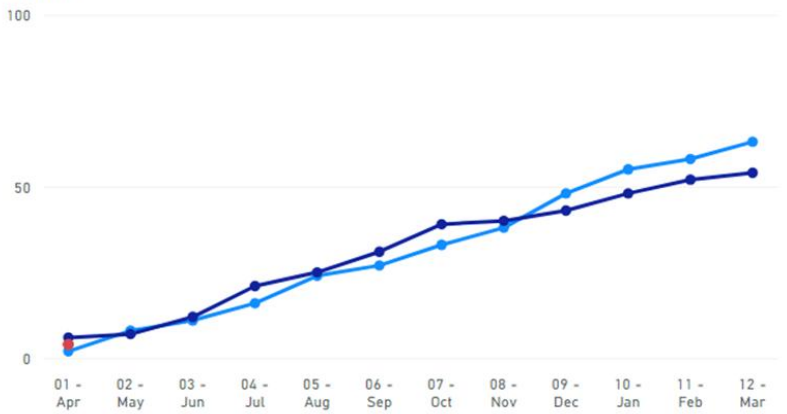
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	4	2	N/A	N/A



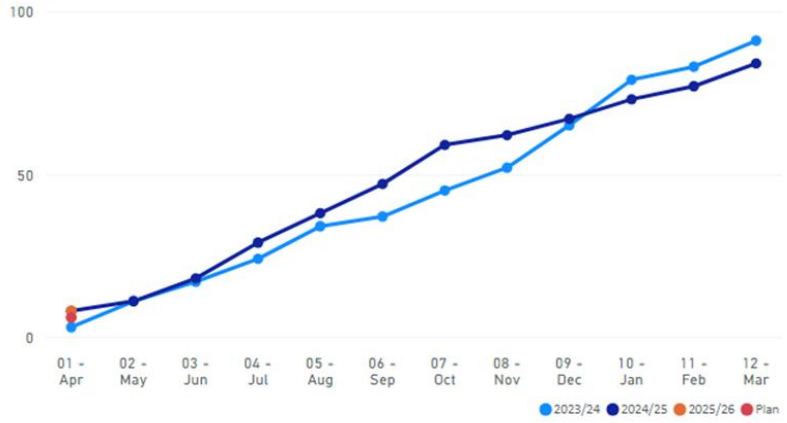
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	4	4	N/A	N/A



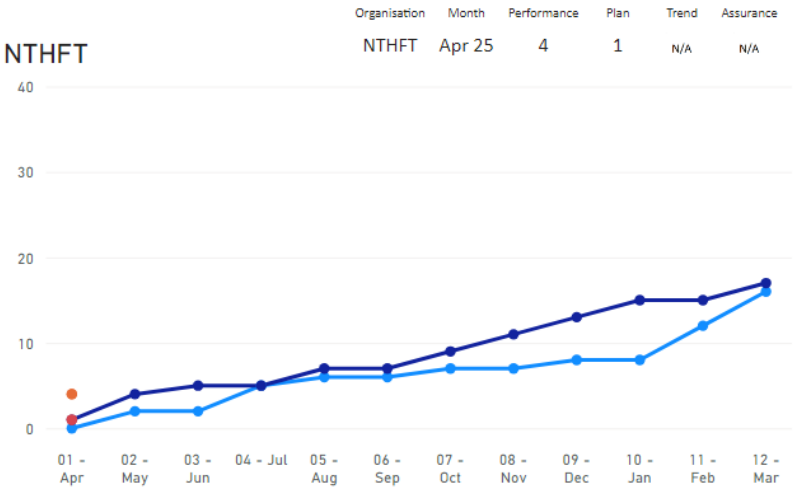
UHT

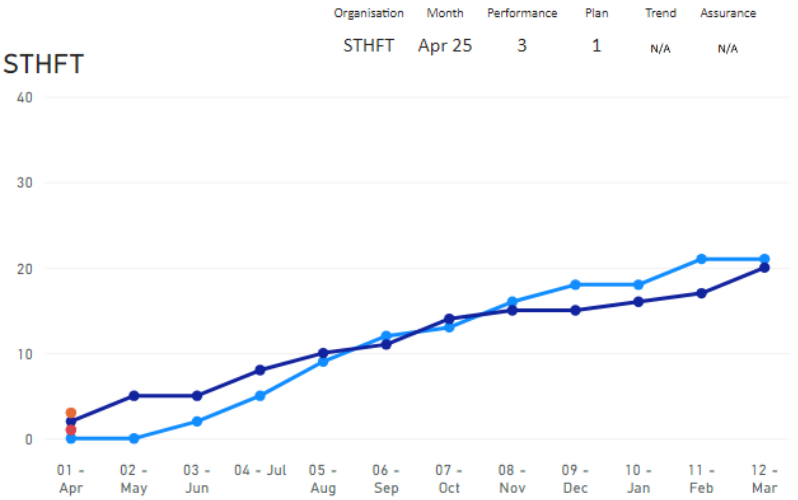
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	8	6	N/A	N/A

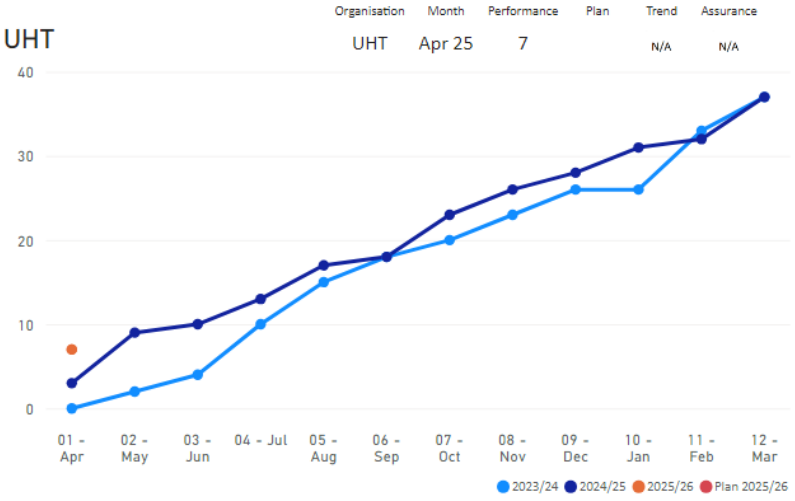


Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: Still to be confirmed
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 cases in April against trajectory of 2. STHFT: 4 cases in April against trajectory of 4.
Assurance: NTHFT: Alert, more cases than trajectory YTD. STHFT: Advise, cases align to trajectory YTD.
Action taken: Planned vascular access audit at NTHFT with focus on documentation and assessment, aligned across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Pseudomonas (YTD)







Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: Still to be confirmed
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 cases in April against trajectory of 1. STHFT: 3 cases in April against trajectory of 1.
Assurance: NTHFT: Alert, more cases than trajectory YTD. STHFT: Alert, more cases than trajectory YTD.
Action taken: Focus on water safety due to recent outbreaks. Agreed removal of water coolers across NTHFT following concerns over cleaning and maintenance, clear communications to be developed.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MATERNITY SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

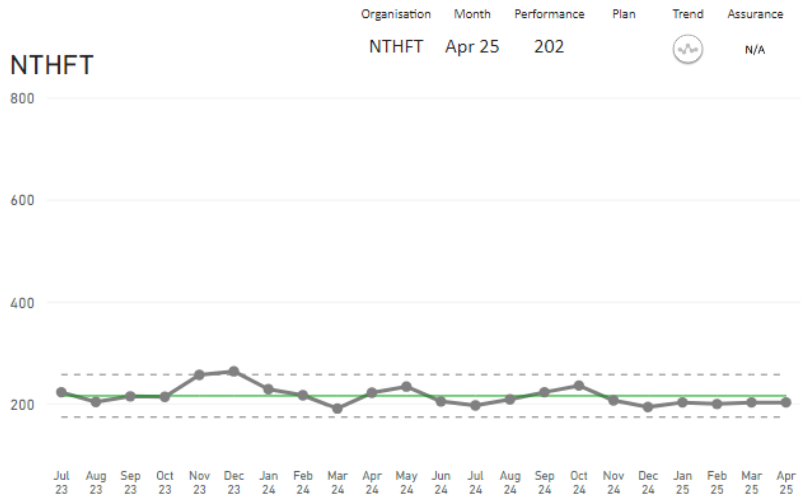
Trends in maternity services metrics reflect the different case mix at the two Trusts, with a greater proportion and the more complex of the high-risk pregnancies, being cared for at the James Cook University Hospital, which impacts on metrics. The increasing still birth rate at NTHFT is alerted to the Board, whilst a reducing rate is seen at STHFT. Breastfeeding rates are a focus, with actions in place and new roles being developed at NTHFT to support and promote breastfeeding. Both Trusts participate in simulation exercises, care bundles and research studies to identify where clinical care can be further improved.

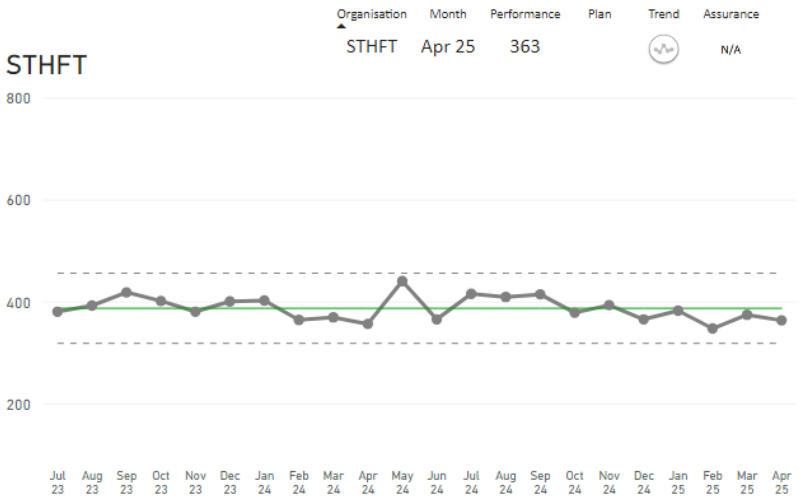
Regular in-depth reporting on maternity services takes place through Quality Assurance Committee and the Local Maternity and Neonatal System Board.

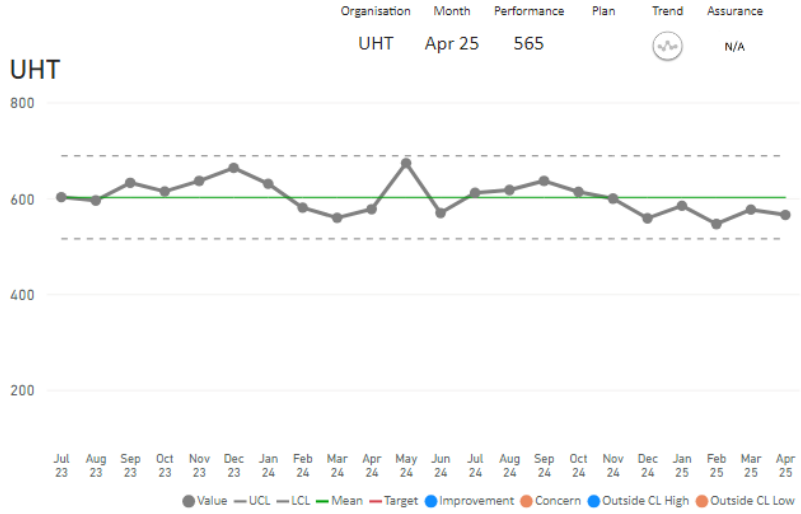
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
No. of babies born		233	204	196	208	222	235	206	193	202	199	202	202
Still Birth Rate (Rolling 12 months, per 1000 births)		2.23	2.63	1.9	2.27	1.89	2.62	3.05	2.74	3.17	3.19	3.97	4
Breast Feeding at First Feed	72.3%	45.3%	54.7%	56.1%	50.2%	50%	48.5%	52.7%	53.9%	52.2%	51.5%	53%	51.5%
PPH >= 1500ml Rate per 1000 Births		12.8	29.6	30.5	33.8	27	25.4	34.1	25.5	40	45.5	24.8	29.6
3rd/4th Degree Tear (%)		0.4%	0.5%	0.5%	0%	2.3%	1.3%	1%	1.5%	0.5%	2%	0.5%	1.5%

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
No. of babies born		440	365	415	409	414	378	393	365	382	347	374	363
Still Birth Rate (Rolling 12 months, per 1000 births)		4.05	4.05	3.6	4.01	3.8	4.03	4.23	4.26	3.64	3.87	3.22	3.43
Breast Feeding at First Feed	77.1%	66.6%	67.1%	69.7%	69.5%	70.1%	67.2%	66.3%	67.8%	64.3%	63.4%	68.2%	63.9%
PPH >= 1500ml Rate per 1000 Births		32.3	36	42	34.4	31.9	51.4	36.2	30.6	26.8	32.4	29.6	28.1
3rd/4th Degree Tear (%)		1.5%	2.9%	2.5%	2.8%	1.8%	2.3%	4%	2.8%	0.9%	2.6%	5.7%	2.4%

SAFE No. of babies born

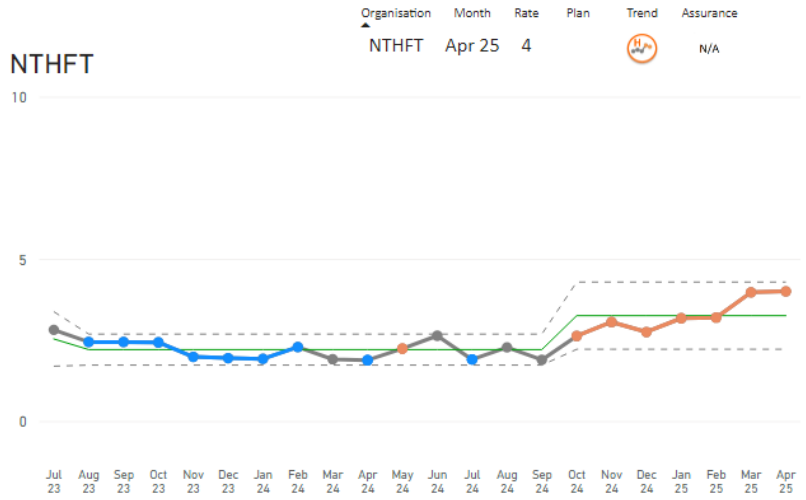


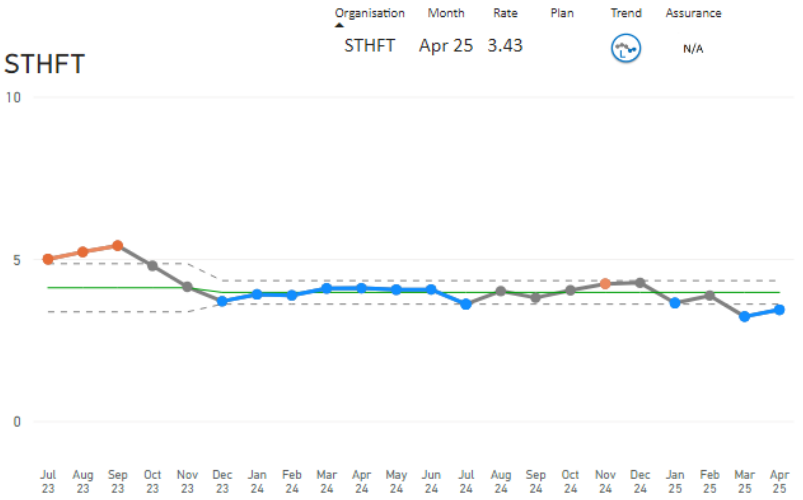


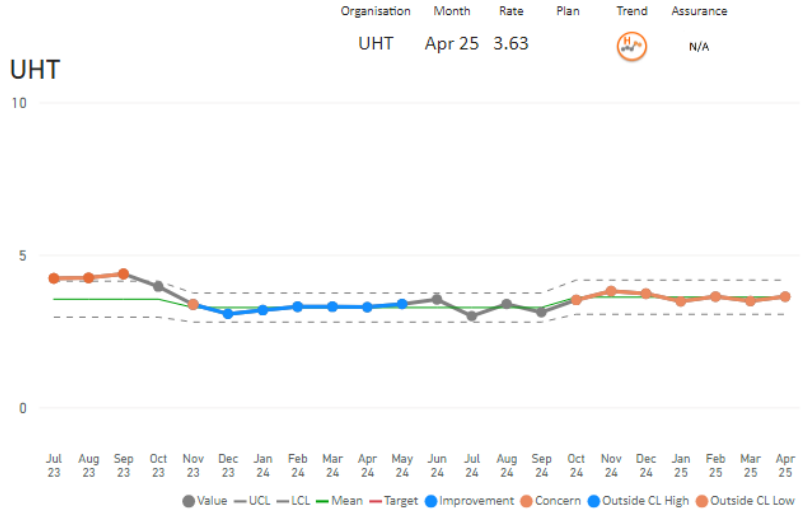


Metric: Count of babies born under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: Number of births at NTHFT and STHFT is stable over 2-year timeframe.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Still Birth Rate (Rolling 12 months, per 1000 births)





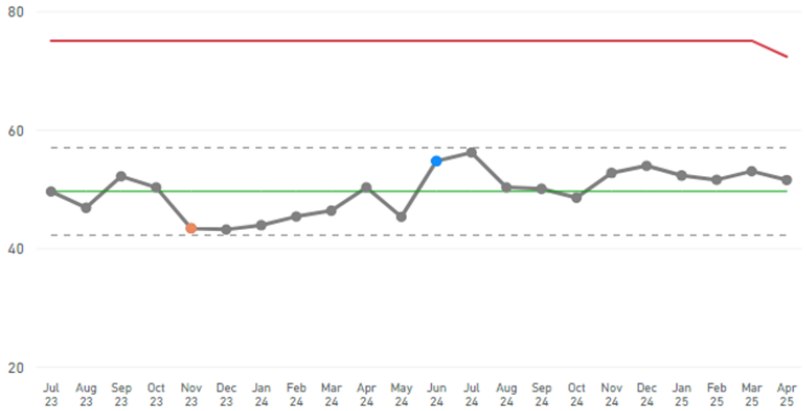


Metric: Still birth rate (Rolling 12 months per 1000 births).
Plan: National ambition to reduce still births by 50% by 2025
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: Still births showing an increasing trend over last 7 months. STHFT: Stable trend with a rate in 3 of last 4 months lower (better) than range of expected rate.
Assurance: n/a.
Action taken: Perinatal losses are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team. Additionally, a thematic review is in progress and will be reported on for July 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Breast Feeding at First Feed

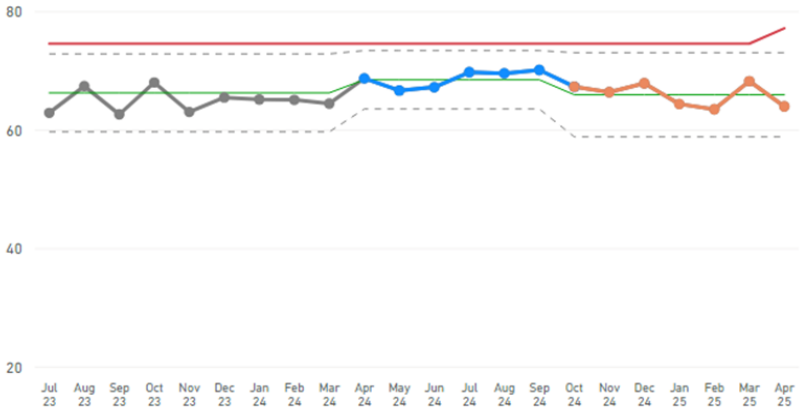
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	51.5%	72.3%		



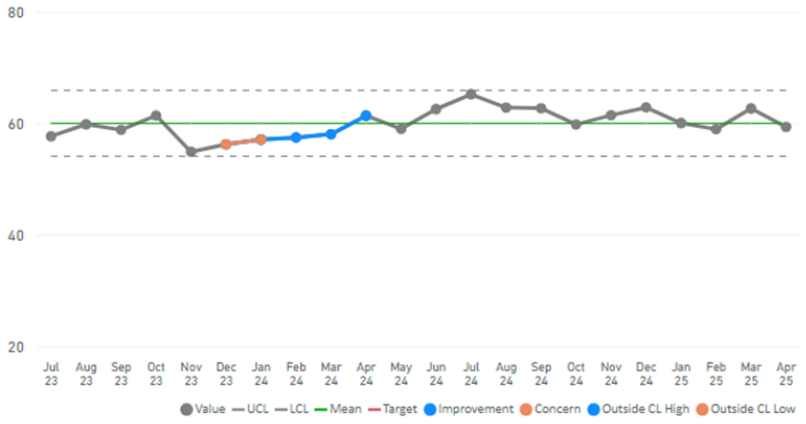
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	63.9%	77.1%		



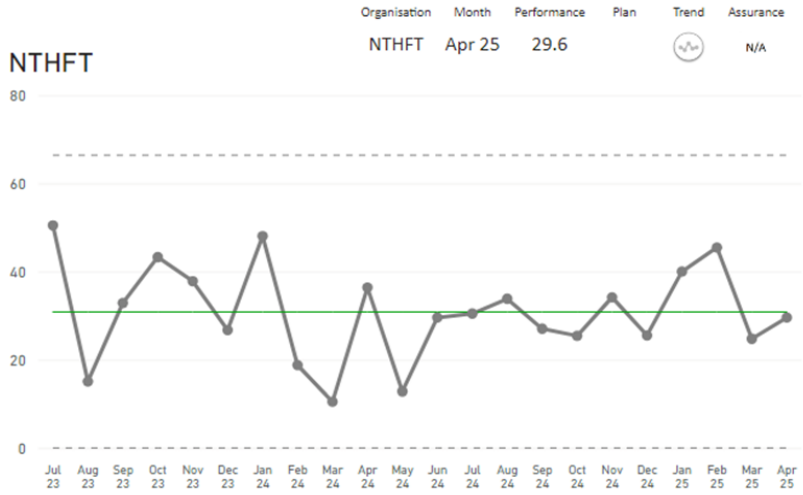
UHT

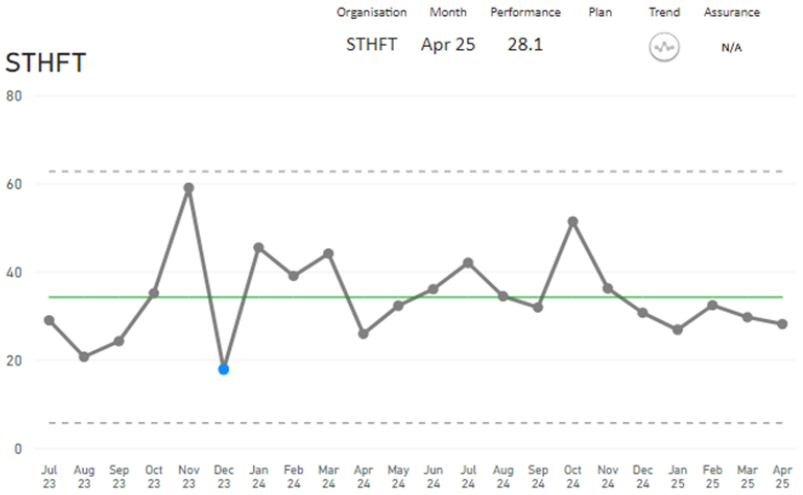
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	59.3%			N/A

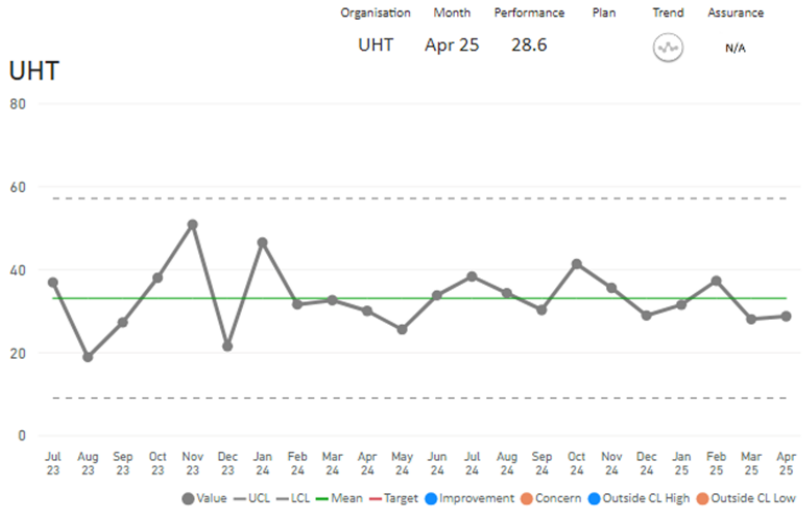


Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 25/26 to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: UNICEF Baby Friendly breast-feeding initiative; national maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: no trend and the 6week drop off rate is stable. STHFT: rates lower than expected in two out three recent months.
Assurance: Alert.
Action taken: Both sites are working towards breast-feeding initiative accreditation, which includes staff training, support to parents and infant feeding plans.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE PPH >= 1500ml Rate per 1000 Births





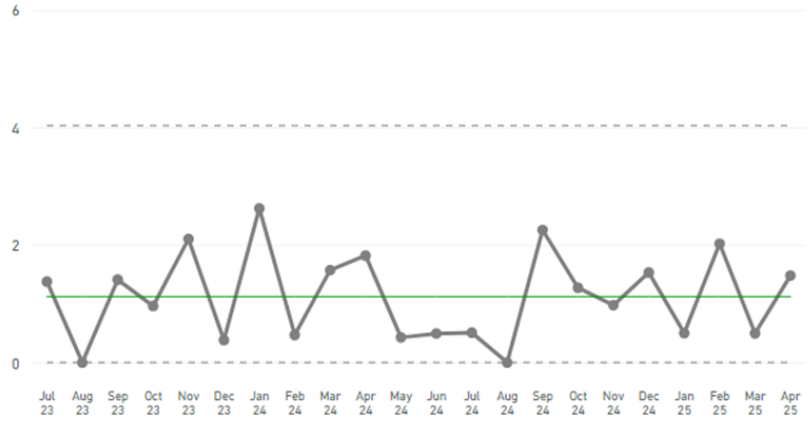


Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births
Plan: n/a
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: n/a
Action taken: Both NTHFT and STHFT are now part of a research study to look at interventions to reduce PPH.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE 3rd/4th Degree Tear (%)

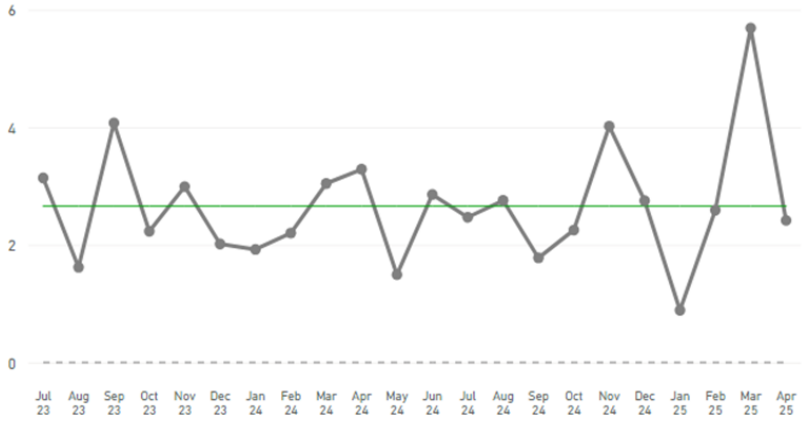
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	1.5%			N/A



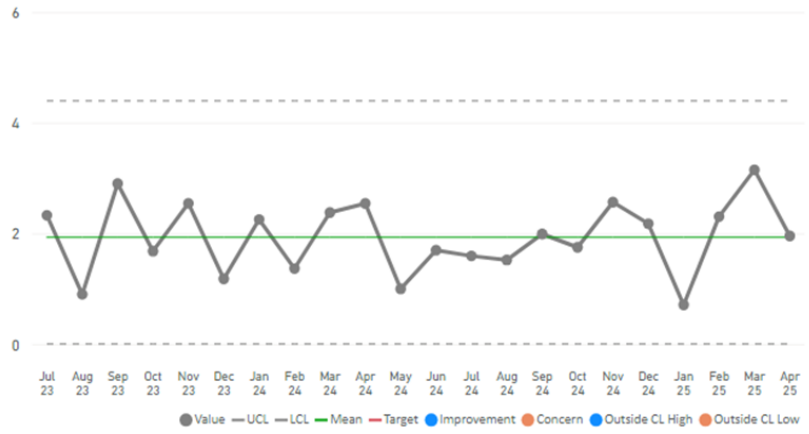
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	2.4%			N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	2%			N/A



Metric: Percentage of births with 3rd/4th degree maternal tear.
Plan: n/a.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: n/a
Action taken: Monitored and reviewed monthly as part of the Royal College of Obstetricians & Gynaecologists care bundle (OASI) which continues at both NTHFT and STHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

EFFECTIVE DOMAIN SUMMARY

Executive lead: Dr Michael Stewart, Chief Medical Officer Accountable to: Quality Assurance Committee

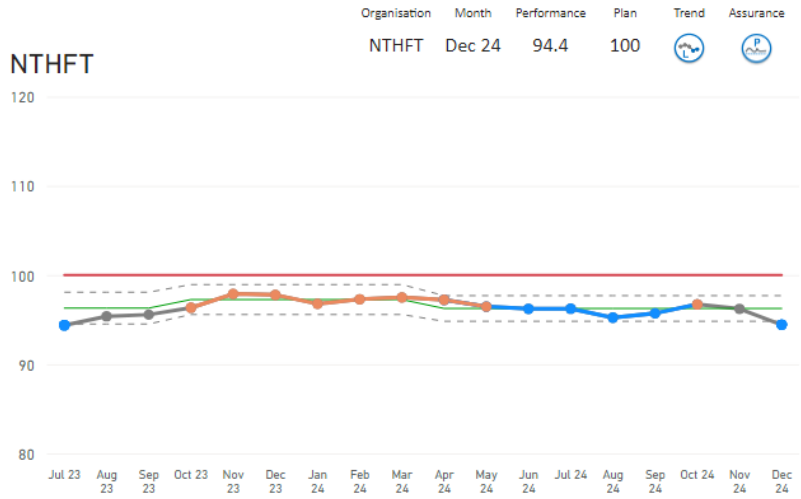
Summary Hospital-level Mortality Indicator (SHMI) is 'as expected' for both Trusts. Assurance is also provided by non-statistical approaches: Trust Medical Examiners review >98% of deaths and refer relevant cases to the Trust Mortality Surveillance team for further review/investigation/action where required. SHMI is influenced by the depth of co-morbidity coding: coding of co-morbidities is a theme in the STHFT coding action plan. Benchmarking identified this as an area for further improvement, and it appears that increased depth of codes recorded and flowing for analysis is impacting positively on SHMI. Learning across UHT contributes to this, as NTHFT benchmark well.

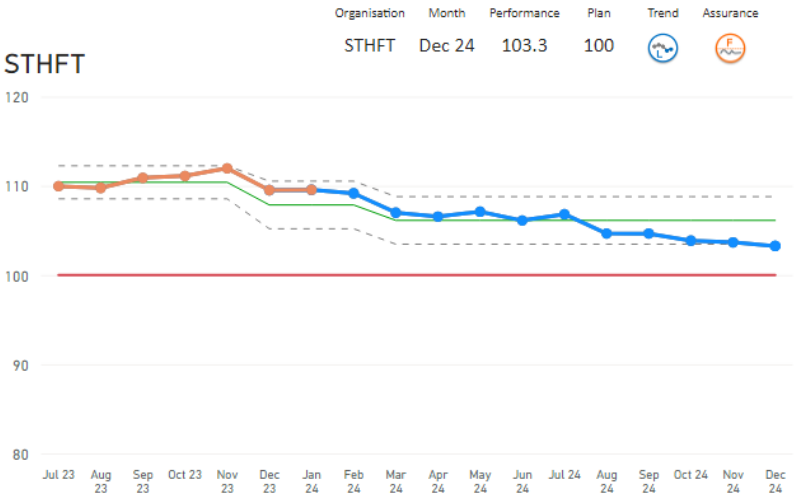
Both Trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. The IPR reports a standardised metric to enable benchmarking.

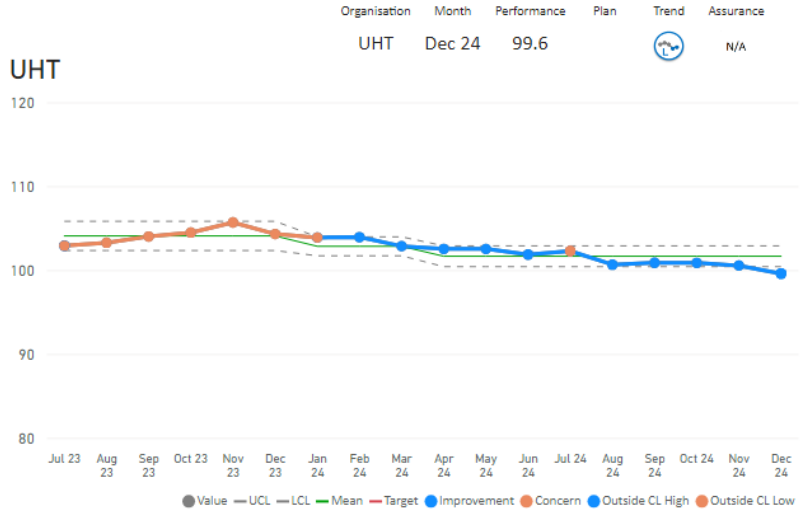
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Summary Hospital-Level Mortality Indicator	100	96.5	96.2	96.2	95.2	95.7	96.7	96.2	94.4	
Readmission Rate (%)	8.4%	10.9%	11.4%	10.8%	10.2%	10.4%	10.5%	11.1%	11.2%	10.7%

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Summary Hospital-Level Mortality Indicator	100	107.1	106.1	106.8	104.7	104.6	103.9	103.7	103.3	
Readmission Rate (%)	8.4%	8.5%	8.5%	8.8%	8.7%	9.1%	9.1%	8%	8.8%	8.1%

EFFECTIVE Summary Hospital-Level Mortality Indicator

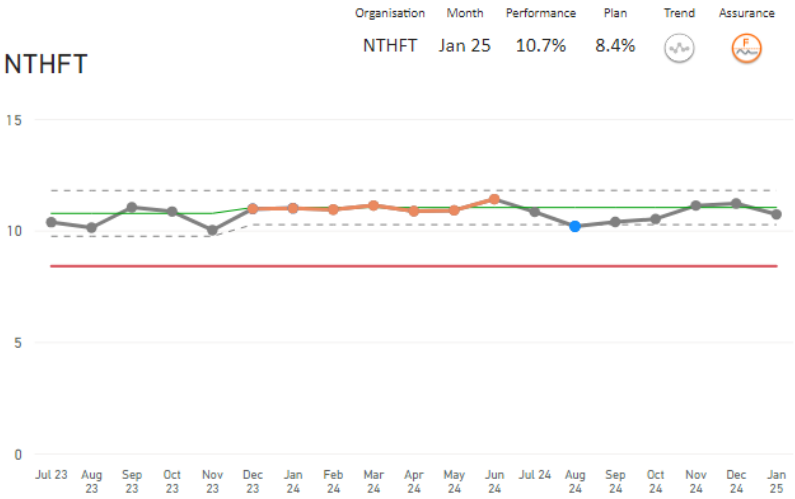


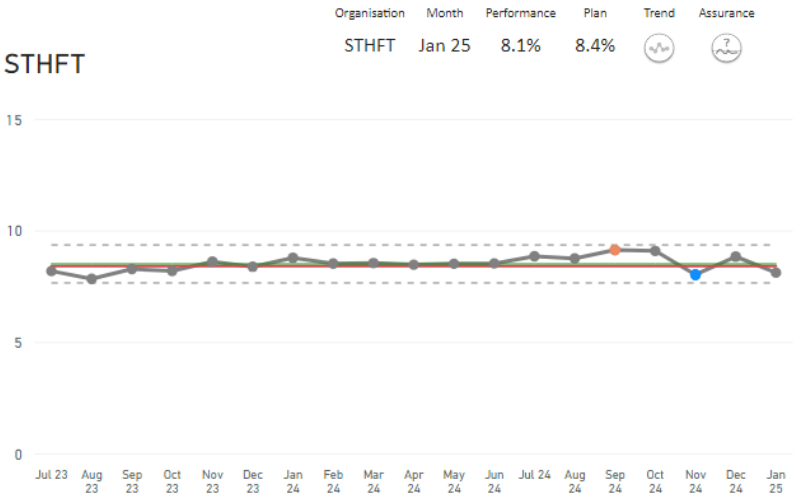


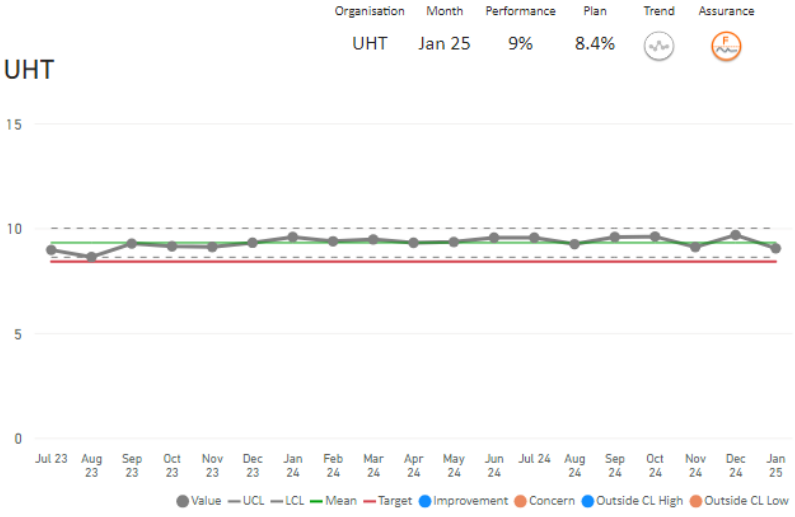


Metric: Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: stable trend. STHFT: improved SHMI is now sustained.
Assurance: NTHFT: Assure. Consistently below (better than) the national benchmark. STHFT: Advise. Above the national benchmark but within expected variation.
Action taken: Continued improved depth of coding at STHFT may lead to further improvement in SHMI.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

EFFECTIVE Readmission Rate (%)







Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
Trend: No trend.
Assurance: NTHFT: Alert. Readmission rates consistently above national average. STHFT: Advise. Rates are close to national average.
Action taken: A pilot audit will be conducted during June at both Trusts on COPD re-admissions, which represent one of the highest re-admission rates across both organisations. Key stakeholders (including representation from Respiratory specialties) have been invited to form part of the pilot MDT. Initial analysis to be available in July 2025.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director **Accountable to: Resources Committee**

Urgent and emergency care

Assurance on ambulance handover performance at NTHFT improved following winter pressures, with minimal numbers of delays over 60 minutes. At STHFT significant improvement is evident from February 2025 following service improvement work to reduce release ambulance crews earlier.

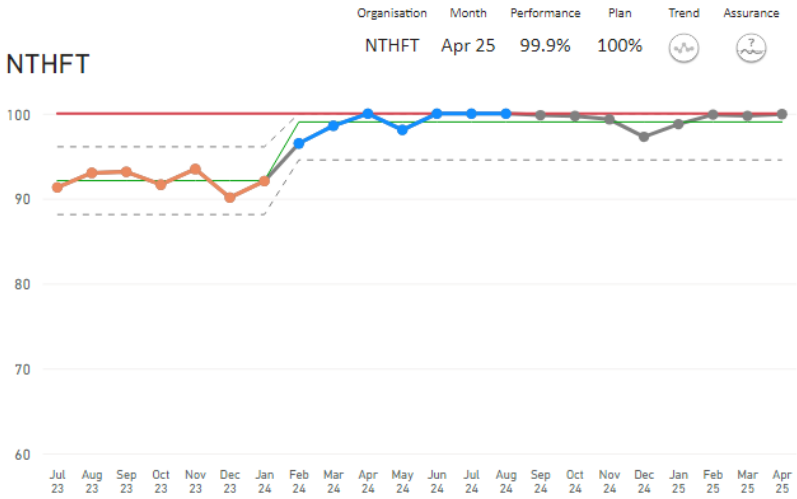
Whilst the IPR analysis alerts that the more challenging agreed operational plan for 4-hour standard held by NTHFT was not met, the national recovery standard of 78% was exceeded throughout for NTHFT as one of the top performing trusts nationally. NTHFT has been awarded urgent and emergency care incentive capital allocation in recognition of the high performance. There is continued focus at STHFT, including piloting new ways of working, to return to an improvement trend. Both Trusts achieved <2%12-hour breaches in April.

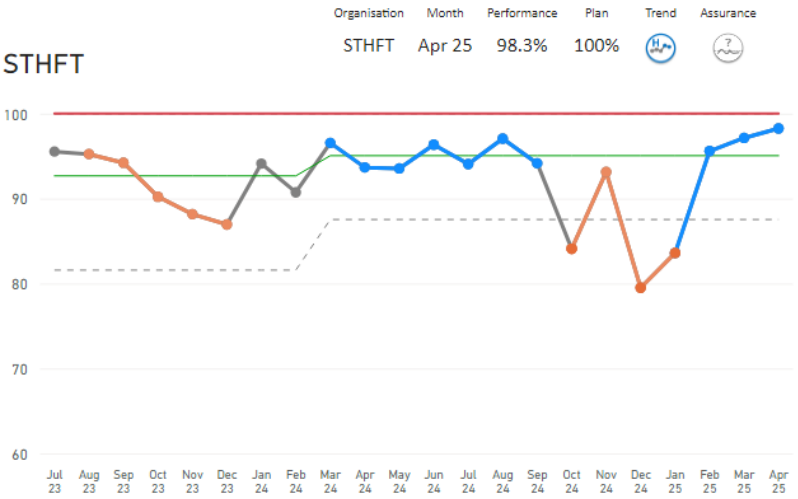
Above-standard performance in the community urgent 2-hour response reflects effective support to EDs by caring for patients in the most appropriate setting. Elective operations cancelled on the day not rebooked within 28 days requires improvement at STHFT: performance and actions are monitored at the Surgical Improvement Group.

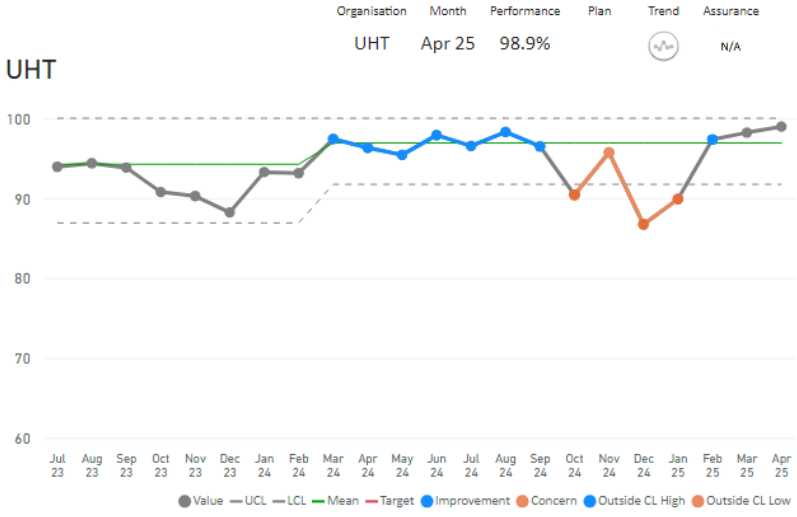
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Handovers - Within 60 Mins (%)	100%	98.1%	100%	100%	100%	99.8%	99.7%	99.3%	97.3%	98.8%	99.9%	99.7%	99.9%
4-Hour A&E Standard	88.9%	87.2%	89.2%	87.3%	89.4%	85.6%	83.8%	81.9%	80.9%	81.3%	85.5%	85.6%	83.3%
12-Hour A&E Breaches Rate	2%	0.2%	0%	0.2%	0.1%	0.4%	0.6%	1.1%	1.9%	2%	0.3%	0.5%	0.7%
Community UCR 2hr Response Rate (%)	70%	84%	82%	72%	75%	76%	79%	77%	73%	79%	72%	74%	
Cancelled Ops - Not Rebooked Within 28 days	0	1	3	2	2	2	3	3	4	5	10	0	3

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Handovers - Within 60 Mins (%)	100%	93.5%	96.3%	94.1%	97.1%	94.2%	84.1%	93.1%	79.5%	83.6%	95.6%	97.1%	98.3%
4-Hour A&E Standard	77.9%	73.5%	74.3%	76.9%	78.7%	77.3%	73.5%	75%	72.1%	74.2%	75.4%	75.7%	77%
12-Hour A&E Breaches Rate	2%	1.9%	1.7%	1%	0.7%	1%	3.6%	1.8%	4.1%	5%	2.1%	1.7%	1.8%
Community UCR 2hr Response Rate (%)	70%	86%	87%	86%	89%	83%	82%	83%	81%	80%	83%	86%	
Cancelled Ops - Not Rebooked Within 28 days	0	27	16	13	15	13	21	21	18	19	26	16	10

RESPONSIVE Handovers - Within 60 Mins (%)

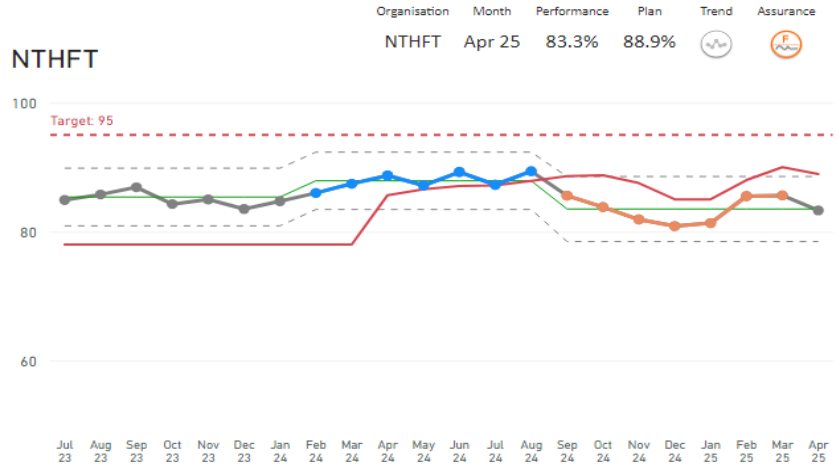


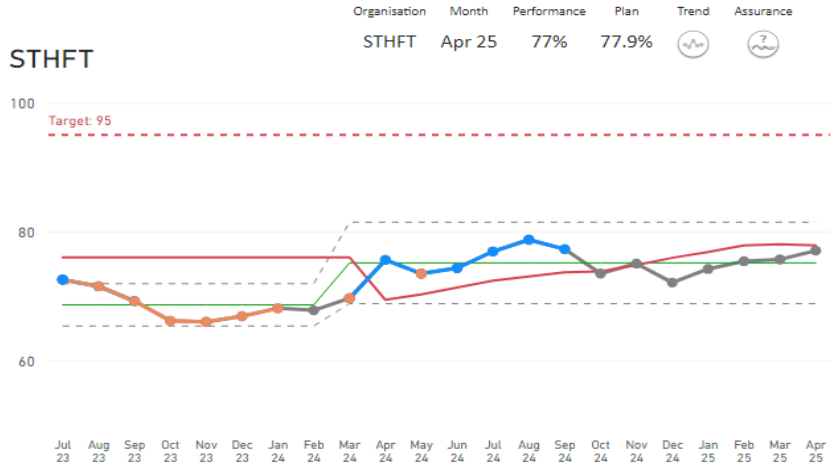


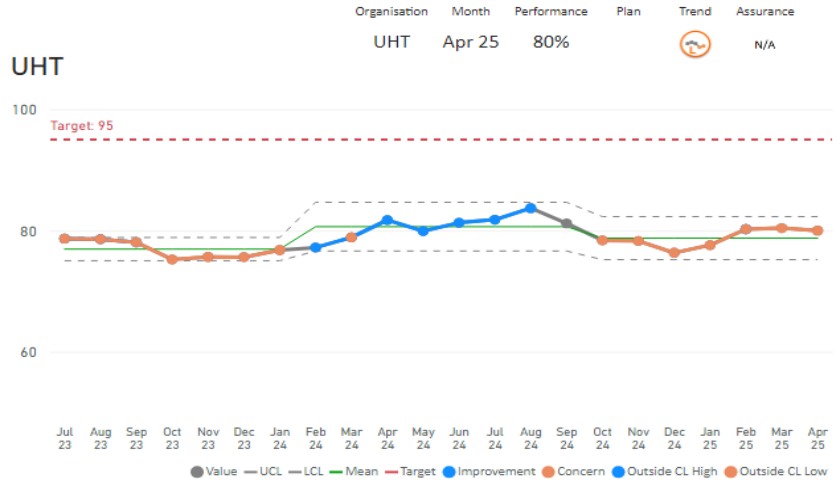


Metric: Percentage of ambulance handovers completed within 60 minutes of arrival at ED. During 25/26 this will be amended to 45 minutes to reflect the planning guidance.
Plan: 100% within 60 minutes.
Rationale: NHS Contract metric.
Data quality: Advisory: validated data from Trust systems may differ from published data from ambulance services.
Trend: NTHFT: No trend. STHFT: improving trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT continue focusing on timely release of crews to full compliance with the standard, utilising corridor care at times of surge to release ambulance crews. STHFT ED and admissions unit teams are embedding improvement trajectory learning. A new pathway trial has shifted 10% ambulance activity from ED.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 4-Hour A&E Standard





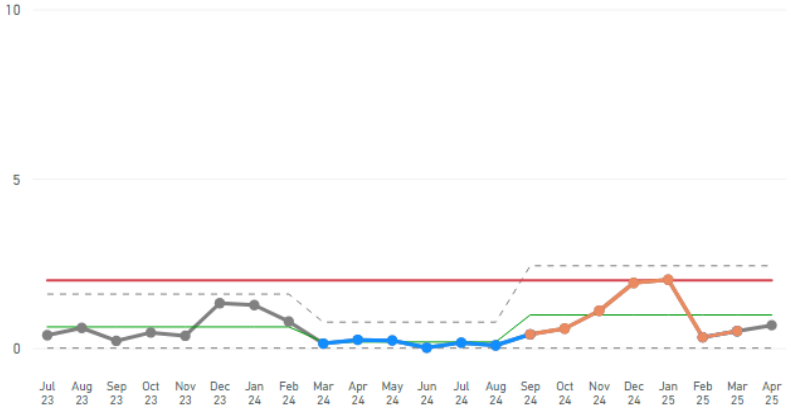


Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, agreed operational plan to achieve 90% NTHFT, 78% STHFT by March 2026.
Rationale: NHS Contract metric.
Data quality: NTHFT recent performance may have been impacted by data quality, being resolved with EPR supplier.
Trend: No trend.
Assurance: NTHFT: Alert, Trust plan not met. STHFT: Advise, Trust plan not met for last five months.
Action taken: NTHFT: Partnership working to improve flow within and out of the Trust, monitored via the 4-hour steering group. Working with BI and EPR team to ensure accuracy and validation of data. STHFT: Planning to implement new model in June to reduce time to clinician assessment. Trial of ambulance admission pathways underway and being evaluated.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 12-Hour A&E Breaches Rate

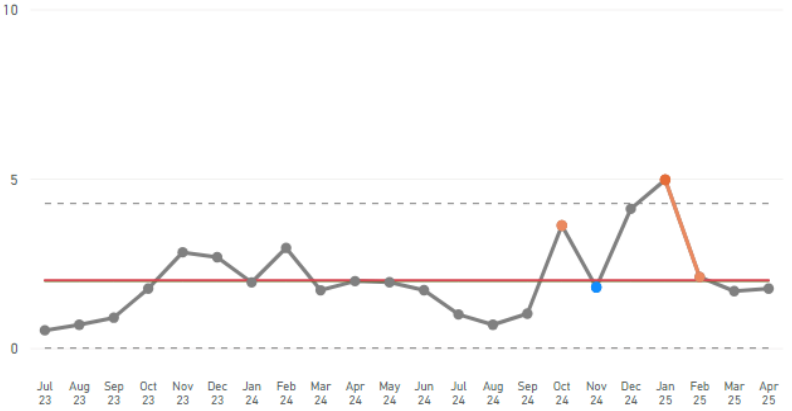
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	0.7%	2%		

NTHFT



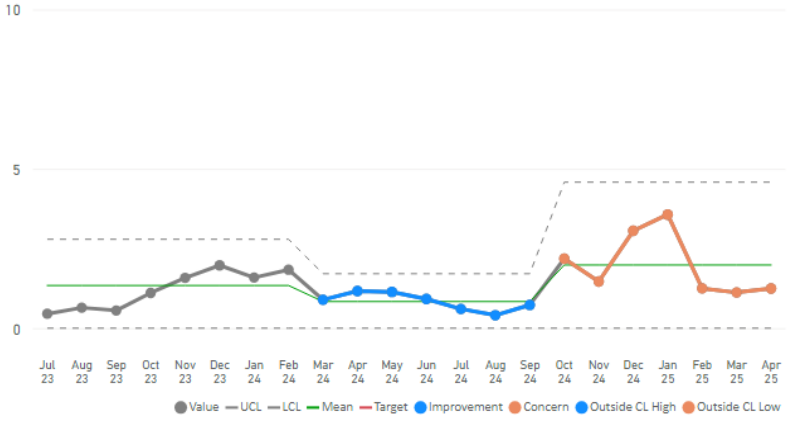
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	1.8%	2%		

STHFT



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	1.2%			N/A

UHT

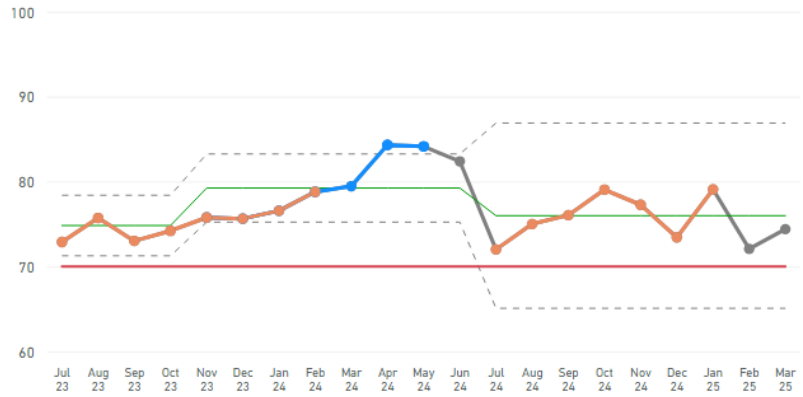


Metric: Percentage of patients admitted or discharged from A&E (all types) after 12 hours.
Plan: NHS Contract standard: No more than 2% of patients attending spend more than 12 hours in A&E.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Advise.
Action taken: NTHFT utilise all available escalation beds and temporary escalation spaces at times of surge, alongside Full Capacity Protocol reviewed at daily OPEL meetings to manage patient flow. All breaches are audited to identify key themes weekly. With a return to more typical breach rates, assurance return to Advise (from Alert). STHFT auditing 12-hour breaches with service improvement initiatives currently being delivered .
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Community UCR 2hr Response Rate (%)

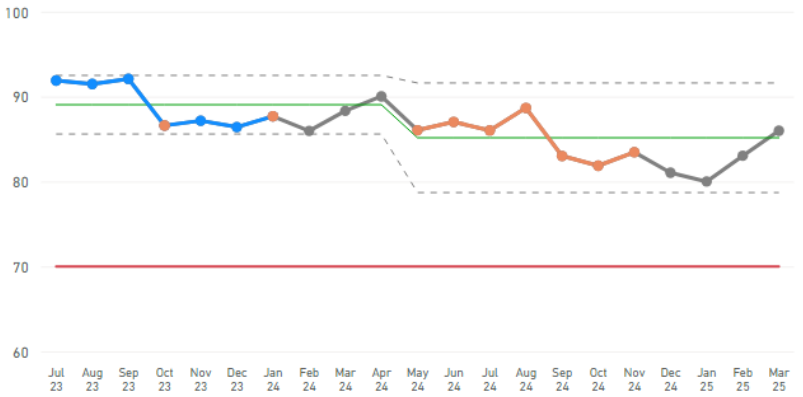
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Mar 25	74%	70%		



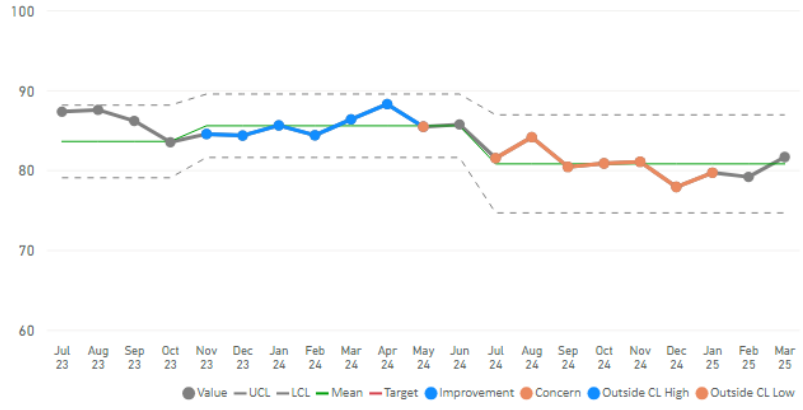
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Mar 25	86%	70%		



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Mar 25	82%			N/A

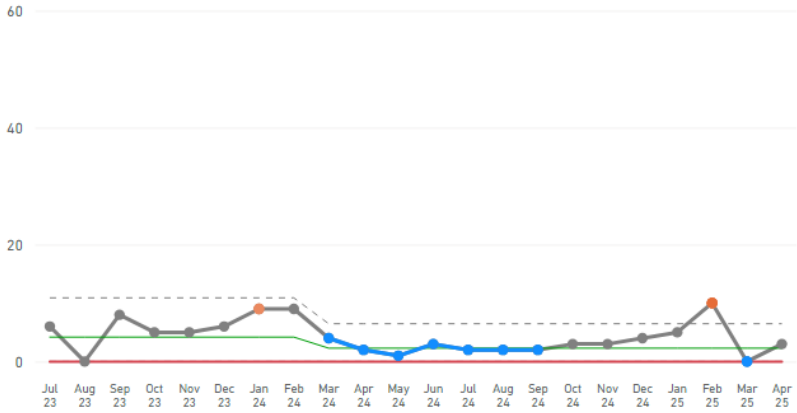


Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, and available one month in arrears. A national change to the inclusion criteria for this metric has been applied retrospectively, minimal performance impact.
Trend: No trend.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: Community rapid response services remain a key element of caring for patients in the most appropriate setting, with focus on consistency of response rates returning STHFT performance to assured after a trend of reducing compliance.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days

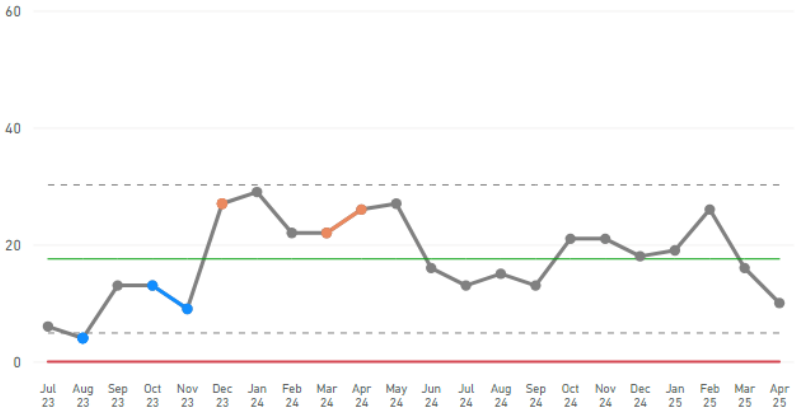
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	3	0		

NTHFT



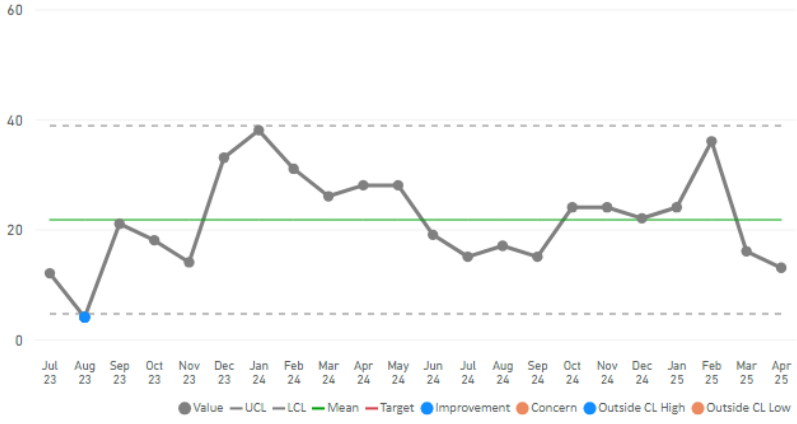
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	10	0		

STHFT



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	13			N/A

UHT



Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Special cause variation for February 2025 (high) and March 2025 (low). STHFT: No trend.
Assurance: NTHFT: Advise, number of operations not rebooked in 28 days lower than expected. STHFT: Alert, standard is consistently not met.
Action taken: Daily review of all cancellations is in place at NTHFT, and services remain focussed and committed to reappointing patients within the timeframe. At STHFT, two pilots have been undertaken to reduce avoidable cancellations with a view to wider roll out and services are working to improve compliance with 28-day rebooking.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director **Accountable to: Resources Committee**

Elective, diagnostic and cancer care

Achievement of key access targets continues to be challenging and are logged as strategic risks for both Trusts. Cancer faster diagnosis standard performance is not assured for NTHFT, while STHFT performance has deteriorated. Trusts have an agreed recovery trajectory to meet 80% by March 2026 as timely diagnosis is critical to improving cancer pathways. STHFT has entered tiered support from NHS England in February 2025 to improve 62-day standard performance and robust action plans are being implemented, beginning with the diagnostic process in the Urology prostate pathway where changes are being closely monitored. At NTHFT tumour specific pathway improvements continue to be driven by the clinically-led Cancer Delivery Group. Respiratory and Urology pathways have been identified as key focus areas for service improvement. Challenging yet achievable recovery plans have been agreed for 2025/26 with improvements being seen in Month 1.

For 2025/26 operational recovery trajectories have been agreed per Trust, for RTT 18-week standard, time to first appointment and percentage of patients wating more than 52 weeks. Actions and interventions in hand include waiting list validation, clinic template review and additional 'super clinics' in targeted specialties with the greatest patient access/demand challenges. Patients with the longest waits are targeted, with no patients waiting over 65 weeks at NTHFT since September 2024.

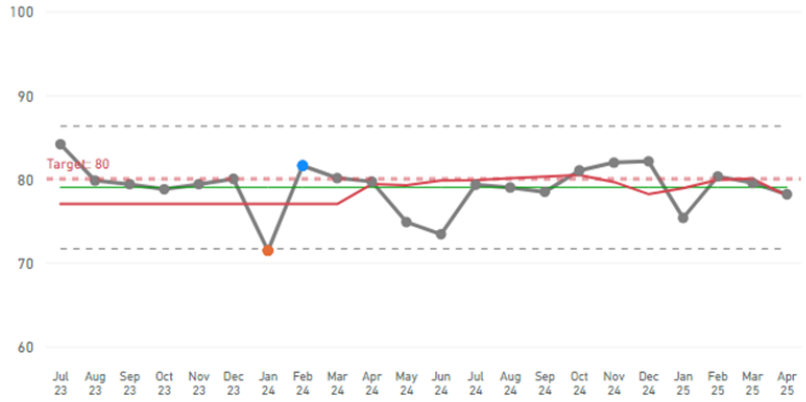
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Cancer Faster Diagnosis Standard (%)	78%	74.9%	73.4%	79.3%	79%	78.4%	81%	81.9%	82.1%	75.3%	80.3%	79.5%	78.2%
Cancer 31 Day Standard (%)	96.2%	97.8%	95.8%	96.3%	97.9%	91.8%	94.7%	96.2%	96.6%	96.6%	96.4%	93.8%	97.2%
Cancer 62 Day Standard (%)	71.5%	65.1%	59.7%	62.2%	72.7%	60.1%	70.8%	71.6%	76.2%	72.2%	63.4%	67%	64.3%
Diagnostic 6 Weeks Standard (%)	95%	74.5%	69%	72.9%	72.3%	77.7%	82.7%	86.5%	83.9%	91.6%	95.1%	96.7%	95.1%
RTT Incomplete Pathways (%)	71.5%	72.5%	72.2%	71.7%	71.6%	72.1%	72.4%	71.5%	72.5%	73.2%	74.4%	75.5%	74.5%
RTT 52 Week Waiters Rate	0.9%	0.8%	0.8%	0.9%	0.9%	0.8%	0.9%	1.1%	0.9%	0.8%	0.8%	0.8%	1%
RTT Time to First Appointment (%)	78.6%	79.5%	79.4%	78.6%	77.3%	77.8%	79.2%	78.6%	79.5%	80.1%	81.8%	82.2%	81.7%

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Cancer Faster Diagnosis Standard (%)	77%	80.5%	79.2%	78%	78.9%	78.9%	73.6%	75.7%	75.2%	72.2%	75.9%	71.1%	72.3%
Cancer 31 Day Standard (%)	91%	91.5%	92.4%	93.1%	92.3%	91.1%	90.5%	89.1%	88.3%	81.1%	86.8%	82.6%	86.6%
Cancer 62 Day Standard (%)	60%	58.7%	59.3%	63.7%	59.2%	61.9%	56.7%	58.5%	59.9%	63.1%	61%	61.2%	62.3%
Diagnostic 6 Weeks Standard (%)	95%	81.6%	80.9%	83.2%	82.3%	84.9%	85.9%	85.5%	85%	88.7%	88.7%	87.4%	85%
RTT Incomplete Pathways (%)	60.3%	61.6%	60.7%	60.3%	58.9%	59.1%	60.2%	60%	59.4%	59.5%	59.9%	60.3%	61.1%
RTT 52 Week Waiters Rate	2.7%	3.3%	3.7%	3.7%	3.8%	3.2%	2.6%	2.8%	2.7%	2.9%	2.9%	2.7%	2.8%
RTT Time to First Appointment (%)	65.6%	66.3%	65.1%	64.6%	63.5%	63%	65.1%	65.2%	64.3%	64.3%	64.8%	64.7%	66.2%

RESPONSIVE Cancer Faster Diagnosis Standard (%)

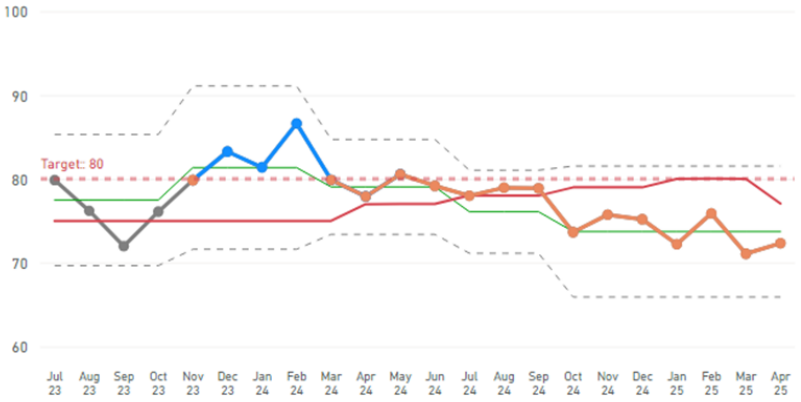
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	78.2%	78%		

NTHFT



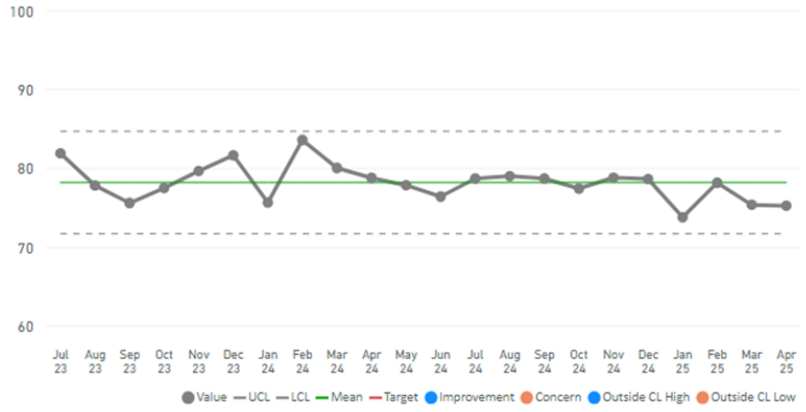
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	72.3%	77%		

STHFT



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	75.2%			N/A

UHT

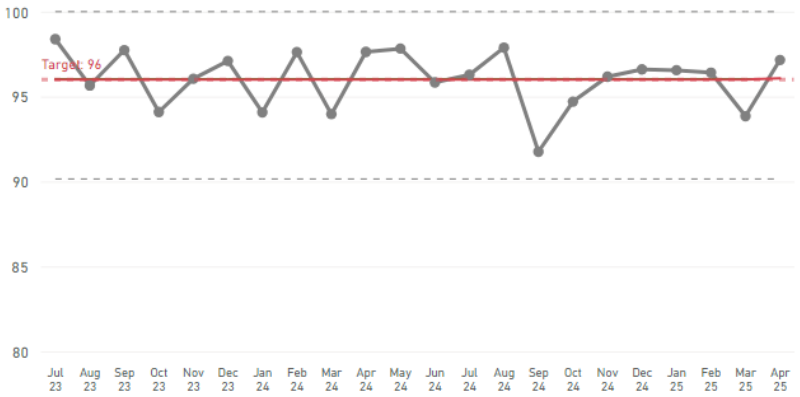


Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 80% (from April 2025). Agreed operational planning trajectories: NTHFT 81%, STHFT 80% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: deteriorating trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: NTHFT continue to focus on further improving compliance in urology and respiratory pathways. STHFT focus is on further improving compliance in urology and gastro-intestinal tumour groups. Recent changes in prostate diagnostic pathway are being monitored with early evidence of improvement in process steps from April 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Cancer 31 Day Standard (%)

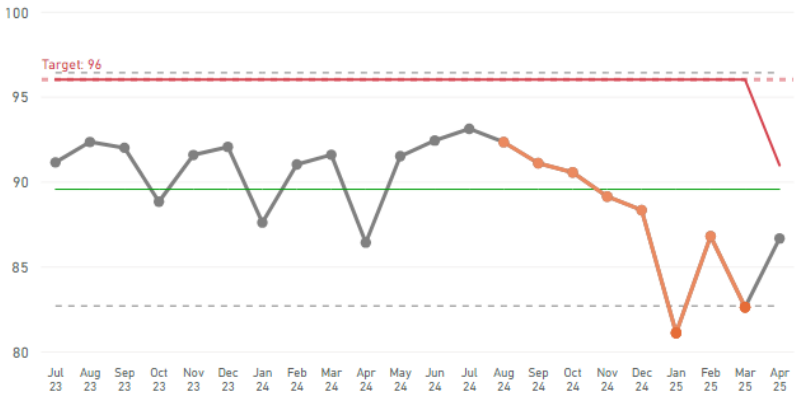
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	97.2%	96.1%		



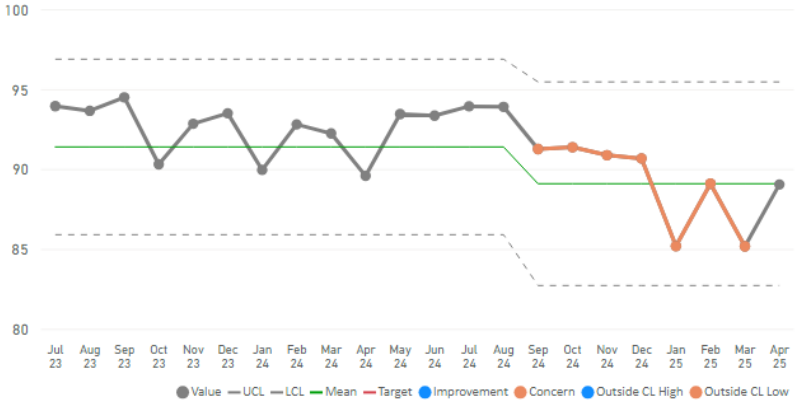
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	86.6%	91%		



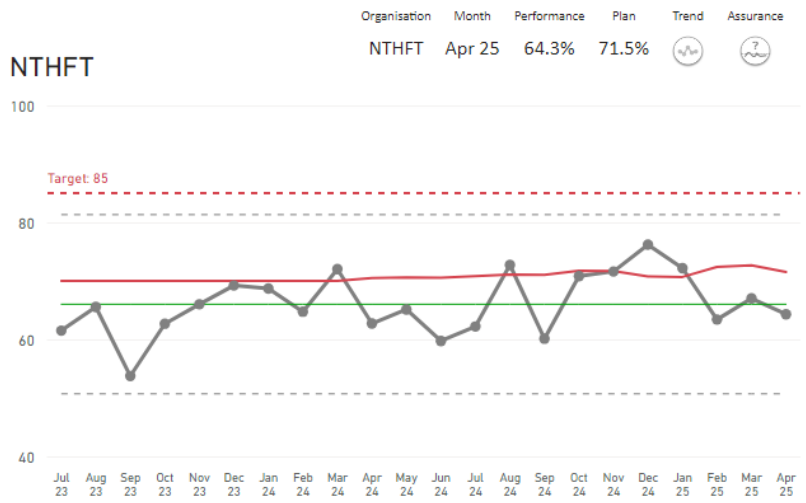
UHT

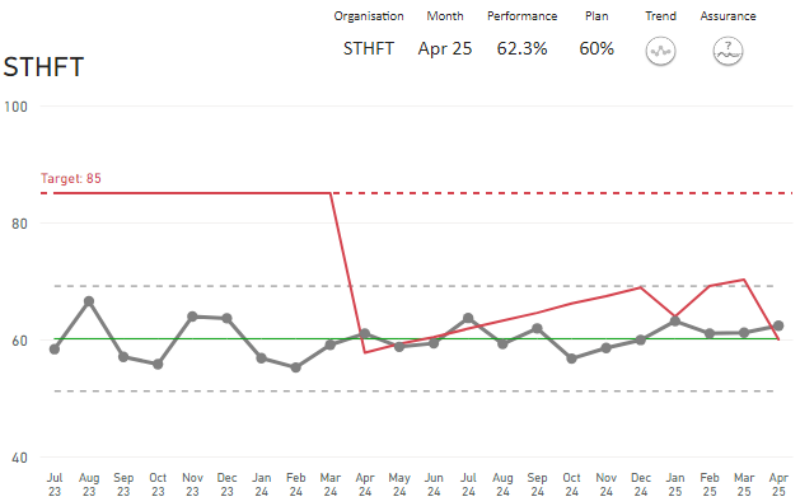
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	89%			N/A

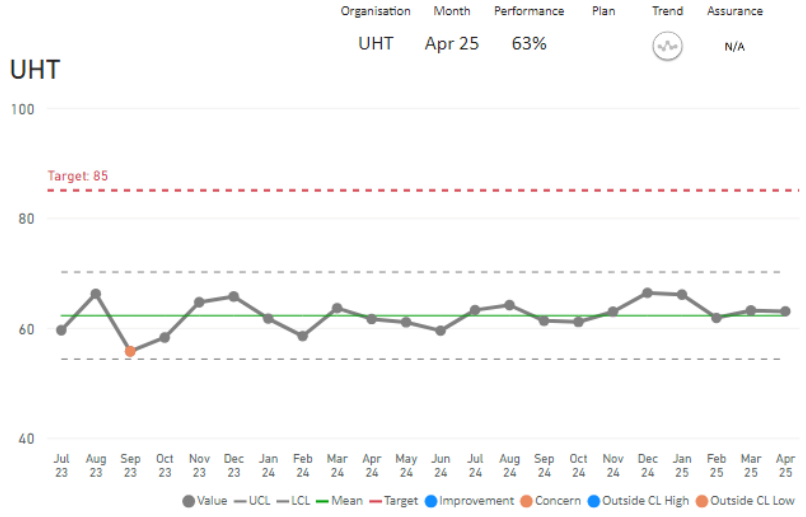


Metric: Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
Plan: NHS Constitution standard 96%. Agreed operational planning trajectories to 96.5% NTHFT, 93.1% STHFT by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT: Urology pathways identified as key focus areas for performance improvement throughout 2025-26 **.** STHFT focus is the patients waiting longest for treatment (overall pathway time) and pathway improvement work for suspected prostate cancer. Action plan for timeliness of radiotherapy subsequent treatments.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Cancer 62 Day Standard (%)

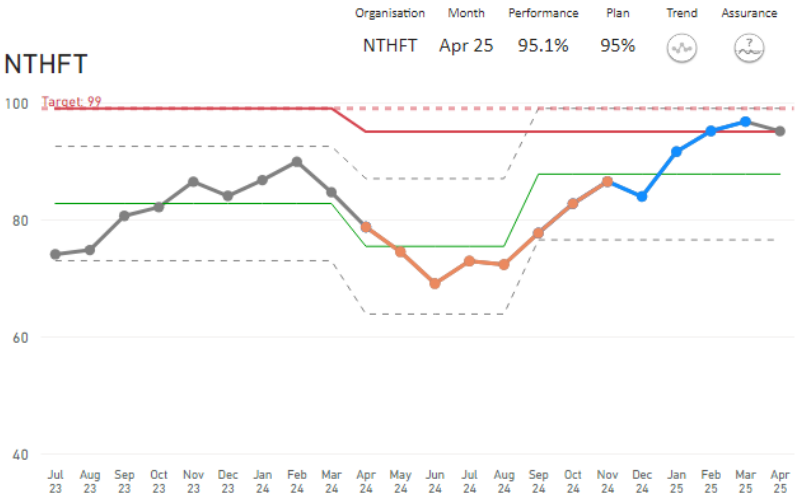


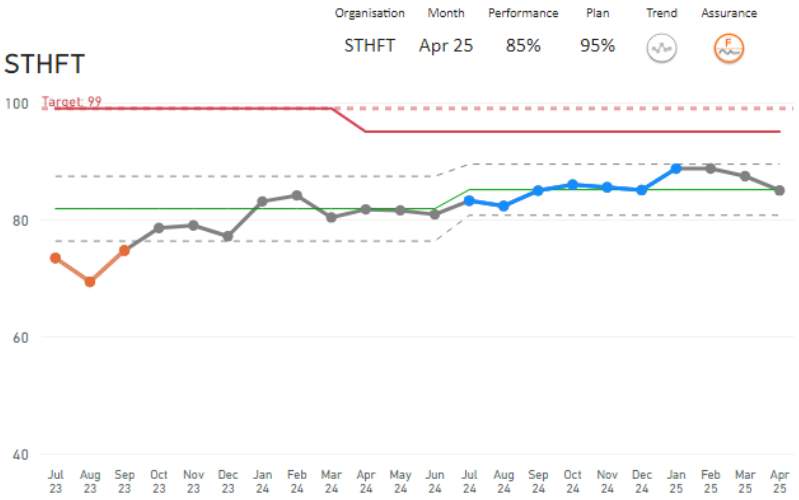


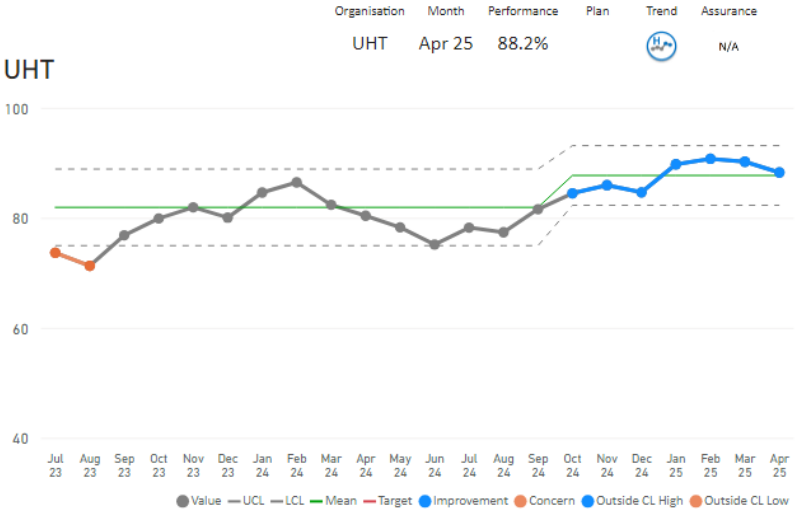


Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Agreed operational planning trajectories: NTHFT 75% and STHFT 68.3% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus for both Trusts is the patients waiting longest for treatment, this brings patients beyond 62-days into the metric. Service improvement work across the Group is underway across tumour groups with recent changes in prostate diagnostic pathway being monitored for improvements which are expected to be evident from May 2025 with full effect from June 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Diagnostic 6 Weeks Standard (%)

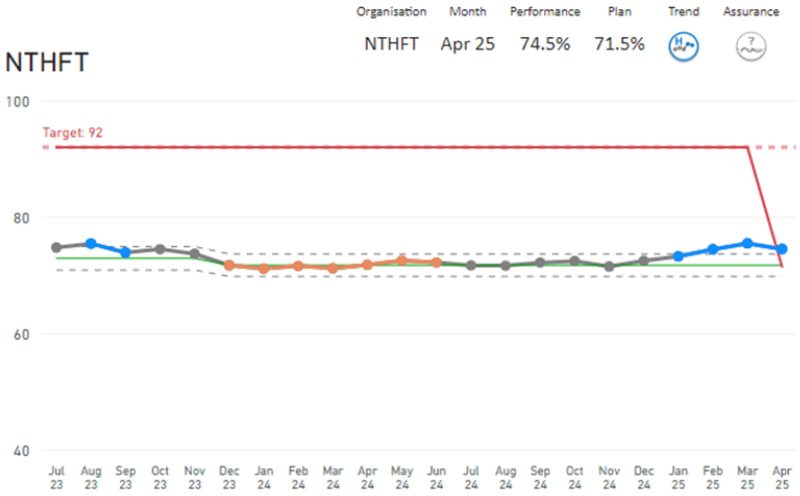


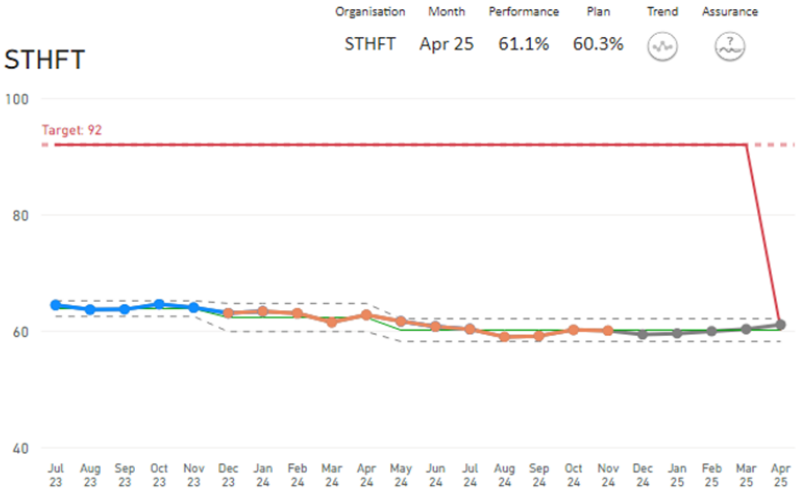


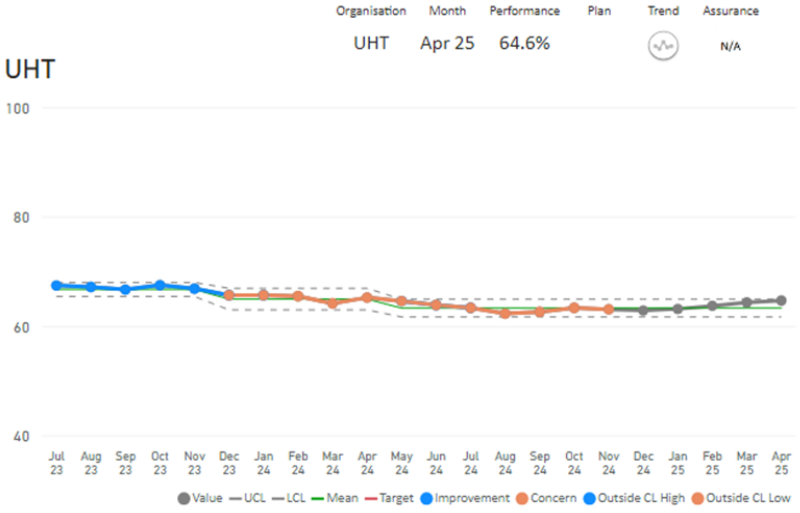


Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise. STHFT: Alert, as previous improvement trend stalled, impacted by a change in scope of metric to include more planned/surveillance patients.
Action taken: Both Trusts gained additional capacity from April 2025 with the opening of the Stockton Community Diagnostic Centre, which will improve compliance. STHFT: improvement work is underway in specialist services but will show only incremental improvement over several months.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT Incomplete Pathways (%)

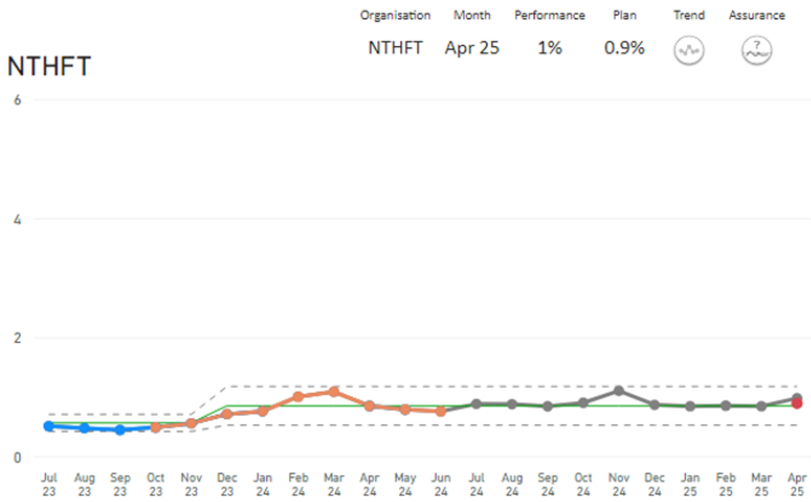


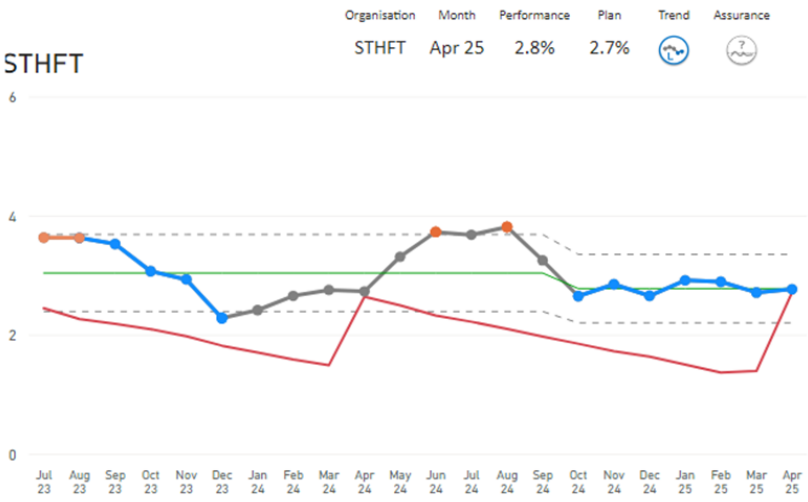


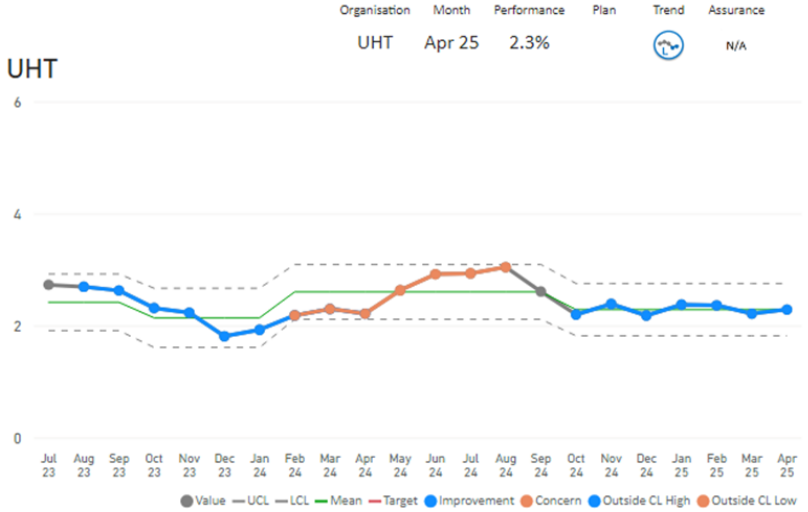


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%. Agreed operational planning trajectories: NTHFT 76.5%, STHFT 65.0% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improved performance since January 2025. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks, and both Trusts out-performed the new plan in April 2025. Focused plans are being developed to achieve 5% improvement for 25/26, including further validation of lists.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT 52 Week Waiters Rate

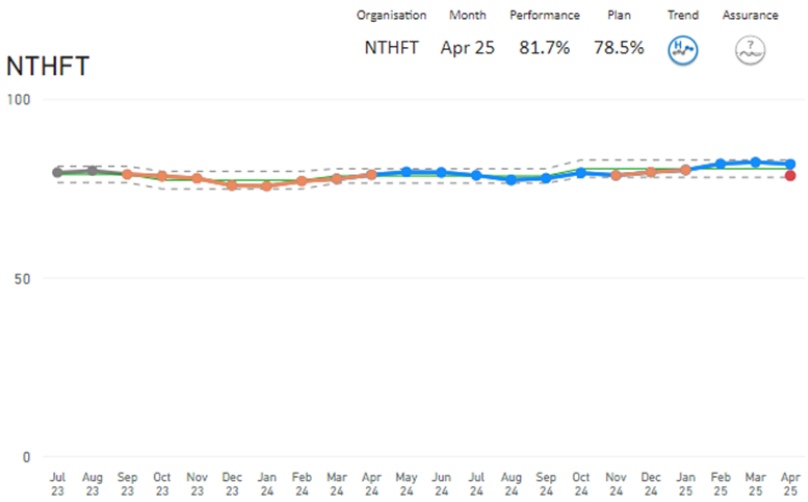


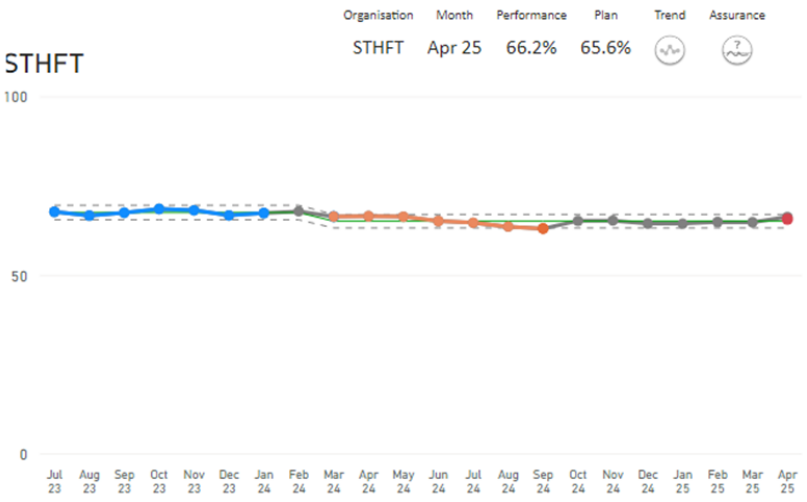


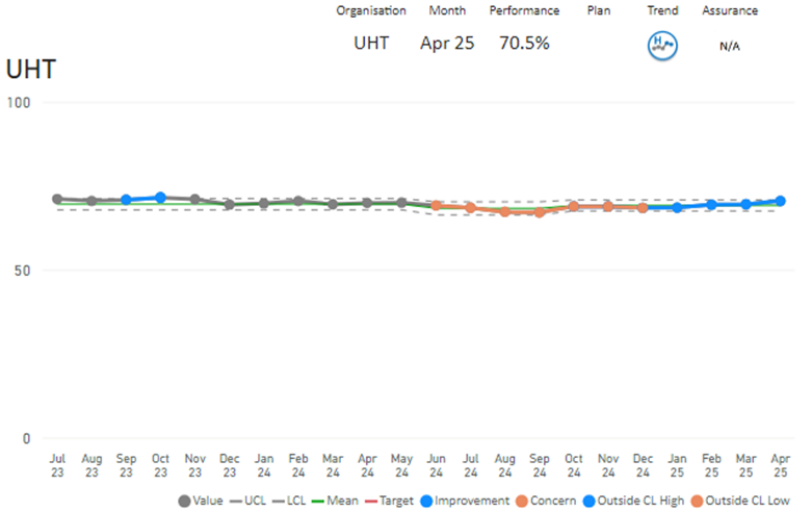


Metric: Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To reduce the number of 52-week waiters and eliminate 65-week waiters by September 2024.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: improving position since October 2024.
Assurance: NTHFT: Advise; STHFT: Advise.
Action taken: Both Trusts are working at both organisational and system level to reduce longer waits. NTHFT currently refreshing capacity and demand across all specialties. STHFT have increased capacity in Neurology and Urology, specialties with demand and sub-specialism capacity challenges, to reduce long waits in Q1 25/26.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT Time to First Appointment (%)







Metric: RTT Referral to First Appointment within 18 weeks.
Plan: Agreed operational planning trajectories: NTHFT 78.5%, STHFT 72.3% by end March 2026.
Rationale: 25/26 NHSE planning guidance priority.
Data quality: assured, validated data.
Trend: NTHFT: improving trend since February 2025; STHFT no trend.
Assurance: NTHFT: Advise; STHFT: Advise.
Action taken: Waiting list validation sprint April-June 2025, and outpatient clinic template review being undertaken across UHT. Both Trusts out-performed plan in this new metric in April 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

CARING DOMAIN SUMMARY

Narrative

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall very good or good. In April, NTHFT were on or above plan in all the five surveys with statistical assurance of consistently positive responses from the A&E setting. STHFT were above plan in all surveys except A&E, with statistical assurance in outpatient and community services. Assurance on STHFT inpatient feedback has reduced as the new, slightly higher plan for 25/26 is not achieved consistently. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care, supported by digital data collection.

Further work is being undertaken in Q1 25/26 to ensure consistency in timely responses to complaints, concerns and enquiries. Patient experience teams continue to support and escalate to the clinical and operational teams, requiring their focus on resolving these in a timely manner, prioritising those longest in progress.

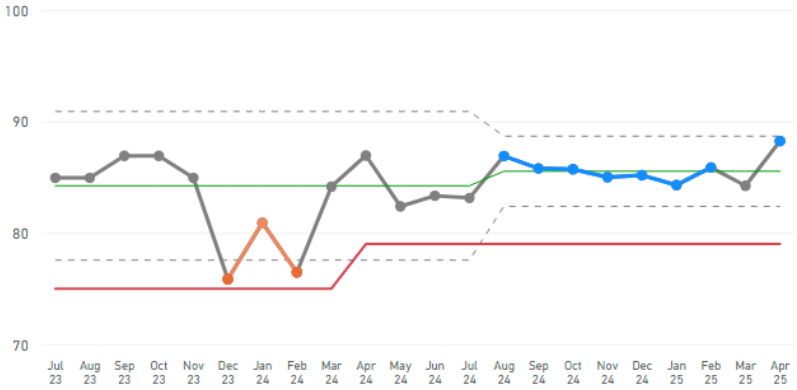
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
A&E Experience (%)	79%	82.4%	83.3%	83.1%	86.9%	85.8%	85.7%	85%	85.2%	84.3%	85.9%	84.2%	88.2%
Inpatient Experience (%)	95%	89.8%	91.6%	90.7%	93.5%	95.8%	94.7%	94.8%	94.8%	91.2%	92.4%	91.5%	95%
Maternity Experience (%)	92%	93.3%	87.5%	90.5%	100%	83.3%	87.5%	100%	87.5%	96.3%	100%	100%	93.3%
Outpatient Experience (%)	94%	94.7%	95.8%	94.8%	95.3%	93.6%	93.8%	94.9%	94%	93.8%	94.4%	93.1%	99.4%
Community Experience (%)	94%	94.9%	97.5%	96.8%	96%	96.4%	98.3%	96.9%	97.1%	97.5%	94%	97%	100%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	61.2%	63%	60.4%	70.9%	54.4%	52.6%	72.1%	55.4%	60.9%	73.1%	67%	71%

South Tees Hospitals NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
A&E Experience (%)	79%	77.1%	77.2%	80.4%	83%	80.5%	75.5%	79.8%	76.7%	78.5%	78.3%	80%	76.9%
Inpatient Experience (%)	95%	97.3%	97.4%	97.3%	97.8%	97.6%	99.1%	96.8%	96.9%	98.9%	97.8%	98.2%	96.9%
Maternity Experience (%)	92%	85.2%	88.3%	92.7%	91%	94.6%	92.3%	91.7%	87.6%	89.6%	94.3%	93.4%	93.3%
Outpatient Experience (%)	94%	96.7%	96.1%	97.2%	97.2%	97.1%	96.5%	95.5%	96.7%	96.1%	95.8%	95.9%	95.2%
Community Experience (%)	94%	100%	98.9%	98.9%	99.4%	97.5%	97.5%	100%	100%	97.3%	100%	100%	100%
Feedback Acknowledged in 3 Days (%)	100%	75.8%	54.3%	88.2%	97%	98.7%	100%	100%	100%	100%	99.3%	96.5%	99%
Complaints Closed Within Target (%)	80%	12.5%	31.6%	47.4%	16.7%	56.8%	34%	37.3%	40.4%	45.3%	58.7%	50.9%	75%

CARING A&E Experience (%)

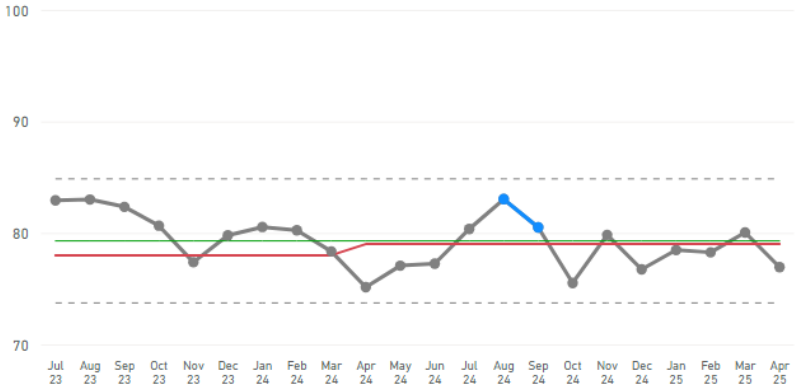
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	88.2%	79%		



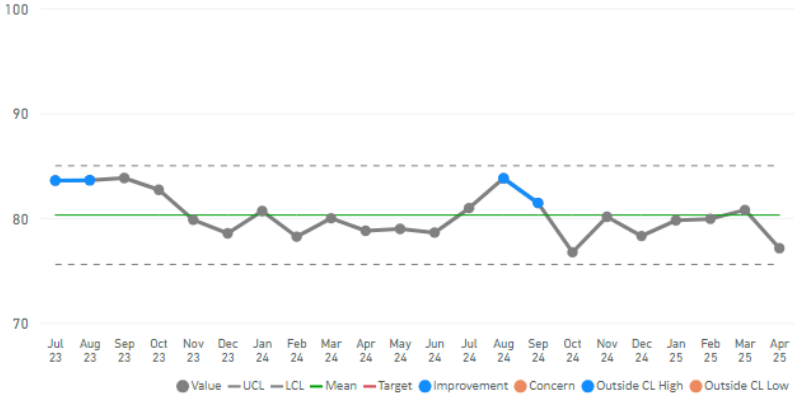
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	76.9%	79%		



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	77.1%			N/A

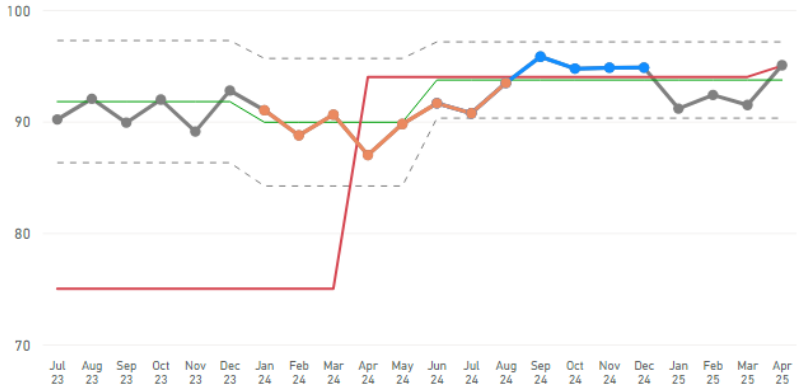


Metric: Percentage of respondents who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems). NTHFT response rate low due to lack of digital platform during April for FFT returns, resolved in June.
Response rates: NTHFT 0.3%, STHFT 8.1%.
Trend: No trend.
Assurance: NTHFT: Assure. STHFT: Advise, plan achieved in some months.
Action taken: Note that patient feedback appears to correlate inversely with A&E waiting times metrics, so focused improvement of A&E waiting times is expected to improve patient feedback.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Inpatient Experience (%)

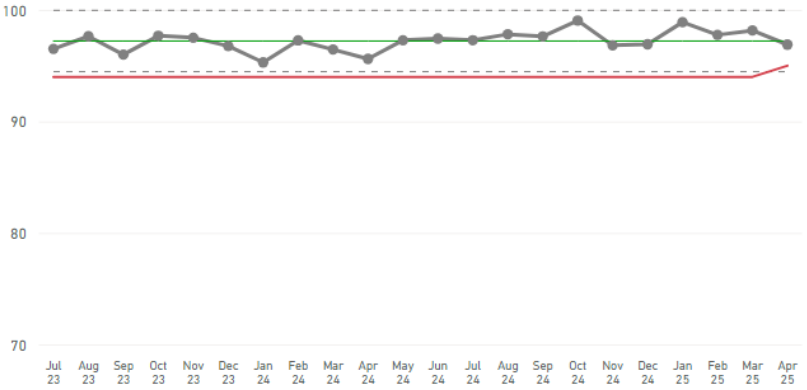
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	95%	95%		



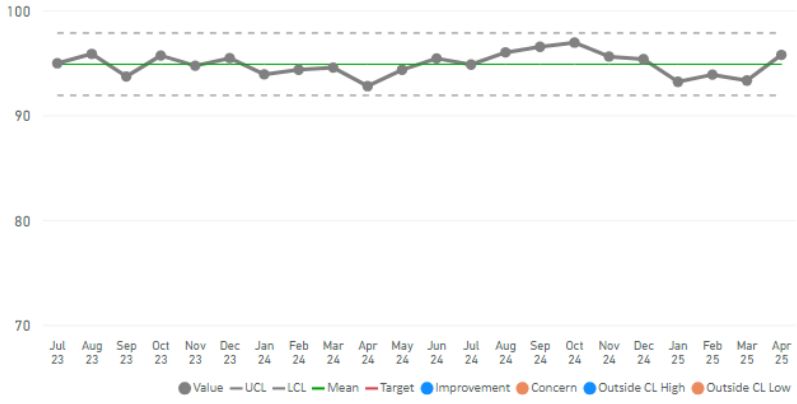
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	96.9%	95%		



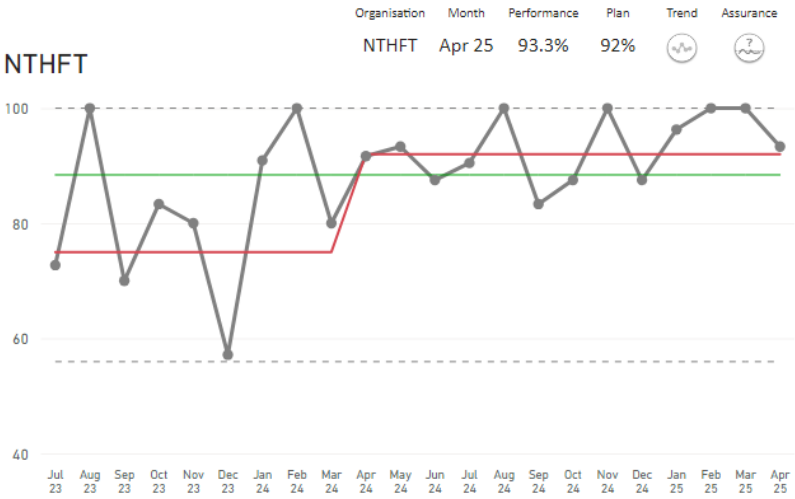
UHT

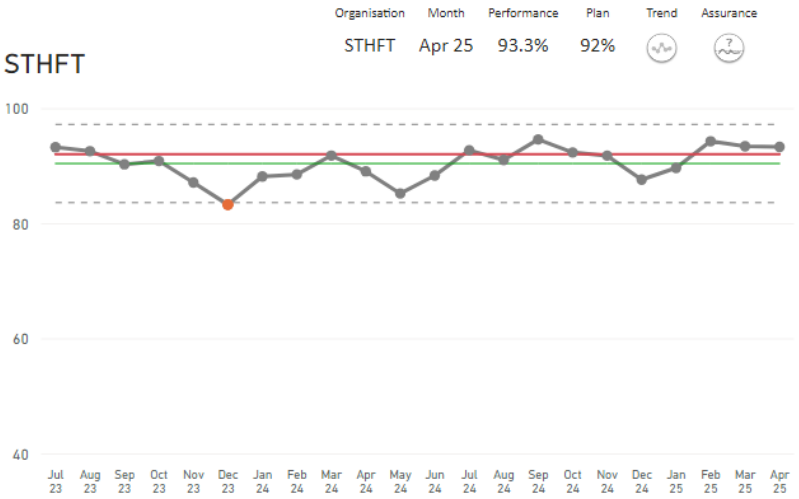
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	95.7%			N/A

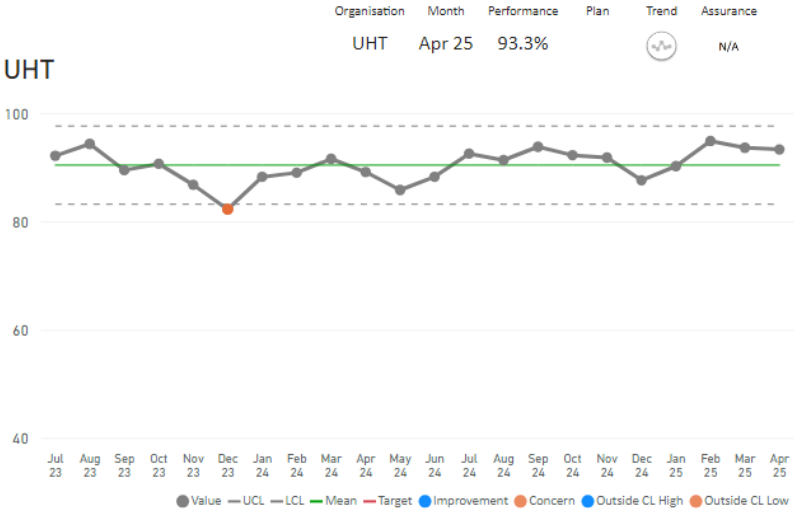


Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 7.9%, STHFT 16.9%.
Trend: No trend.
Assurance: NTHFT: Advise, plan met in April, but not consistently met. STHFT: Advise, achievement of 25/26 plan is not assured.
Action taken: NTHFT Associate Directors of Nursing raising awareness and actions through senior management teams and Directorate meetings.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Maternity Experience (%)





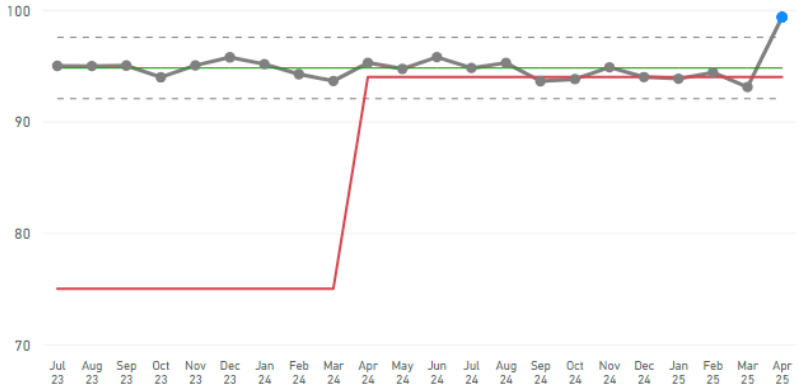


Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, reported figure is Birth only.
Response rates: NTHFT 6.0%, STHFT 14.4%.
Trend: No trend.
Assurance: Advise.
Action taken: To continue to promote engagement with Friends and Family Test.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Outpatient Experience (%)

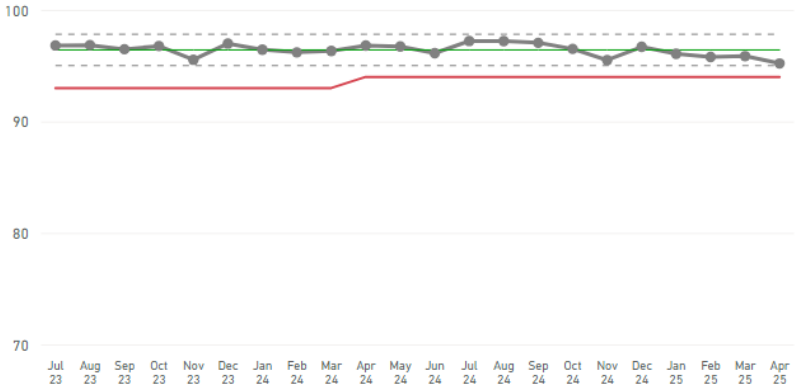
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	99.4%	94%		



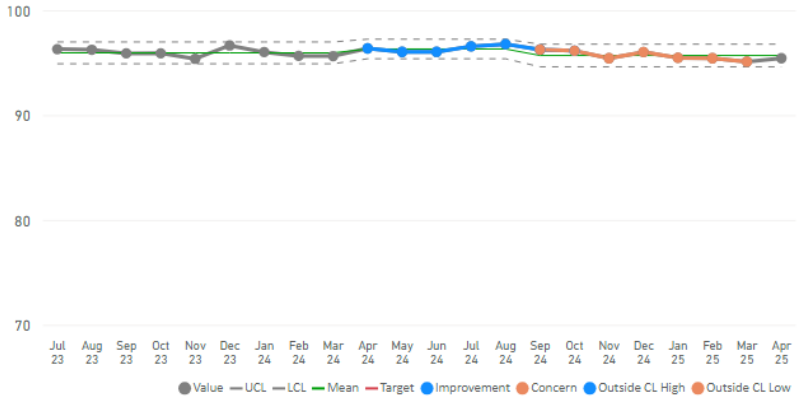
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	95.2%	94%		



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	95.4%			N/A

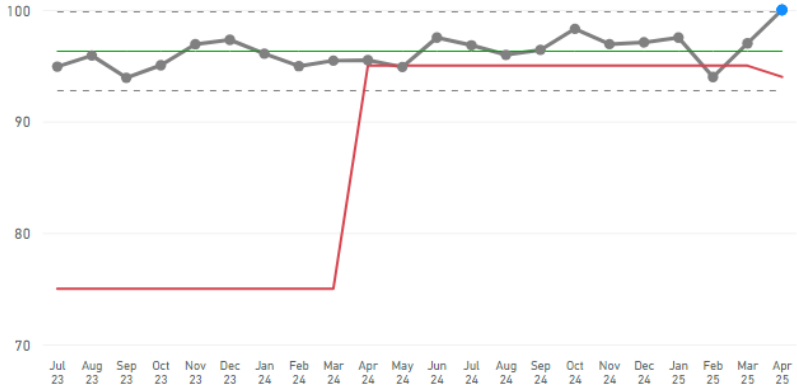


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. NTHFT response rate low due to lack of digital platform during April for FFT returns, resolved in June.
Response rates: NTHFT 1.0%, STHFT 15.0% .
Trend: NTHFT: High outlier point in April 2025. STHFT: No trend.
Assurance: NTHFT: Advise, performance is close to plan each month but does not always achieve. STHFT: Assure.
Action taken: Action plan to be developed by NTHFT outpatient departments to consistently achieve positive feedback.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Community Experience (%)

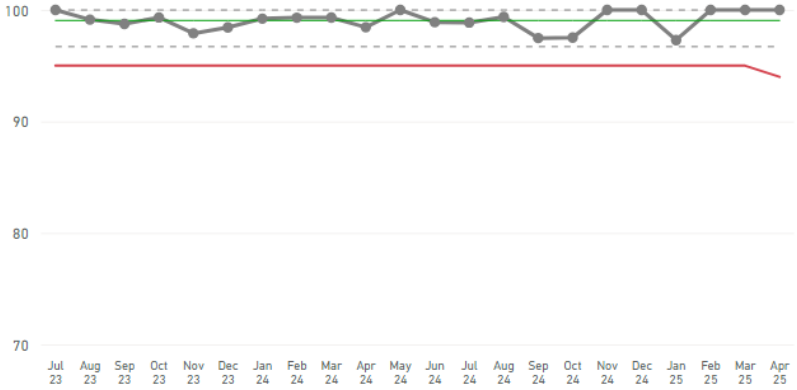
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	100%	94%		



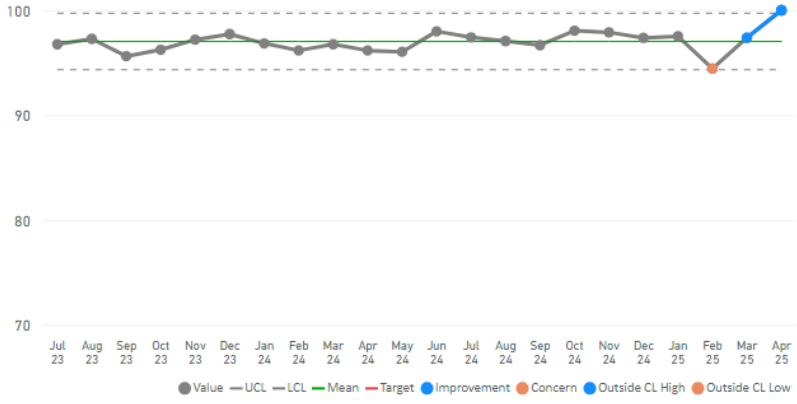
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	100%	94%		



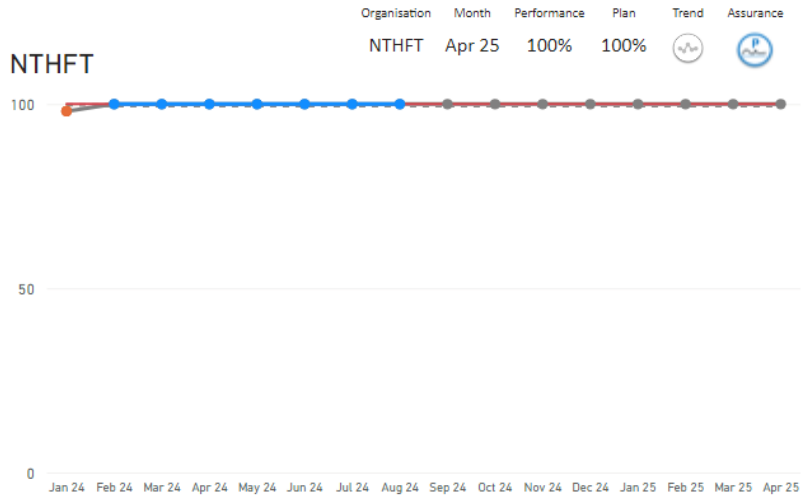
UHT

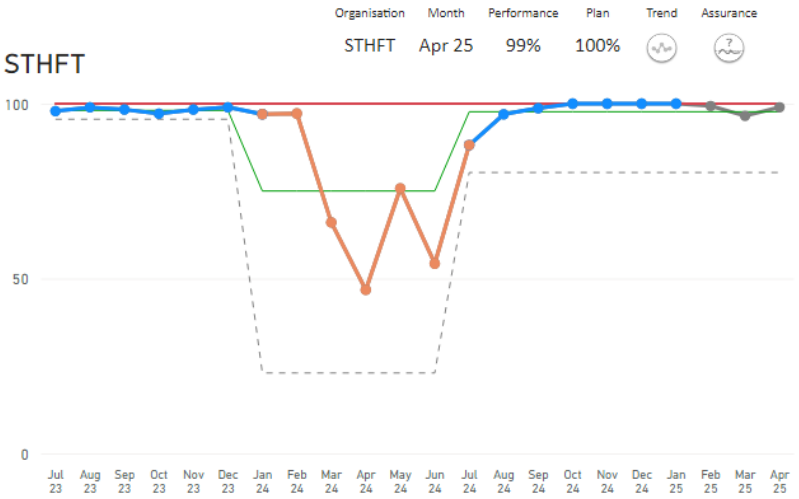
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	100%			N/A

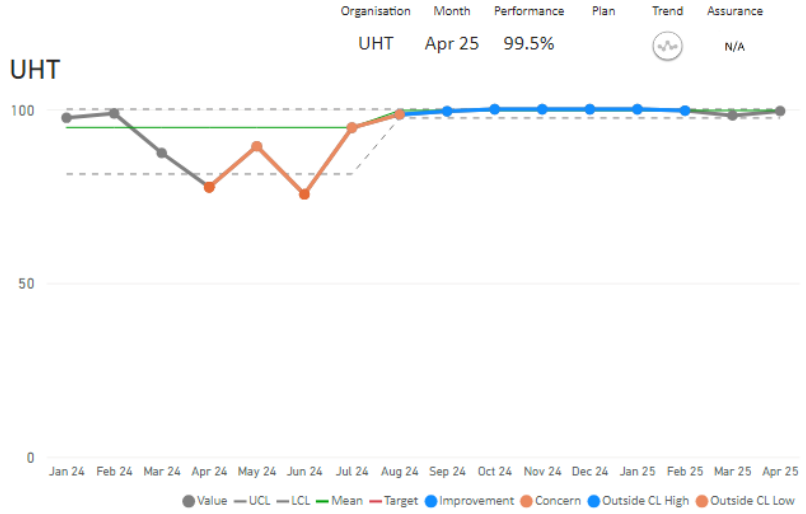


Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: 1.0% NTHFT, STHFT 5.0%.
Trend: NTHFT: Improving; STHFT: No trend.
Assurance: NTHFT: Advise, plan not consistently met. STHFT: Assure.
Action taken: Further work is required to ensure NTHFT community services consistently achieve positive feedback, and to improve response rates.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Feedback Acknowledged in 3 Days (%)

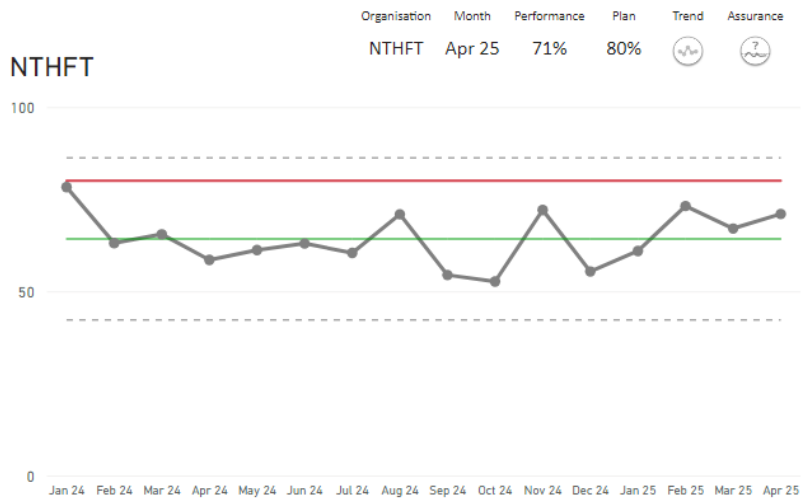


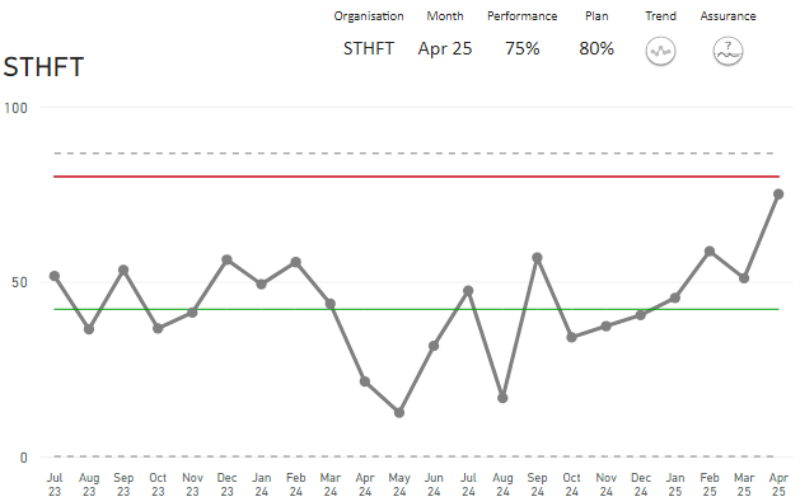


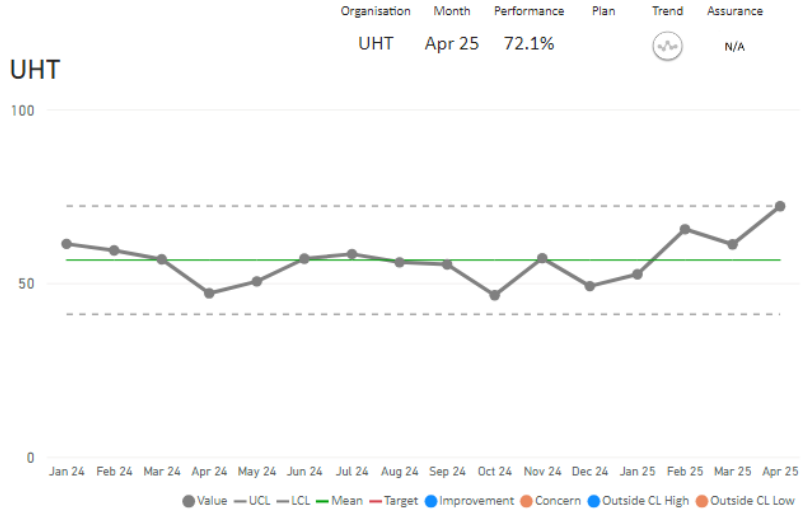


Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: STHFT: new process for acknowledging complaints implemented in July 2024 led to more consistent, improved performance.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Complaints Closed Within Target (%)







Metric: Percentage of complaints closed in agreed target time frame.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Advise. Plan is now within the range of current performance.
Action taken: NTHFT: InPhase reporting to be improved to allow increased performance monitoring within Care Groups. STHFT: off-target complaint responses are reported weekly for senior focus and accountability for completing responses by Collaboratives.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

WELL LED DOMAIN SUMMARY

Executive leads: Rachael Metcalf, Chief People Officer
Chris Hand, Chief Finance Officer

Accountable to: People Committee
Resources Committee

Absence management team has been appointed to deliver a work programme supporting progress towards the sickness absence target. Work continues to implement the national mandatory training reforms with a target completion date of end June. All actions are on track to meet NHSE requirements. The transfer of staff counselling service to Alliance Health provision will take place in July 2025 which will improve the counselling and supported offered to staff.

The Board is advised that financial position shows a small adverse variance to plan at the end of month 1 (April) for both NTHFT and STHFT. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

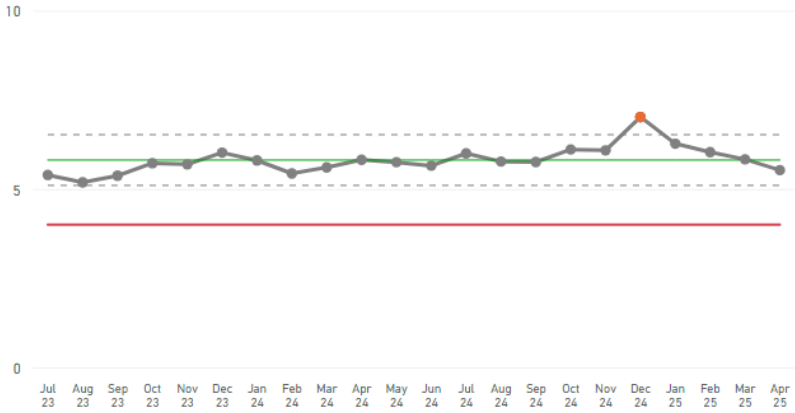
North Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Sickness Absence (%)	4%	5.8%	5.7%	6%	5.8%	5.8%	6.1%	6.1%	7%	6.3%	6%	5.8%	5.5%
Staff Turnover (%)	10%	7.4%	7.2%	7.2%	7.3%	7.3%	7.3%	7.2%	6.9%	7.1%	7%	7.2%	7.5%
Annual Appraisal (%)	85%	86.4%	86.6%	86.9%	86.7%	87.2%	86.9%	86.9%	87%	87.2%	86.6%	85.9%	86.3%
Mandatory Training (%)	90%	88.6%	89.3%	89.4%	89.7%	89.5%	89.8%	89.4%	88.9%	88.9%	88.1%	88.9%	88.7%
Cumulative YTD Financial Position (£'millions)	£0.445	-£0.817	-£1.227	-£1.266	-£1.24	-£0.861	-£1.114	-£1.289	-£1.404	-£0.994	-£0.473	£0.002	£0.117

South Tees & Hartlepool NHS FT	Month Target	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Sickness Absence (%)	4%	5.2%	5.3%	5.5%	5.4%	5.3%	6%	6%	6.8%	7%	6.2%	5.9%	5.7%
Staff Turnover (%)	10%	10.2%	10%	10%	10.2%	9.8%	9.3%	6.6%	6.5%	6.6%	6.5%	6.6%	6.7%
Annual Appraisal (%)	85%	79.6%	79%	80.3%	80.3%	80%	78.8%	78.7%	78.8%	78.8%	80.2%	82.2%	82%
Mandatory Training (%)	90%	90.7%	90.2%	90.3%	90%	89.7%	89.2%	87.8%	87.3%	86.8%	86.7%	85.6%	85.6%
Cumulative YTD Financial Position (£'millions)	-£1.803	-£10.008	-£13.615	-£15.87	-£19.33	-£12.715	-£14.342	-£16.684	-£18.873	-£7.583	-£7.489	-£7.796	-£2.065

WELL LED Sickness Absence (%)

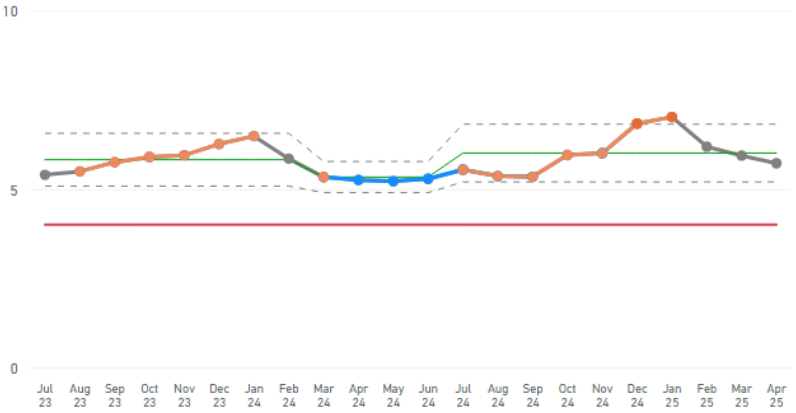
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	5.5%	4%		



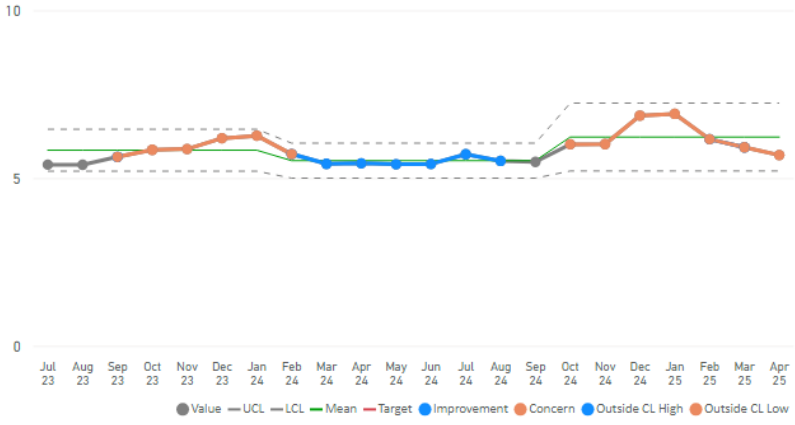
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	5.7%	4%		



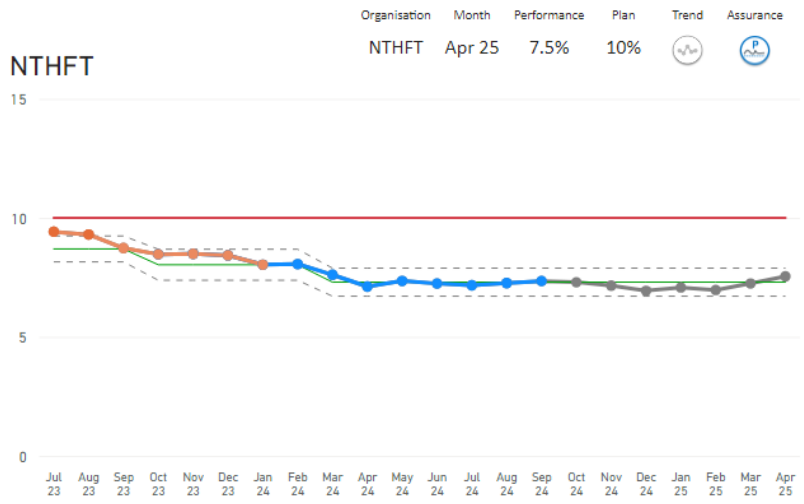
UHT

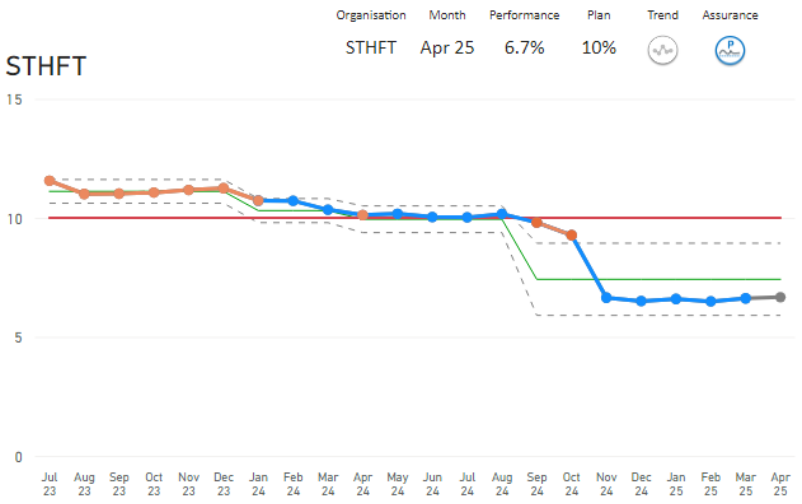
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	5.7%			N/A

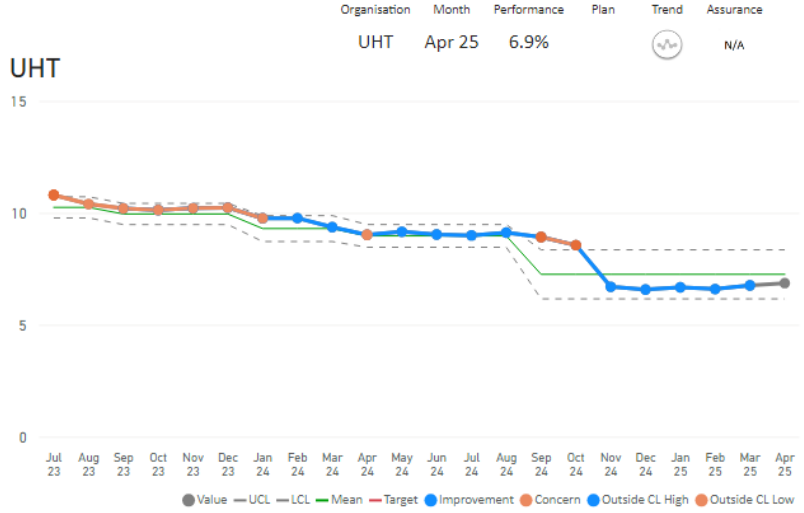


Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Alert: plans are not met.
Action taken: Absence team commence July 2025. Primary focus will be reduction of absence in conjunction with training and coaching for managers and the development of a UHT absence policy. Absence cases in April 2025 NTHFT: 133 long-term, 513 short-term; STHFT 355 long-term, 1,431 short-term.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Staff Turnover (%)

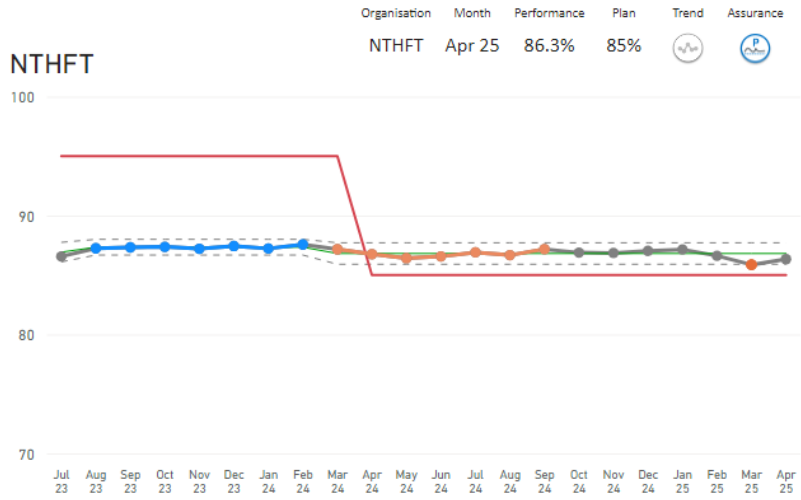


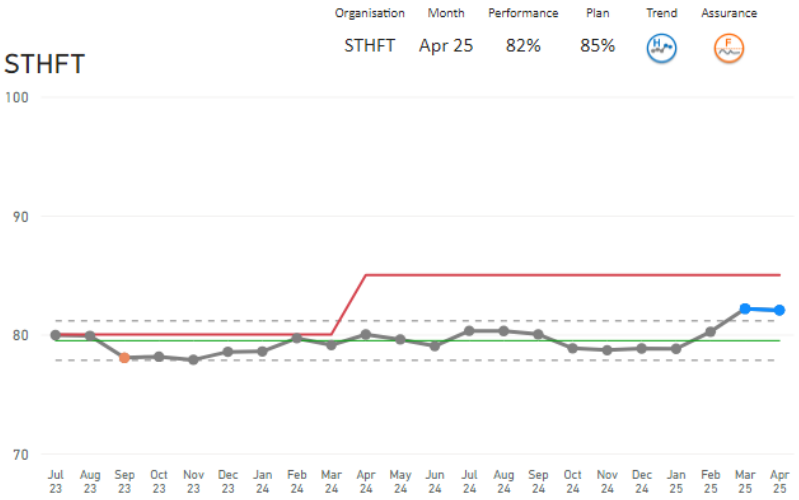


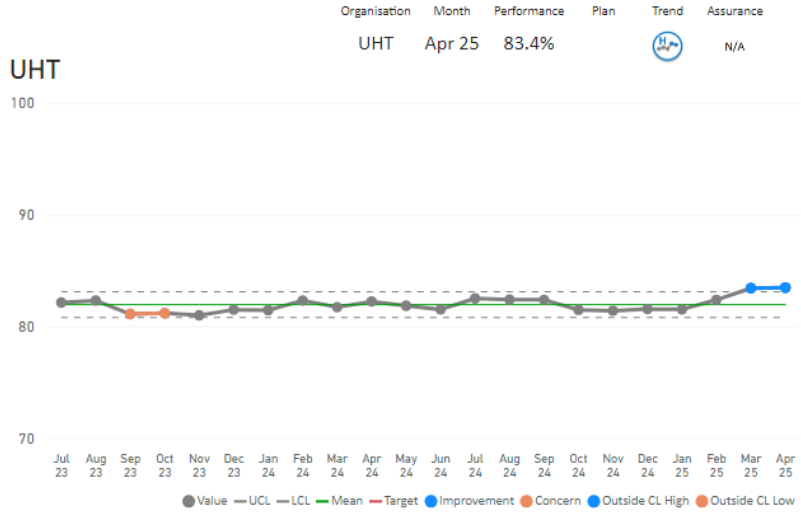


Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: No trend.
Assurance: Assure.
Action taken: Overall turnover is consistently low in both Trusts with none of the eight staffing groups being outliers.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Annual Appraisal (%)





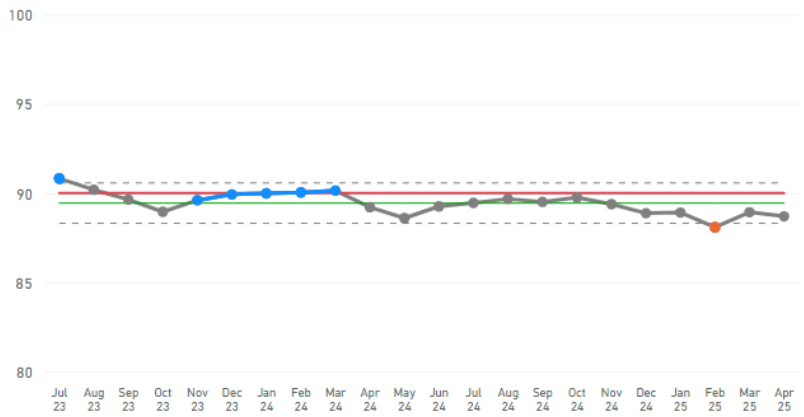


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: no trend. STHFT: improved performance in March and April 2025 exceeding expected variation.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: Additional support to managers to reduce number of staff without an appraisal for over 24 months has been effective reducing the size of this cohort from 462 to 253 at NTHFT; 831 to 241 at STHFT, now targeting staff who are more than 6 months overdue. Work planned to review managers accountability for People KPIs.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Mandatory Training (%)

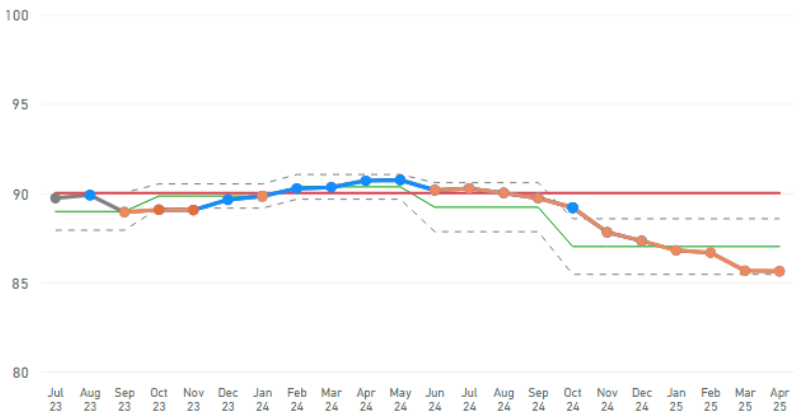
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	88.7%	90%		



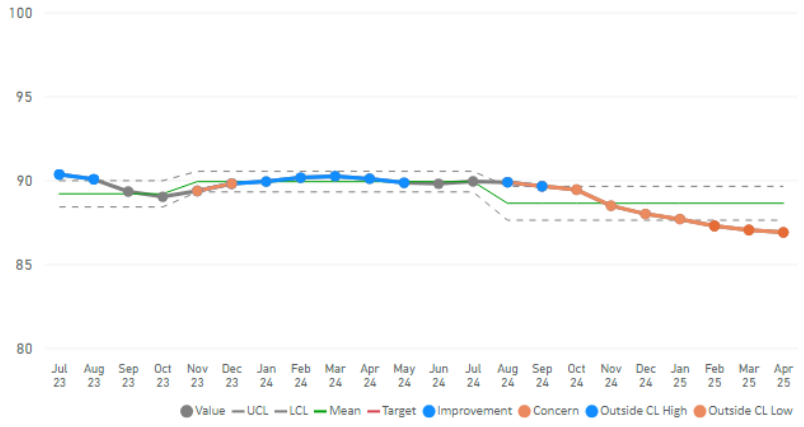
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	85.6%	90%		



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	86.9%			N/A

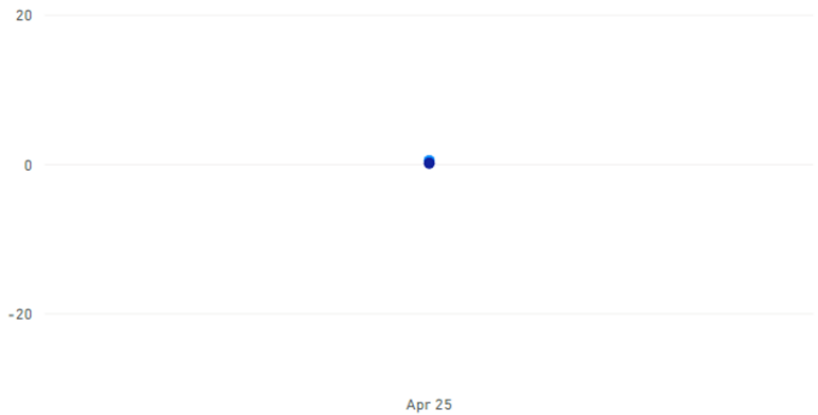


Metric: Percentage of mandatory training elements within date, across all staff groups at month end.
Plan: Trust internal plans: 90%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: reducing compliance, since June 2024.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Work continues to implement the workstreams of the national reform programme. Current focus is to ensure consistent alignment of Training Needs Analysis to roles across UHT. Work underway to implement the national mandatory training policy. Work underway to ensure standardised reporting across UHT. Focused work to improve compliance across all face-to-face topics.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Cumulative YTD Financial Position (£'millions)

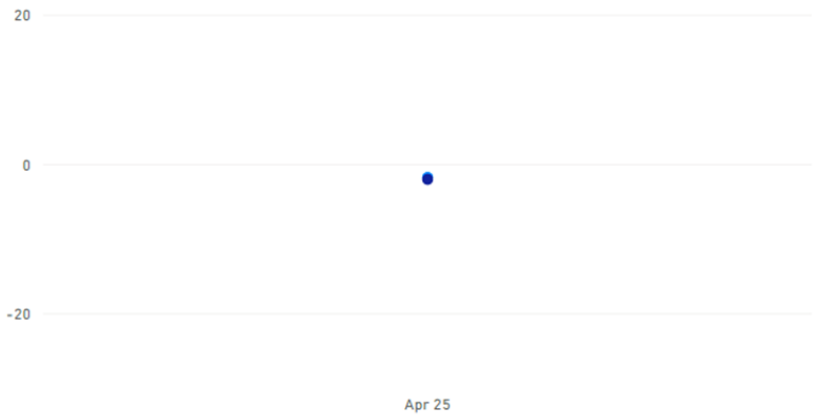
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 25	£0.117	£0.445	N/A	N/A



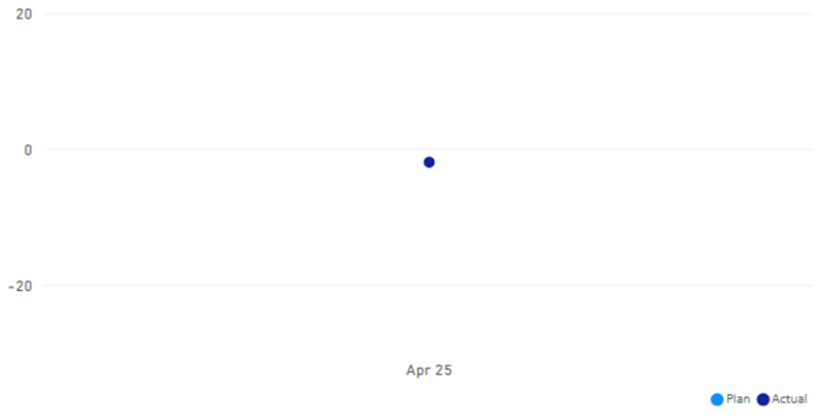
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 25	-£2.065	-£1.803	N/A	N/A



UHT

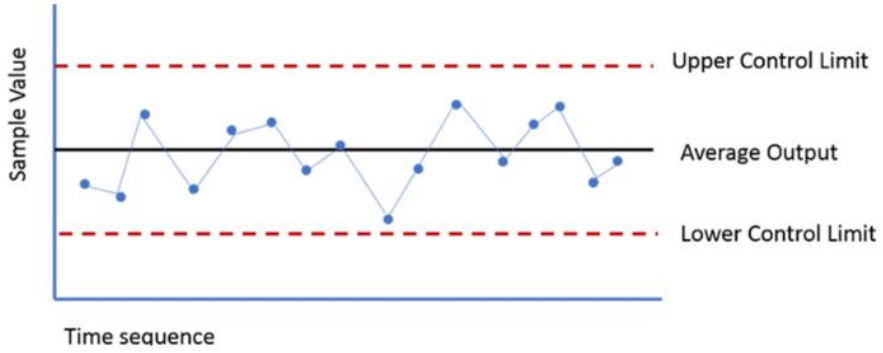
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 25	-£1.948		N/A	N/A



Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2025/26. The STHFT control total for 2025/26 is a £9.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: Small adverse variance to plan at month 1 for both NTHFT and STHFT.
Action taken:. Financial controls in place, focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.
Executive lead: Chief Finance Officer
Accountable to: Resources Committee

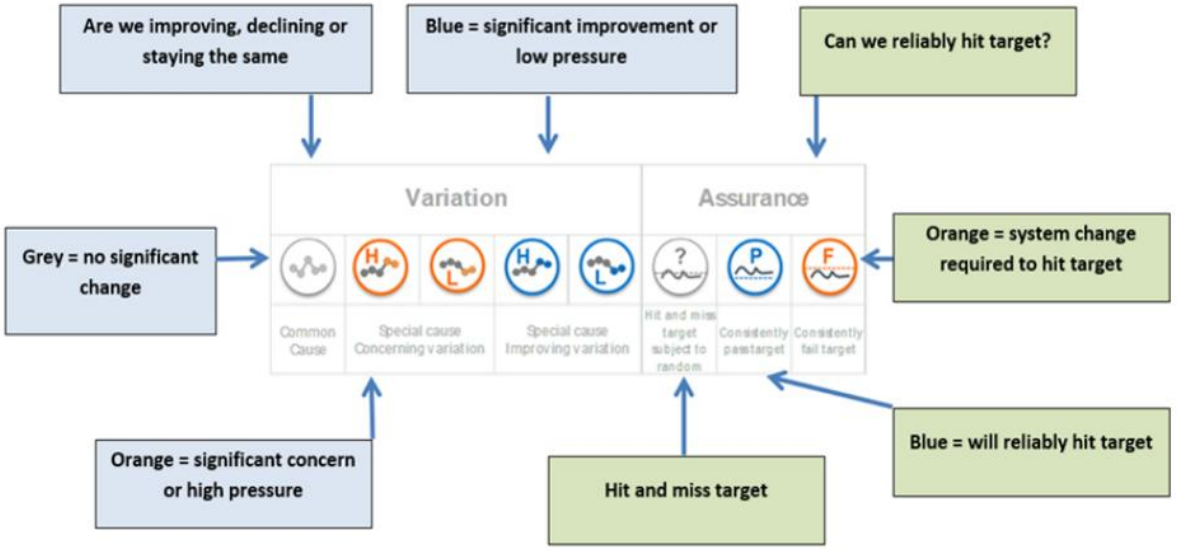
OVERVIEW SPC CHARTS

Statistical Process Control (SPC) charts with indicators of variation and assurance, are utilised where applicable, in line with the best practice standards of Making Data Count.



High level Key - Variation

High level Key - Assurance



Caring Better Together

Thank you

University Hospitals Tees

Green Plan 2025 - 2028

Meeting date: 3 July 2025

Reporting to: Group Board

Agenda item No: 21

Report author: Laura Hallett - Waste & Sustainability Manager (STHFT) and Steve Bell (NTH Solutions - NTHFT) - Environmental Services & Sustainability Manager

Executive director sponsor: Steve Taylor – Group Director of Estates

Action required:
Approval

Delegation status: Jointly delegated item to Group Board

Previously presented to: Interim update to Resource Committee and Executive Team

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☒

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Estates

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Each Trust requires a refreshed Green Plan that needs to be approved at board level and posted on each Trusts website by 31st July 2025.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

The NHS ambition to be the first Net Zero health system in the world and the NHS 2040 & 2045 targets set by Government has provided greater focus on sustainability.

Over the next 3 years we will focus on priority actions across the areas of focus identified in the updated Green Plan guidance as follows:

- Workforce and Leadership
- Digital Transformation
- Net Zero Clinical Transformation
- Medicines
- Travel and Transport
- Estates and Facilities
- Supply Chain and Procurement
- Food and Nutrition
- Adaptation

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Each Trust has a separate unitary board and needs to submit a separate Green Plan to NHS England. However, the Sustainability Managers across North Tees and South Tees have worked together to develop Green Plans that reflect the sustainability ambitions of UHT.

Green Champions have played a vital part in the development of the KPI's. The area of focus within the Green Plans and the associated KPI's are consistent across the Group.

Recommendations:

The Group Board are asked to approve the attached Green Plans that support and reflect the sustainability ambitions of UHT.

North Tees and Hartlepool
NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Green Plan 2025 – 2028

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North Tees and Hartlepool NHS Foundation Trust

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Executive Summary

North Tees and Hartlepool NHS Foundation Trust

The NHS ambition to be the first Net Zero health system in the world and the NHS 2040 & 2045 targets set by Government has provided greater focus on sustainability.

Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. Up to 38,000 deaths a year are associated with air pollution alone, disproportionately affecting the most deprived and further exacerbating health inequalities.

This refreshed Green Plan for North Tees and Hartlepool NHS Foundation Trust covers the period 1 April 2025 to 31 March 2028.

We recognise that if we are to provide the best possible care to our patients and improve their quality of life, we need to significantly reduce our impact on the environment.

Stacey Hunter
Group Chief Executive Officer

Steven Taylor
Group Director of Estates and Net Zero Board Level Lead

United Nations Sustainable Development Goals

The UN Sustainable Development Goals are a universal call to action to end poverty, protect the planet, and improve the lives and prospects of everyone everywhere.

The 17 goals were adopted by all UN Member States in 2015, with the intention of achieving the Goals by 2030.

Our Green Plan, Social Value Charter and Anchor Framework are aligned to the goals, and we will continue to work with our partners to encompass them at the heart of our work.

Introduction to North Tees and Hartlepool Foundation Trust

North Tees and Hartlepool NHS Foundation Trust provides integrated hospital and community healthcare services to around 400,000 people across Hartlepool, Stockton, and parts of County Durham.

The Trust operates from the University Hospital of North Tees and the University Hospital of Hartlepool, as well as various community settings including Peterlee Community Hospital and the recently constructed Tees Valley Diagnostic Centre in the centre of Stockton.

North Tees and Hartlepool is one of the largest employers in the Tees Valley with close to 5,500 medical, nursing, clinical and non clinical staff with every member of our organisation being committed to providing the very best care to our patients, whether they are being treated in our hospitals or out in the community.

The Tees Valley is home to approximately 678,000 people. Over a third of these residents live in the 20% most deprived areas of England, according to the North East Combined Authority in 2024. The Tees Valley faces air quality challenges, particularly due to emissions from the industrial cluster near the River Tees. This area has some of the highest emissions of any area in the UK, both in real terms and per capita.

In 2024, North Tees and Hartlepool NHS Foundation Trust formed University Hospitals Tees with South Tees Hospitals NHS Foundation Trust to enhance collaboration and improve patient outcomes across the Tees Valley.

The shared University Hospital Tees approach to sustainability aligns closely with our NHS role in addressing healthcare inequalities, ill health prevention, and health improvement. We recognise that the indirect and direct impacts of the climate crisis are likely to widen health inequalities in the UK. Therefore, it is crucial that health equity is considered as we develop policies and approaches to reduce greenhouse gas emissions, ensuring their benefits are equally distributed.

Governance and Accountability

North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust Governance Structure

- Trust Unitary Board (Annually)
- Resource Committee (Quarterly)
- Sustainability Group (Monthly)

North East & North Cumbria Provider Collaborative Governance Structure

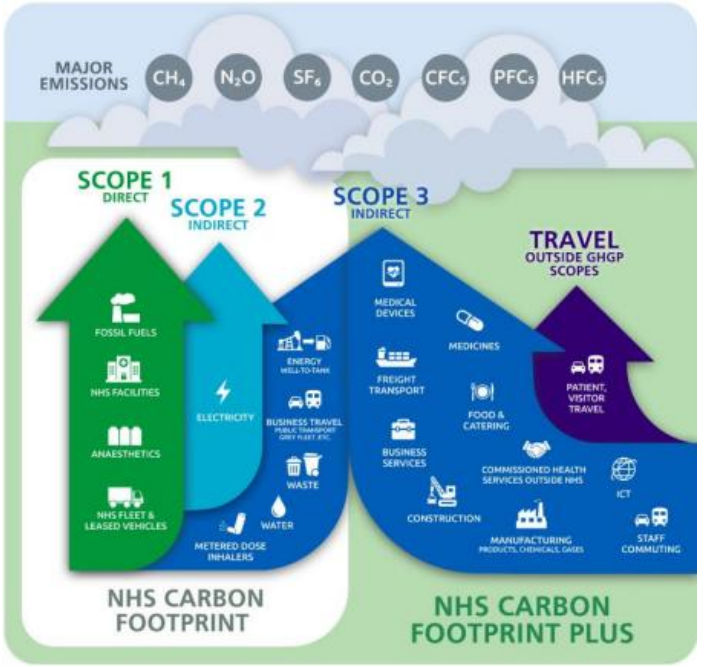
What is a Green Plan and why do we need it?

To support the NHS net zero ambition, each trust and integrated care system should have a Green Plan. It sets out aims, objectives, and delivery plans for carbon reduction and is signed off by the Trust Board, with a board level 'net zero lead' responsible for overseeing its delivery.

Given the pivotal role that integrated care systems (ICSs) play, each system will also develop its own green plan, based on the strategies of its member organisations.

There are several key legislative drivers for change, and specific guidance as to why we need this Green Plan.

- The Paris Agreement 2015 – global, legally binding international treaty with goal of limiting global temperature increase to below 2°C (compared to pre-industrial levels).
- Climate Change Act 2008 - legally binding UK Government targets for the reduction of carbon emissions. The NHS has a duty to respond to meet these targets which are enshrined in law.
- Net Zero by 2050 – binding target for UK Government, regulators and business to meet net zero by 2050.
- The Environment Act 2021 – legally binding targets driven by improving air and water quality. Public bodies held to account on environmental obligations.
- Delivering a Net Zero NHS statutory guidance – set out target of net zero by 2040, duties on all Trusts to contribute.
- Health and Care Act 2022 – the NHS became the first health system to embed net zero targets outlined in the Delivering a Net Zero NHS guidance into legislation.
- CQC Well Led – staff and leadership awareness of threats, educated and empowered to help reduce impacts.
- Comply with applicable legal duties, including the duty to reduce inequalities, the Public Sector Equality Duty, and the duty to have regard to all likely wider effect of decisions.



Our Trust Vision

North Tees and Hartlepool NHS Foundation Trust

As one of the largest employers in the Tees Valley, we have a responsibility to our staff, our patients and our community to play a leading role in thinking ‘green’ and making long lasting changes.

We are on an ambitious journey to achieve net zero carbon emissions as an organisation – creating sustainable healthcare for the patients of today and tomorrow by actively protecting the environment.

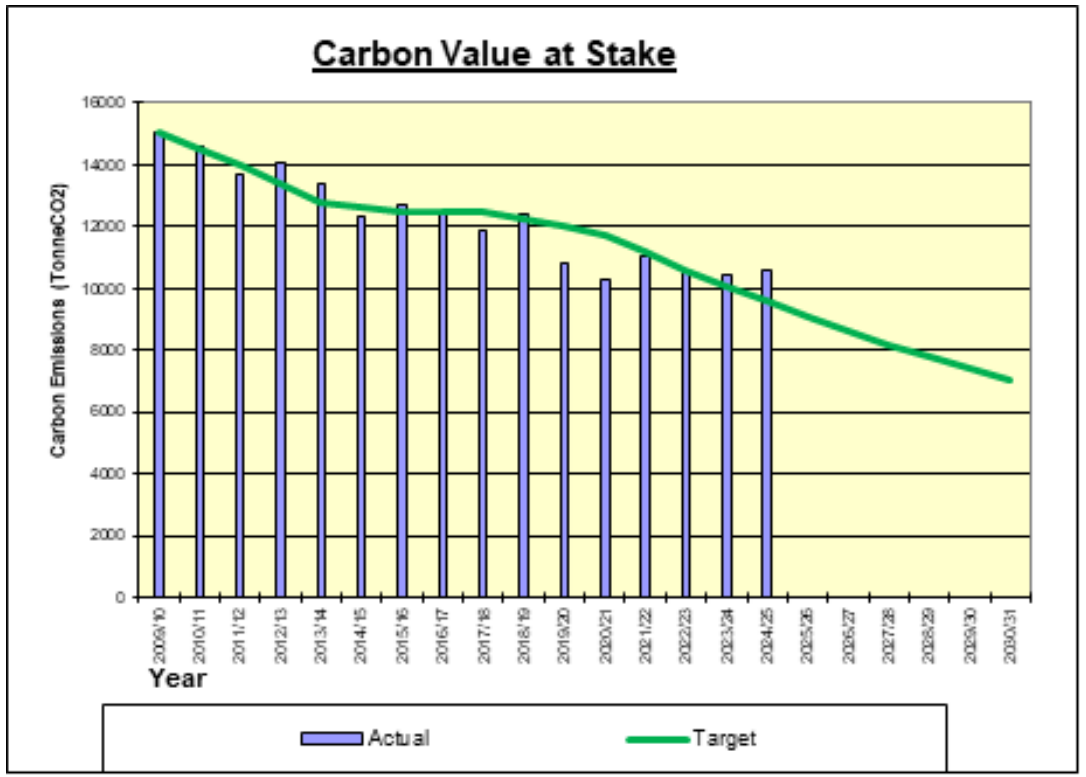
It’s only by working together – with staff, patients and our community – that we can make the difference we need to.

The aims of our Green Plan are:

- Reducing carbon emissions and our carbon footprint
- Sustainable procurement of goods that can be recycled and not just single use
- Encouraging sustainable travel and transport for staff and visitors
- Making our clinical pathways more sustainable
- Reducing our water consumption in key areas
- Increase our recycling of waste
- Work towards climate change adaptation
- Maximise the sustainability of our building and green spaces
- Encourage our workforce to commit to a carbon free future

Carbon Emissions

North Tees and Hartlepool NHS Foundation Trust



Year	Tonnes CO2
2018/2019	12422
2019/2020	10847
2020/2021	10292
2021/2022	11034
2022/2023	9438
2023/2024	9760
2024/2025	10604

Note:

1.More intense use of estate 2023/2024 and 2024/2025 driving up carbon tonnages.

2.The decarbonisation scheme at UHH will bring us in line with set target.

Carbon Emissions

North Tees and Hartlepool NHS Foundation Trust

Greenhouse Gas Emissions

Area		Greenhouse Gas Emissions					
		2022/23	2023/24	2024/25	2022/23	2023/24	2024/25
Finite Resources	Electricity	4811 MWh	3695 Mwh	3725 MWh	£835,929	£1,038,416	£1,197,209
		1135 tCO2	757 tCO2	771 tCO2			
	Gas	48,905 MWh	51,032 MWh	51,699 MWh	£1,981,754	£2,152,298	£1,894,838
		10535 tCO2	8998.52 tCO2	9310 tCO2			
	Oil	284,547 kWh	33,832 kWh	142,827 kWh	£80,266	£0	£0
		72.9 tCO2	8.6 tCO2	36.2 tCO2			
Waste	Total Waste	1281.4 t	1330 t	1360 t	£341,072	£370,798	£294,515
Hazardous Waste	Clinical waste to alternative treatment of incineration	300 t	251 t	171 t			
		67.8 tCO2	56.7 tCO2	1.1 tCO2			
Non-hazardous Waste	Landfill	0 t	0 t	0 t			
		0 tCO2	0 tCO2	0 tCO2			
	Re-used / Recycled	67 t	201 t	172 t			
	Incinerated with Energy Recovery	898 t	926 t	999.8 t			
	Electrical Waste (WEEE)	16.4 t	14.1 t	17.2 t			
Travel	Commercial Vehicles Diesel	0	0	0	£0	£0	£0
		0 tCO2	0 tCO2	0 tCO2			
	Lease Vehicles Petrol	191,018 miles	199,028 miles	175,359 miles	£51,080	£79,611	£70,143
		49.7 tCO2	40.2 tCO2	36.5 tCO2			
	Lease Vehicles Diesel	23,939 miles	9,296 miles	3,811 miles	£8,107	£3,720	£1,525
		6.5 tCO2	2.3 tCO2	1.0 tCO2			
	Business Miles	1,204,089	1,230,670	1,112,747	£303,921	£492,268	£445,099
		330.4 tCO2	296.1 tCO2	296.1 tCO2			
Water	Water Consumption	142,623 m3	121,796 m3	121,048 m3	£367,339	£406,944	£443,212
		49.1 tCO2	41.9 tCO2	45.7 tCO2			

Areas of Focus

North Tees and Hartlepool NHS Foundation Trust

Over the next 3 years we will focus on priority actions across the areas of focus identified in the updated Green Plan guidance as follows:

- Workforce and Leadership
- Digital Transformation
- Net Zero Clinical Transformation
- Medicines
- Travel and Transport
- Estates and Facilities
- Supply Chain and Procurement
- Food and Nutrition Achievements
- Adaptation

Workforce and Leadership

North Tees and Hartlepool NHS Foundation Trust

The transition to a net zero NHS will be driven by its people. There is already strong support for a greener future; 9 in 10 staff support the NHS net zero ambition, while 6 in 10 say they are more likely to stay in an organisation taking decisive climate action (YouGov, 2023).

North Tees and Hartlepool NHS Foundation Trust support their staff and leaders to learn, innovate and embed sustainability into everyday actions.

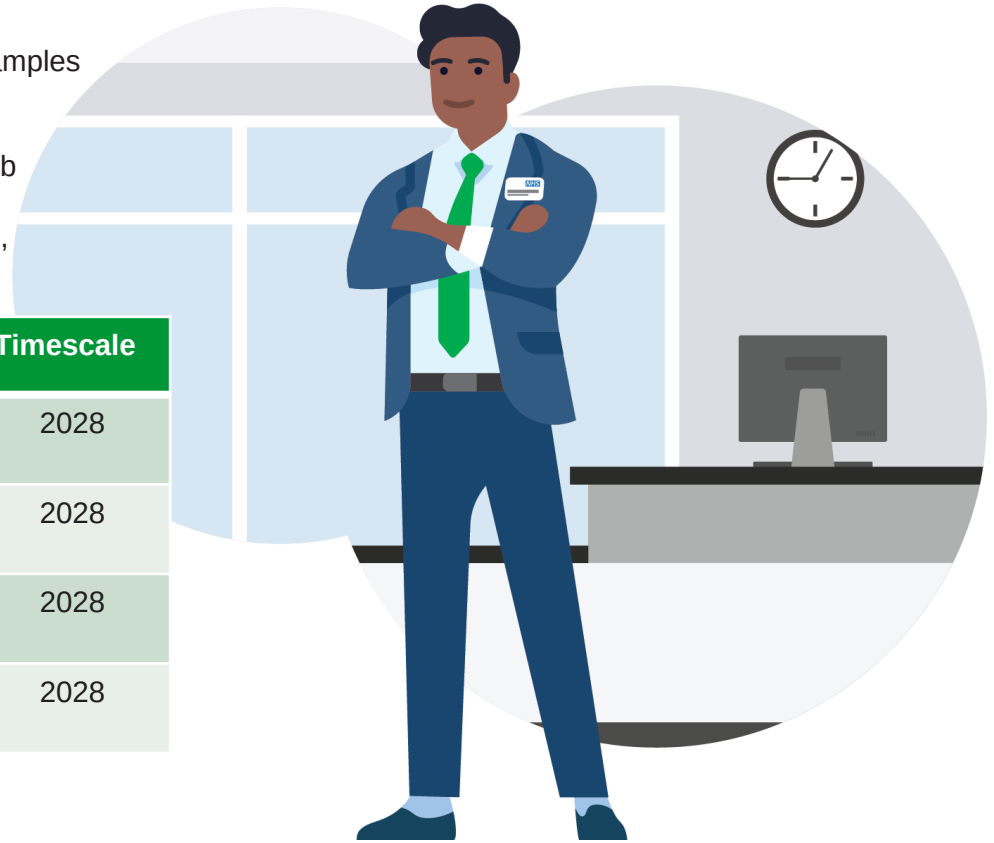
A designated board-level net zero lead has been appointed with clear identified operational support.

Assess workforce capacity and skill requirements for delivering the green plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways.

Promote, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub

Promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians.

Key Performance Indicators	Timescale
Create a culture of sustainable development by ensuring sustainability is embedded into systems and processes	2028
Facilitate the culture change of our staff, patients and visitors attitude towards the environment and sustainability	2028
Work in partnership with neighbouring NHS trusts and public authorities to enhance the delivery of the Green Plan and share best practice.	2028
Promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians	2028



Digital Transformation

North Tees and Hartlepool NHS Foundation Trust

The Trust continues to roll out electronic prescribing across the organisation, which has allowed us to remove the paper charts in the areas where it has been introduced. After completing all adult inpatient wards, we are now looking to introduce it to Critical Care areas, including general critical care and neonates. Later this year, we will also be rolling out the Electronic Record into Outpatients, which will allow outpatient prescriptions to be sent to pharmacy electronically.

A patient engagement portal (PEP) was introduced to the Trust in 2023 which has allowed patients to get access to their appointments and letters through the app on their phone. Around 75% of patients choose this method meaning the Trust has been able to reduce the number of letters it prints and posts out to patients. The Trust has also introduced voice recognition software which integrates with the PEP. This allows clinicians to dictate their clinic letters directly into the PC which is converted to text and uploaded up to the PEP, again reducing the amount of paper letters that are sent to patients through the post. All this saves paper, printing, electricity and reduces emissions from the delivery of letters by the postal service.

The PEP has also replaced the Attend Anywhere video consultation service since April 2024, and due to it being integrated into the same app, we have seen an increase in patients taking up the service. This saves patients from having to travel to site, cutting down emissions, but also allowing clinicians to run the clinic from a single office or even from home. will be integrated to the NHS app. This will reduce the amount of appointment letters printed as patients will receive their letters electronically via the app saving paper, printing, and electricity.

The Trust continue to consolidate its server estate onto to smaller and more environmentally friendly virtual servers which allow multiple systems to be hosted on a single piece of hardware. At the same time it is still exploring the use of cloud hosting where this is appropriate, where systems are held in large multi-organisational data centres. While data centres have their own environmental challenges, companies like Microsoft are continually looking at more sustainable ways to build, power and cool data centres that allow it to meets its own green goals.

Key Performance Indicators	Timescales
Roll out of an electronic record into Critical Care areas removing the need for the paper charts, paper prescribing and other paper records	2026
Consolidated data centres across the group. Rationalisation of data centres and servers across the group, allowing for smaller onsite data centres to be decommissioned saving on power and cooling	2027
Continue to look at Cloud services where appropriate to reduce onsite server hardware	2027 onwards
Standardised equipment. Look to standardise equipment and builds across University Hospitals Tees, allowing equipment to be shared across the group	2027
The ambition for University Hospitals Tees is to have a single shared Electronic Patient Record (EPR) across the group, allowing all clinical staff to see a single shared record. This will remove the need for notes to be printed out transported between sites.	2027/28

Net Zero Clinical Transformation

North Tees and Hartlepool NHS Foundation Trust

The NHS is committed to moving to out-of-hospital and digitally-enabled care where clinically appropriate, improving prevention of ill health and reducing health inequalities. These changes also underpin our commitment to net zero.

Net zero clinical transformation should ensure high-quality, preventative, low carbon care is provided to patients at every stage.

Key Performance Indicators	Timescales
Identify a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance	2026
Share learning and outcomes, through clinical networks, the ICB and NHS England	2026

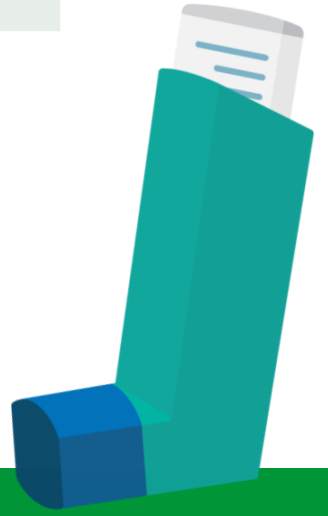
Medicines

North Tees and Hartlepool NHS Foundation Trust

Medicines account for around 25% of NHS emissions.

A few medicines account for a large portion of these emissions, for example, anaesthetic gases (2% of NHS emissions) and inhalers (3%).

Key Performance Indicators	Timescales
Removal of all nitrous oxide across the organisation	2 year target
Optimise respiratory care to reduce carbon footprint related to inhalers and improve respiratory disease outcomes	2 year target
Ongoing improvement of IV to oral switches of medications as clinically appropriate	3 year target
Campaigns for patients and staff promoting reduced medication waste	Target ongoing
Reduction of single use plastics used in relation to the supply or administration of medication (Reduce plastic bottles and use glass bottles)	3 year target
Optimising inhaler choice (considering clinical appropriateness , the environmental impact of inhalers and patient preference)	3 year target



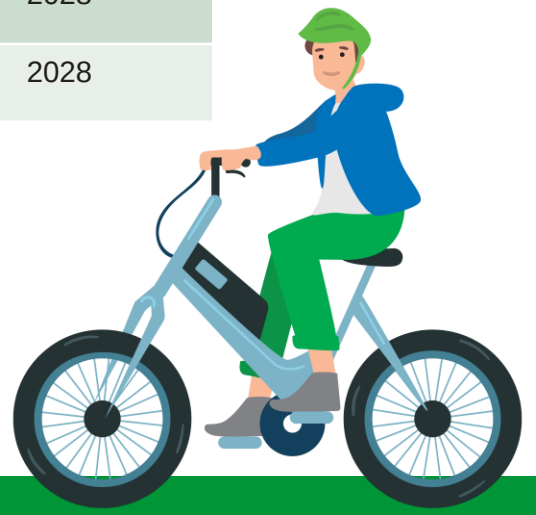
Travel and Transport

North Tees and Hartlepool NHS Foundation Trust

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution.

The NHS Net zero travel and transport strategy outlines a roadmap to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

Key Performance Indicators	Timescales
Develop a sustainable travel plan by December 2026, to be incorporated into the green plan (as an annex), focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting	2026
Invest in a dedicated Lift-share / car share platform	2026
Regional agreement on anti-idling campaign	2026
Regional feasibility study for EV charging infrastructure	2027
Continue partnership working with local authorities and local transport authorities to maximise funding and infrastructure opportunities	2028
Establish and maintain a cycle to work scheme for up to 500 cyclists	2028



Estates and Facilities

North Tees and Hartlepool NHS Foundation Trust

Across University Hospitals Tees we are striving to reduce our impact on the environment and carbon emissions in the way in which we work and the use of resources. A significant proportion of our carbon emissions relate to the burning of fossil fuels in the form of gas as our primary source of heat generation.

Our estates and facilities teams have been actively planning to reduce the reliance on fossil fuels as part of our decarbonisation journey and securing this latest government funding is a big step towards achieving this. University Hospital of Hartlepool's successfully secured £13.4million for funding to improve heating, ventilation, air-conditioning and lighting.

The works will help the group achieve its goal of achieving net zero for carbon emissions by 2040 – in line with national NHS targets.

As a key community partner, and one of the largest employers in the region, it is important that we play our part in helping reduce our carbon emissions and the effects of climate change on the environment. Reducing our reliance on fossil fuels and finding ways to work with increased efficiently also enables more funds to be invested in patient care.

Key Performance Indicators	Timescales
Increase communication around energy consumption and carbon reduction	2026
Increase EV charging points	2028
Apply for grants associated with energy saving	2028
Capital projects – new builds to be built to the NHS Net Zero Carbon Building Standard and achieve BREEAM outstanding	2028
Achieve clinical waste segregation targets of 20:20:60 HTI, AT & OW	2028

Supply Chain and Procurement

North Tees and Hartlepool NHS Foundation Trust

The NHS net zero supplier roadmap outlines steps suppliers must follow to align with the NHS net zero ambition between now and 2030.

Roadmap implementation is a shared responsibility across trusts, systems, regional procurement hubs and nationally.

Organisations should also seek to embed circular solutions, such as using reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost-saving.

Key actions for systems and trusts: embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored via KPIs encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and its suppliers on sustainability priorities

In addition, trusts should: reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects (see Net zero clinical transformation and Annex B: selected resources for additional support tools).

Key Performance Indcators	Timescales
Reduce and avoid use of single use plastics	2028
Adopt innovation	2028
Understand the CO2 footprint of our procured items	2028
Remove antimicrobial coated curtains	2027
Trial reusable tourniquets and evaluate cost and CO2 savings	2026

Food and Nutrition Achievements

North Tees and Hartlepool NHS Foundation Trust

- Waste Review: Food storage, waste and vegetarian options are being reviewed alongside patient experience within ongoing benchmarking work.
- Accessibility: Inpatient menus are now available online to support accessibility and reduce waste at ward level. Menu cards will still be available at ward level.
- with lower carbon options.
- Annual Review: implementation and monitoring of inpatient kitchen, plate, and trolley food waste now conducted annually.
- Menu Review: The inpatient dining menu and waste are regularly reviewed under the Nutrition and Hydration Group, led by dieticians. Feedback is provided to the catering provider.

Key Performance Indicators	Timescales
Policy and Standards Alignment: • Review current compliance with the eight Nutrition and Hydration standards. • Update policies to reflect national and green plan priorities. • Ensure training for relevant staff in food safety, special diets, and allergens.	December 2025
Data Collection and Baseline Measurement: • Conduct PLACE assessments, patient surveys, and waste audits. • Monitor carbon emissions and energy use related to catering. • Gather feedback on current food quality, portion sizes, and dietary options.	2028
Initial Improvements: • Introduce or expand recycling programs. • Trial plant-based menu items and aim to reduce single-use plastics in catering. • Address identified "quick wins" in patient and staff feedback.	2028
Training and Awareness: • Educate staff on sustainable food practices and nutrition-related health promotion.	2028

Adaptation

Climate change threatens the ability of the NHS to deliver its essential services in both the near and longer term.

Resilience and adaptation should be built into business continuity and longer-term planning to avoid climate-related service disruptions.

Partnership working between sustainability leads, public health, emergency response teams and estates leads at trust and system level is crucial.

Key Performance Indicators	Timescales
Conduct a climate change risk assessment for all sites	2026
Develop and implement an Adaptation Plan to ensure the resilience of NT&H services to extreme weather events	2026
Continue working with the NENC ICS Climate Adaptation group to develop a regional approach to climate adaptation	2028

Summary

North Tees and Hartlepool NHS Foundation Trust

This Green Plan is a live document and will be regularly reviewed for progress against the action plans.

We will monitor, measure and show our green plan progress by meeting quarterly with sustainability leads for each focus area, reporting routinely to Resource Committee and Board.

Adequate budgets and resources will be needed to achieve our goals and deliver sustainable care.

Climate Change poses many threats to our care population and how we deliver care. This Green Plan will enable us to become an adaptable and resilient organisation.

We will continue an open dialogue with all stakeholders to improve our Green Plans and the care we deliver.


NHS
EMERGENCY AMBULANCE

NHS
South Tees Hospitals
NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Green Plan 2025 – 2028

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Executive Summary

The NHS ambition to be the first Net Zero health system in the world and the NHS 2040 & 2045 targets set by Government has provided greater focus on sustainability. Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. Up to 38,000 deaths a year are associated with air pollution alone, disproportionately affecting the most deprived and further exacerbating health inequalities

This refreshed Green Plan for South Tees Hospitals NHS Foundation Trust covers the period 1 April 2025 to 31 March 2028. We recognise that if we are to provide the best possible care to our patients and improve their quality of life, we need to significantly reduce our impact on the environment.

Stacey Hunter
Group Chief Executive Officer

Steven Taylor
Group Director of Estates Net Zero Board Level Lead

Introduction to South Tees Hospitals NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust provides a wide range of specialist services to over 1.5 million patients across Teesside, North Yorkshire, and beyond. The Trust manages several key facilities, including the James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton (South Tees Hospitals NHS Foundation Trust, 2025).

The Trust is also a major regional centre for trauma care, operating one of the UK's few robotic surgical systems. It plays a crucial role in ensuring that specialist care is accessible to patients across the region, helping to address health inequalities in local communities (South Tees Hospitals NHS Foundation Trust, 2025).

South Tees Hospitals NHS Foundation Trust is the largest employer in Teesside and North Yorkshire, with more than 10,000 staff members. This workforce is dedicated to providing high-quality care and contributing positively to the local area (South Tees Hospitals NHS Foundation Trust, 2025).

The Tees Valley is home to approximately 678,000 people. Over a third of these residents live in the 20% most deprived areas of England, according to the North East Combined Authority in 2024. The Tees Valley faces air quality challenges, particularly due to emissions from the industrial cluster near the River Tees. This area has some of the highest emissions of any area in the UK, both in real terms and per capita.

Our approach to sustainability aligns closely with our NHS role in addressing healthcare inequalities, ill health prevention, and health improvement. We recognise that the indirect and direct impacts of the climate crisis are likely to widen health inequalities in the UK. Therefore, it is crucial that health equity is considered as we develop policies and approaches to reduce greenhouse gas emissions, ensuring their benefits are equally distributed.

South Tees Hospitals
NHS Foundation Trust

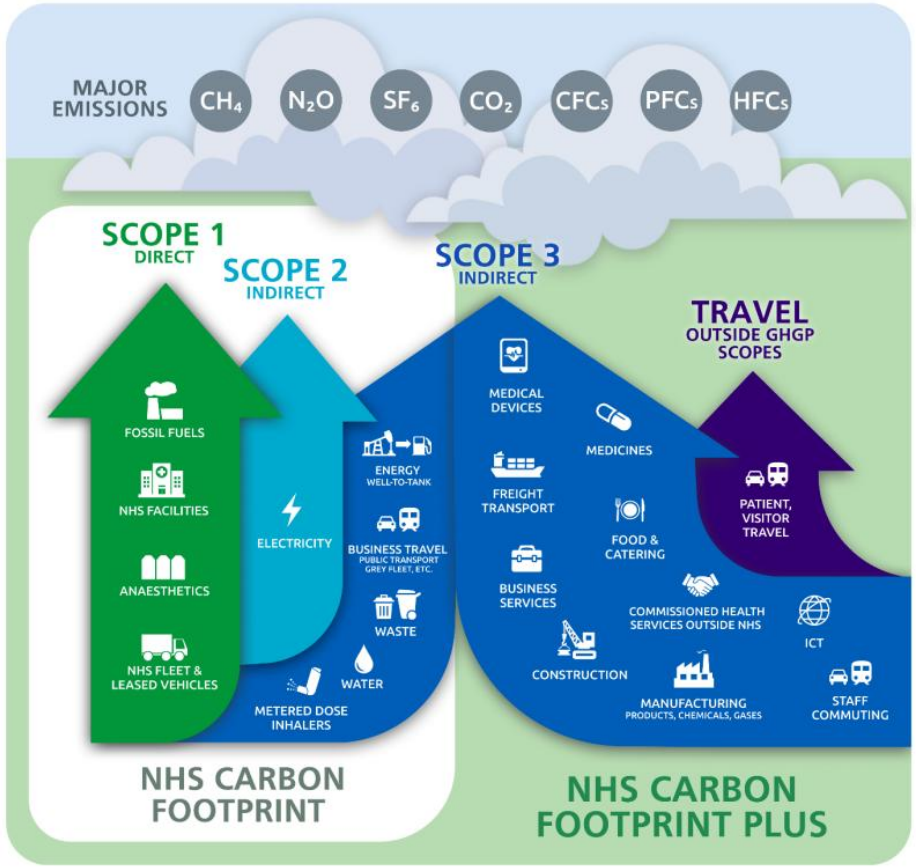
What is a Green Plan? To support our net zero ambition, each trust and integrated care system should have a green plan which sets out their aims, objectives, and delivery plans for carbon reduction. In each case, this should be signed off by the Trust Board, with a boardlevel 'net zero lead' responsible for overseeing its delivery. Given the pivotal role that integrated care systems (ICSs) play, each system will also need to develop its own green plan, based on the strategies of its member organisations.

Why do we need a green plan?

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition. The Health and Care Act 2022 reinforced this commitment, placing new duties on integrated care boards (ICBs), NHS trusts and foundation trusts (referred to collectively in this guidance as trusts) to consider statutory emissions and environmental targets in their decisions.

Drivers for Change Greener NHS The NHS is responsible for 4% of the UK's total carbon emissions. In October 2020, NHS England became the world's first health system to commit to reaching net zero carbon emissions, as outlined in the Delivering a 'Net Zero' National Health Service report, which has two targets:

- To be net zero by 2040 for directly controlled emissions
- To be net zero by 2045 for emissions that the NHS Influences.



Why do we need a Green Plan ?

South Tees Hospitals NHS Foundation Trust

- There are several key legislative drivers for change, and specific guidance as to why we need this Green Plan.
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- Climate Change Act 2008 - legally binding UK Government targets for the reduction of carbon emissions. The NHS has a duty to respond to meet these targets which are enshrined in law.
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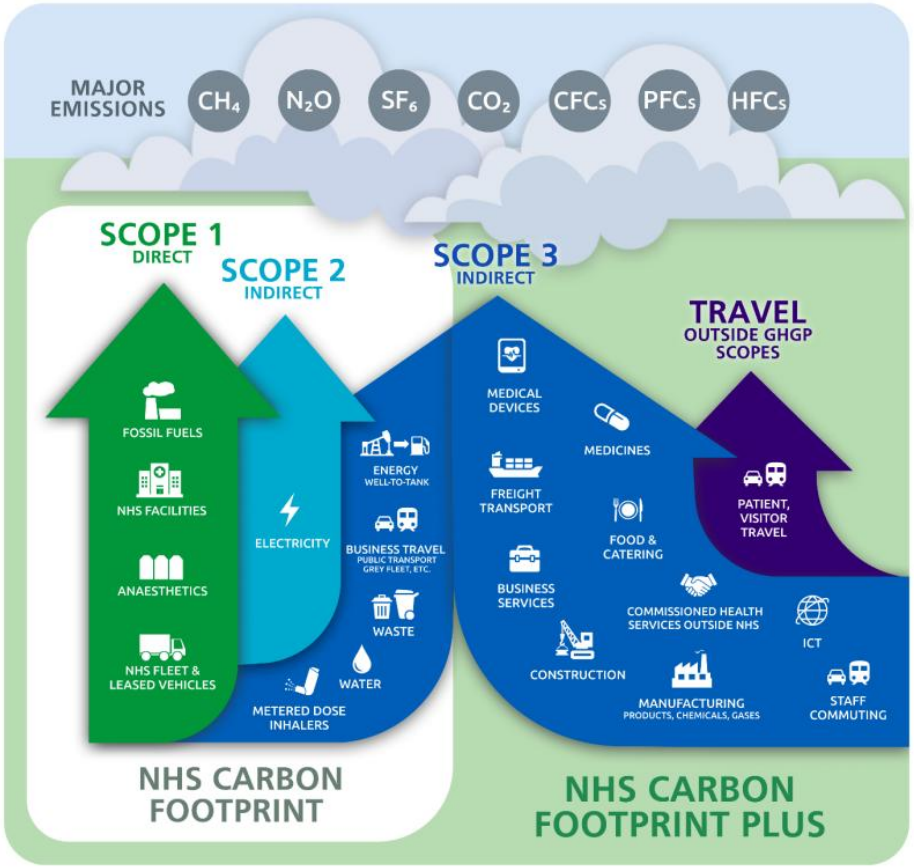


South Tees Hospitals
NHS Foundation Trust

Trust Vision

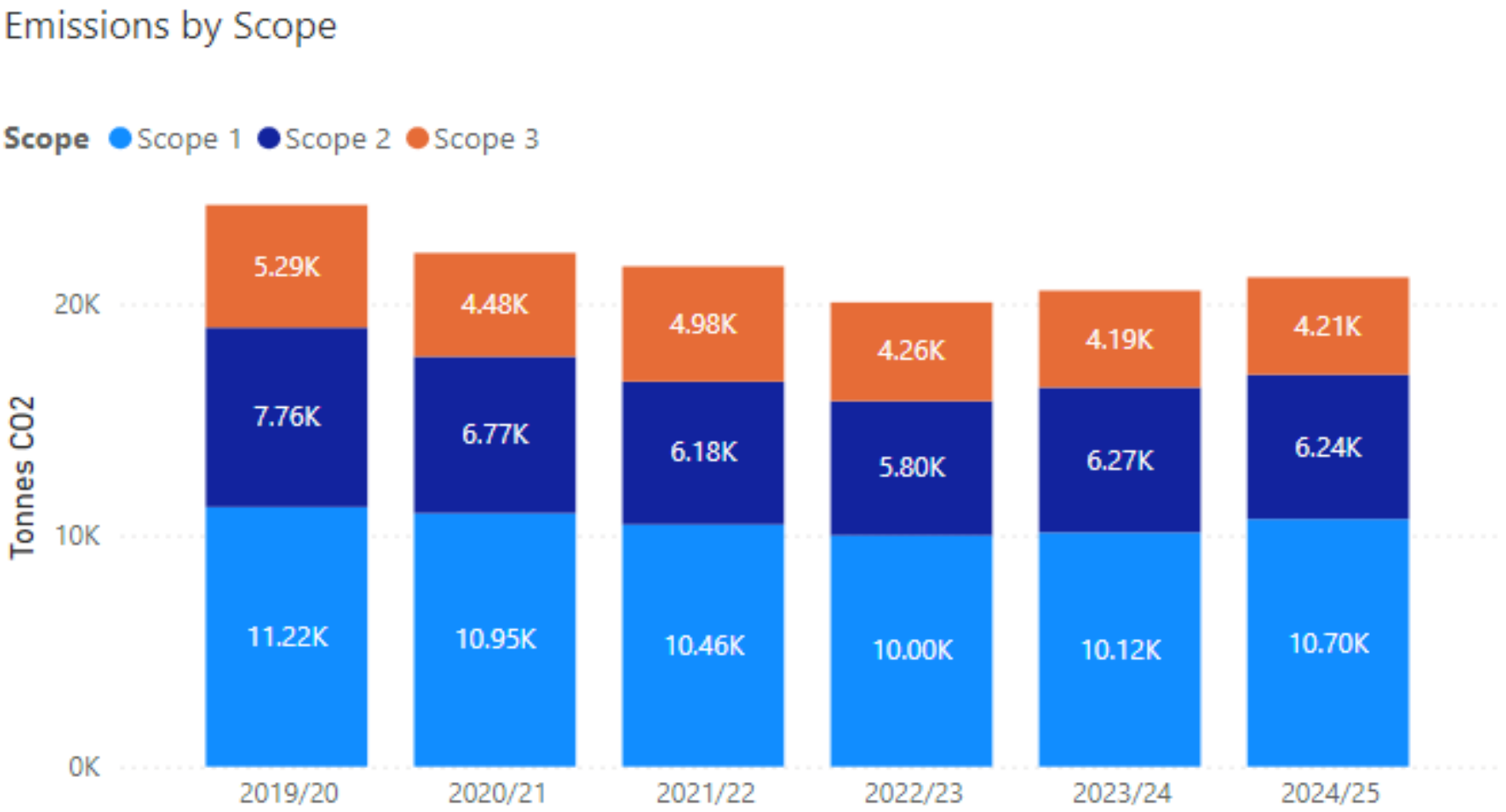
Our vision is to be a leader in sustainable healthcare, committed to reducing our environmental impact and promoting the health and well-being of our community to ensure we meet Net Zero on or before 2040.

United Nations Sustainable Development Goals

The UN Sustainable Development Goals are a universal call to action to end poverty, protect the planet, and improve the lives and prospects of everyone everywhere. The 17 Goals were adopted by all UN Member States in 2015, with the intention of achieving the Goals by 2030. Our Green Plan, Social Value Charter and Anchor Framework are aligned to the Goals, and we will continue to work with our partners to encompass them at the heart of our work.

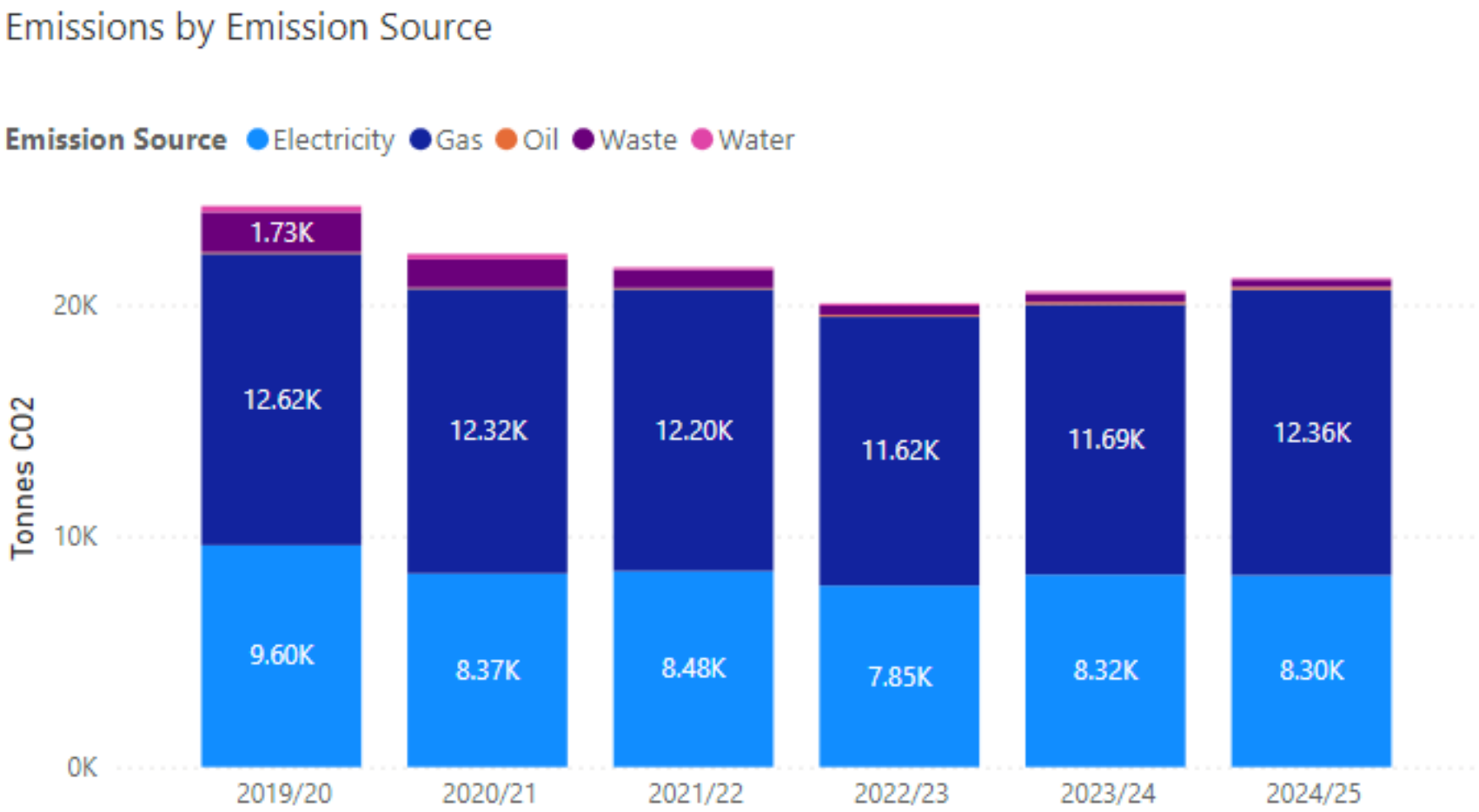
Carbon Emissions

South Tees Hospitals NHS Foundation Trust



Carbon Emissions

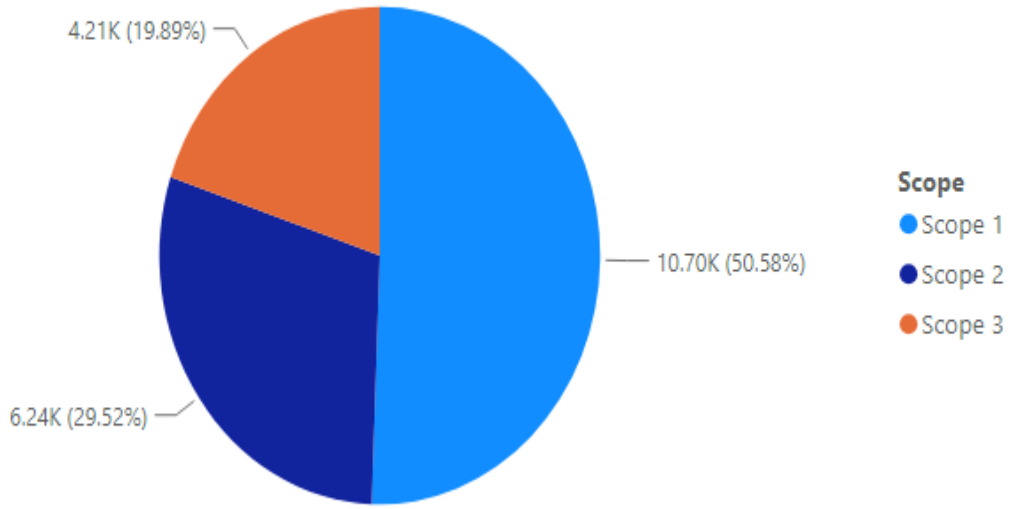
South Tees Hospitals NHS Foundation Trust



Carbon Emissions

South Tees Hospitals NHS Foundation Trust

Emissions by Scope

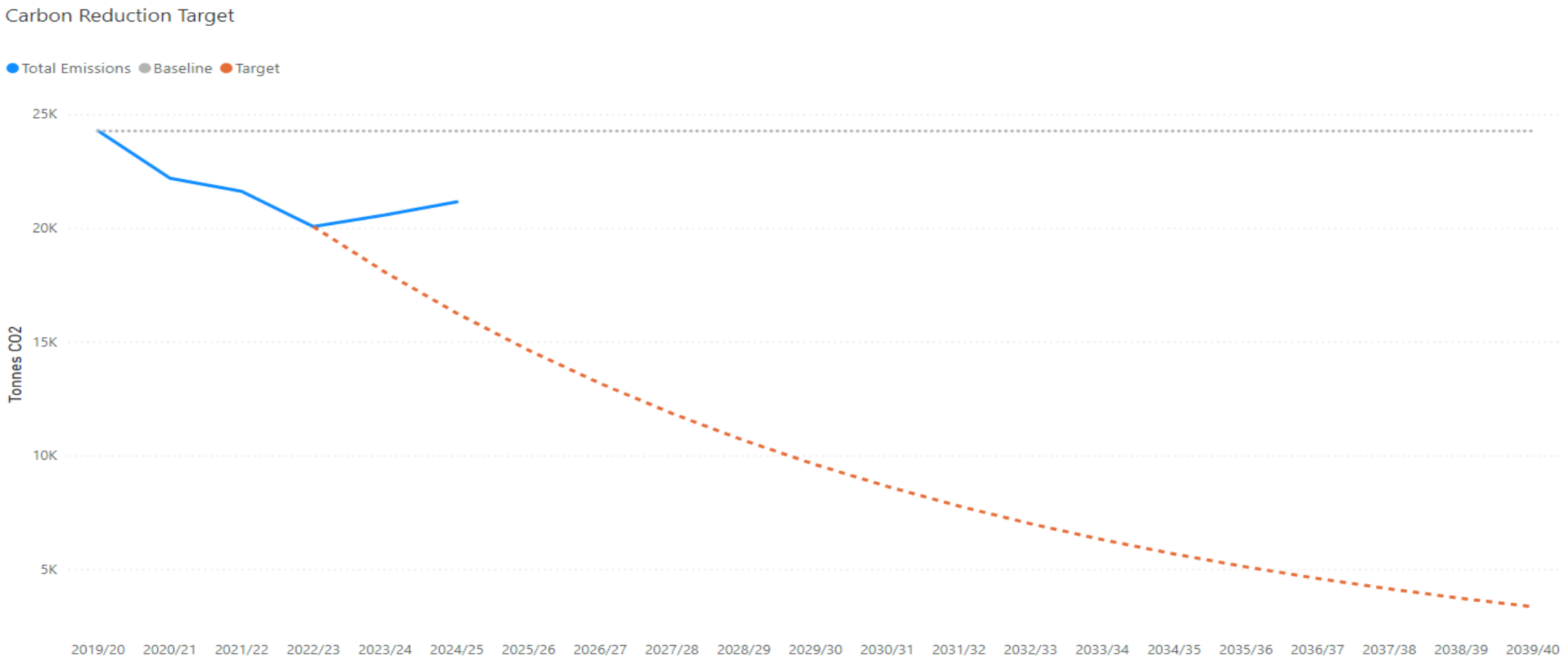


Emissions by Scope and Site

Scope	FHN	JCUH	**Total**
Scope 1	1,914.22	8,783.12	**10,697.35**
Scope 2	953.54	5,289.49	**6,243.03**
Scope 3	660.78	3,546.55	**4,207.33**
Total	**3,528.55**	**17,619.16**	**21,147.71**

Carbon Emissions

South Tees Hospitals NHS Foundation Trust



Areas of focus

South Tees Hospitals NHS Foundation Trust

This section outlines the priority actions the Trust will implement over the next three years for each area of focus, as detailed in the updated Green Plan guidance, as follows:

- Workforce and Leadership
- Digital Transformation
- Net Zero Clinical Transformation
- Medicines
- Travel and Transport
- Estates and Facilities
- Supply Chain and Procurement
- Food and Nutrition
- Adaptation

Each area of focus includes time-bound actions and associated key performance indicators (KPIs) to support progress tracking. A lead is assigned to each area of focus, and KPIs are tracked quarterly with progress reported to the resource committee

Workforce and Leadership

The transition to a net zero NHS will be driven by its people. There is already strong support for a greener future; 9 in 10 staff support the NHS net zero ambition, while 6 in 10 say they are more likely to stay in an organisation taking decisive climate action (YouGov, 2023).

South Tees Hospitals NHS Foundation Trust support their staff and leaders to learn, innovate and embed sustainability into everyday actions.

A designated board-level net zero lead has been appointed with clear identified operational support.

Action - assess workforce capacity and skill requirements for delivering the green plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways
Promote, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub
Promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians

Workforce and Leadership

Key Performance Indicators	Timescales
Create a culture of sustainable development by ensuring sustainability is embedded into systems and processes	Ongoing
Facilitate the culture change of our staff, patients and visitors attitude towards the environment and sustainability	2028
Work in partnership with neighbouring NHS trusts and public authorities to enhance the delivery of the Green Plan and share best practice.	Ongoing
Add sustainability to Trust induction	2026
Promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians	2027

Net Zero Clinical Transformation

South Tees Hospitals NHS Foundation Trust

The NHS is committed to moving to out-of-hospital and digitally-enabled care where clinically appropriate, improving prevention of ill health and reducing health inequalities. These changes also underpin our commitment to net zero. Net zero clinical transformation should ensure high-quality, preventative, low-carbon care is provided to patients at every stage.

Key Performance Indicators	Timescale
Identify a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance	2026
Share learning and outcomes, through clinical networks, the ICB and NHS England	2026

Digital Transformation

The Trust continues to roll out electronic prescribing across the organisation, which has allowed us to remove the paper charts in the areas where it has been introduced. After completing all adult inpatient wards, we are now looking to introduce it to Critical Care areas, including general critical care and neonates. Later this year, we will also be rolling out the Electronic Record into Outpatients, which will allow outpatient prescriptions to be sent to pharmacy electronically.

A patient engagement portal (PEP) was introduced to the Trust in 2023 which has allowed patients to get access to their appointments and letters through the app on their phone. Around 75% of patients choose this method meaning the Trust has been able to reduce the number of letters it prints and posts out to patients.

The Trust has also introduced voice recognition software which integrates with the PEP. This allows clinicians to dictate their clinic letters directly into the PC which is converted to text and uploaded up to the PEP, again reducing the amount of paper letters that are sent to patients through the post. All this saves paper, printing, electricity and reduces emissions from the delivery of letters by the postal service.

The PEP has also replaced the Attend Anywhere video consultation service since April 2024, and due to it being integrated into the same app, we have seen an increase in patients taking up the service. This saves patients from having to travel to site, cutting down emissions, but also allowing clinicians to run the clinic from a single office or even from home. will be integrated to the NHS app. This will reduce the amount of appointment letters printed as patients will receive their letters electronically via the app saving paper, printing, and electricity.

The Trust continue to consolidate its server estate onto to smaller and more environmentally friendly virtual servers which allow multiple systems to be hosted on a single piece of hardware. At the same time it is still exploring the use of cloud hosting where this is appropriate, where systems are held in large multi-organisational data centres. While data centres have their own environmental challenges, companies like Microsoft are continually looking at more sustainable ways to build, power and cool data centres that allow it to meets its own green goals:

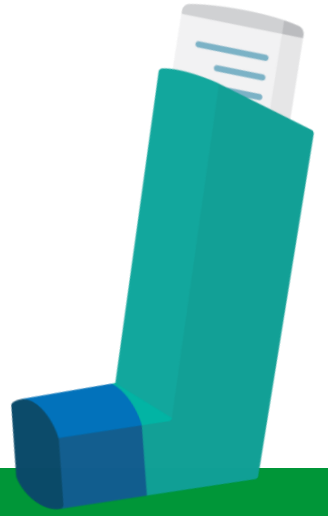
Digital Transformation

Key Performance Indicators	Timescale
Roll out of an electronic record into Critical Care areas removing the need for the paper charts, paper prescribing and other paper records	2026
Consolidated data centres across the group. Rationalisation of data centres and servers across the group, allowing for smaller onsite data centres to be decommissioned saving on power and cooling	2027
Continue to look at Cloud services where appropriate to reduce on-stie server hardware	2027 and on-going
Standardised equipment. Look to standardise equipment and builds across University Hospitals Tees, allowing equipment to be shared across the group	2027
Single EPR. The ambition for University Hospitals Tees is to have a single shared Electronic Patient Record (EPR) across the group, allowing all clinical staff to see a single shared record. This will remove the need for notes to be printed out transported between sites.	2027 and into 2028
WEEE (Waste Electrical and Electronic Equipment) hardware recycling	Ongoing

Medicines

Medicines account for around 25% of NHS emissions. A few medicines account for a large portion of these emissions, for example, anaesthetic gases (2% of NHS emissions) and inhalers (3%).

Key Performance Indicators	Timescale
Removal of all nitrous oxide across the organisation	Target 1 year
Optimise respiratory care to reduce carbon footprint related to inhalers and improve respiratory disease outcomes	Target 2 years
Ongoing improvement of IV to oral switches of medications as clinically appropriate	Target 3 years
Campaigns for patients and staff promoting reduced medication waste	Target ongoing
Reduction of single use plastics used in relation to the supply or administration of medication (Reduce plastic bottles and use glass bottles)	Target 3 years
Optimising inhaler choice (considering clinical appropriateness , the environmental impact of inhalers and patient preference)	Target 3 years



Travel and Transport

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution. The NHS Net zero travel and transport strategy outlines a roadmap to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

Key Performance Indicators	Timescale
Develop a sustainable travel plan by December 2026, to be incorporated into the green plan (as an annex), focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting	Target 2026
Invest in a dedicated Liftshare / car share platform	Target 2026
Regional agreement on anti-idling campaign	Target 2027
Regional feasibility study for EV charging infrastructure	Target 2027
Continue partnership working with local authorities and local transport authorities to maximise funding and infrastructure opportunities	Ongoing

Travel and Transport

Key Performance Indicators	Timescale
Implement an ANPR system, which should reduce the number of non-authorised vehicles on site, reducing CO2 emissions.	2025
Increase cycle to work scheme to 500 staff	2026

Estates and Facilities

The latest announcements include £18.95million of national funding for the James Cook site and £9.5million for the Friarage.

This significant investment will see work at both sites over the next two years to replace gas burning equipment, install photovoltaic panels to generate electricity and replace windows, reducing our reliance on fossil fuels and enhancing the environment for patients and staff.

Across the hospital group we are striving to reduce our impact on the environment and carbon emissions in the way in which we work and the use of resources.

A significant proportion of our carbon emissions relate to the burning of fossil fuels in the form of gas as our primary source of heat generation.

Our estates and facilities teams have been actively planning to reduce the reliance on fossil fuels as part of our decarbonisation journey and securing this latest government funding is a big step towards achieving this.

It follows on from the University Hospital of Hartlepool's successful £13.4million bid last year for funding to improve heating, ventilation, air-conditioning and lighting.

Together the works will help the group achieve its goal of achieving net zero for carbon emissions by 2040 – in line with national NHS targets.

As a key community partner, and one of the largest employers in the region, it is important that we play our part in helping reduce our carbon emissions and the effects of climate change on the environment.

Reducing our reliance on fossil fuels and finding ways to work with increased efficiently also enables more funds to be invested in patient care.

The funding has been approved by Salix, an organisation which administers funds on behalf of the Department for Energy Security and Net Zero.

Estates and facilities

South Tees Hospitals NHS Foundation Trust

Key Performance Indicators	Timescale
For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032	2028
Increase communication around energy consumption and carbon reduction	2026
Increase EV charging points	2028
Apply for grants associated with energy saving	2028
Implementation of LED on lifecycle / new projects	100% FHN ? JCUH
Recruit energy manager	2028
Capital projects – new builds to be built to the NHS Net Zero Carbon Building Standard and achieve BREEAM outstanding	Ongoing
Achieve clinical waste segregation targets of 20:20:60 HTI, AT & OW	2026
Partake in No Mow May to rewild sections of our green space on selected trust sites	Ongoing

Supply Chain and Procurement

The NHS net zero supplier roadmap outlines steps suppliers must follow to align with the NHS net zero ambition between now and 2030. Roadmap implementation is a shared responsibility across trusts, systems, regional procurement hubs and nationally. Organisations should also seek to embed circular solutions, such as using reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost-saving.

Key actions for systems and trusts:

embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored via KPIs
encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and its suppliers on sustainability priorities
In addition, trusts should:

reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects (see Net zero clinical transformation and Annex B: selected resources for additional support tools)

Supply Chain and Procurement

Key Performance Indicators	Timescale
Reduce and avoid use of single use plastics	Ongoing
Adopt innovation	Ongoing
Understand the CO2 footprint of our procured items	2028
Remove antimicrobial coated curtains	2027
Trial reusable torniquets and evaluate cost and CO2 savings	2026

Food and Nutrition Achievements

James Cook University Hospital

- Waste Review: Food storage, waste and vegetarian options are being reviewed alongside patient experience within ongoing benchmarking work.
- Accessibility: Inpatient menus are now available online to support accessibility and reduce waste at ward level. Menu cards will still be available at ward level.

Friarage Hospital

- Waste Review: Completed a full review of meals with the highest waste production in December, following patient feedback and support from the housekeeping team.
- Menu Changes: High waste meals are being removed from the new menu launching in April.
- Vegetarian Options: Added 4 new vegetarian options to replace lamb and beef dishes after a tasting session with clinical teams.

East Cleveland Primary Care Hospital

- Menu Change: Implemented a new 2-week menu in February 2025, replacing the previous 4-week menu.
- Annual Review: implementation and monitoring of inpatient kitchen, plate, and trolley food waste in place.
- Waste Reduction: This change has led to a reduction in kitchen and trolley waste, cost and space savings.
- Carbon Reduction: Embodied carbon of meals has been calculated, showing a 33% reduction from 53 to 36 kgCO2e. High-carbon lamb dishes have been replaced with lower carbon options.

Friary

- Annual Review: implementation and monitoring of inpatient kitchen, plate, and trolley food waste now conducted annually.
- Menu Review: The inpatient dining menu and waste was reviewed in October 2024, and feedback was provided to the catering provider.

Redcar Primary Care Hospital

- Menu Finalisation: A new menu is being finalised, with vegetarian options moved to the top to promote uptake.

Food & Nutrition

South Tees Hospitals NHS Foundation Trust

Key Performance Indicators	Timescale
Policy and Standards Alignment: • Review current compliance with the eight Nutrition and Hydration standards. • Update policies to reflect national and green plan priorities. • Ensure training for relevant staff in food safety, special diets, and allergens.	December 2025 Improve compliance with standards, and initiate data collection.
Data Collection and Baseline Measurement: • Conduct PLACE assessments, patient surveys, and waste audits. • Monitor carbon emissions and energy use related to catering. • Gather feedback on current food quality, portion sizes, and dietary options.	
Initial Improvements: • Introduce or expand recycling programs. • Trial plant-based menu items and aim to reduce single-use plastics in catering. • Address identified "quick wins" in patient and staff feedback.	
Training and Awareness: • Launch a trust wide training program for all food service staff. • Educate staff on sustainable food practices and nutrition-related health promotion.	

Food & Nutrition

South Tees Hospitals NHS Foundation Trust

Key Performance Indicators	Timescale
Waste Reduction Initiatives: • Implement targeted interventions based on waste audit findings (e.g., adjust portion sizes, improve ordering processes). • Monitor and manage plate waste, unserved meals, and production waste.	December 2026 Address identified gaps, reduce waste, and enhance menu offerings.
Menu Development and Inclusivity: • Expand plant-based and culturally appropriate menu options. • Collaborate with dietitians, catering staff, and patient groups to prevent menu fatigue. • Pilot pictorial and read-aloud menus for vulnerable groups on all sites.	
Sustainability Enhancements: • Reduce delivery frequency through efficient ordering processes. • Measure and lower energy and water use in catering operations. • Assess and improve the carbon footprint of meals served.	
Improving Staff and Visitor Food Services: • Ensure 24/7 access to healthy and affordable meal options. • Upgrade break facilities to support health and hydration. • Tailor food offerings based on staff Health Needs Assessment feedback.	
Monitoring and Evaluation: • Evaluate year-one changes using patient, staff, and visitor surveys. • Report outcomes to the Nutrition and Hydration Steering Group and adjust strategies as needed.	

Food & Nutrition

South Tees Hospitals NHS Foundation Trust

Key Performance Indicators	Timescale
Expand Successful Initiatives: • Roll out proven waste reduction programs across all trust sites. • Scale plant-based and sustainable menu options.	December 2027 Ensure sustained impact and scalability of food and drink across all sites.
Long-Term Sustainability Goals: • Achieve measurable reductions in food waste, energy use, and carbon emissions. • Align all catering practices with the Trust's Green Plan and NHS Net Zero goals	
Cultural Change and Engagement: • Embed healthy eating and sustainability into the Trust's culture. • Recognise and reward staff contributions to food and drink improvements.	
Performance Tracking: • Set annual key performance indicators (KPIs) for food quality, waste reduction, and sustainability. • Use PLACE assessments, ERIC data, and patient/staff feedback to report on progress	
Prepare for the Next Strategy Cycle: • Conduct a comprehensive review of the 3-year strategy's successes and challenges. • Draft recommendations for the next Food and Drink Strategy (2028–2031).	

Governance and accountability

South Tees Hospitals NHS Foundation Trust

South Tees NHS Foundation Trust Governance Structure

Trust Unitary Board
(Annually)

Resource Committee
(Quarterly)

Sustainability Group
(Monthly)

North East & North Cumbria Provider Collaborative Governance Structure

Adaptation

Climate change threatens the ability of the NHS to deliver its essential services in both the near and longer term. Resilience and adaptation should be built into business continuity and longer-term planning to avoid climate-related service disruptions.

Partnership working *between sustainability leads, public health, emergency response teams and estates leads at trust and system level is crucial.*

Key Performance Indicators	Timescale
Conduct a climate change risk assessment for all sites	2026
Develop and implement an Adaptation Plan to ensure the resilience of STFT services to extreme weather events	2026
Continue working with the NENC ICS Climate Adaptation group to develop a regional approach to climate adaptation	Ongoing

Green champions

Since the last Green Plan, the Trust has successfully recruited over 90 Green Champions. These Green Champions meet monthly, supporting the Sustainability Manager on the Green Plan actions.

We will introduce three levels for the champions: Bronze, Silver, and Gold. Celebration events will be held to showcase green champion good practices across the Trust.

Biodiversity

- In May 2025, South Tees NHS Foundation Trust, along with our partner NHS trusts within the North East and North Cumbria and Middlesbrough Council, took part in No Mow May. We allowed some small areas of land to grow throughout spring. Leaving areas of grass to grow longer in summer helps native wildflowers grow. These areas are a perfect source of food and shelter for our declining insect species, like bees and butterflies.
- STFT collaborated with The Wildlife Trust and Middlesbrough Environment City and took part in the National Bioblitz. What is a Bioblitz? Definition: A Bioblitz - Bio' means 'life' and 'Blitz' means 'to do something quickly and intensively'. Together they make 'BioBlitz', a collaborative race against the clock to discover as many species of plants, birds, animals, fungi and other organism as possible, within a set location, over a defined time period (usually 24 hours or a week)
- Results - To meet the criteria for a Local Wildlife Site (LWS), the site needs to include three grasses and five herbs that are on the criteria species list. On the James Cook University Hospital site that was surveyed, seven herbs were identified, but only two grasses. This means that the site can be considered a borderline LWS as it is missing one species of grass. As the survey was not comprehensive and was conducted later in the year than is ideal, it is possible that there is another grass species present that would result in the site being classified as an LWS.

Key Performance Indicators	Timescale
Conduct another survey, maintain biodiversity, and promote a signed wellbeing walk around the sites	2025

ISO14001

South Tees Hospitals NHS Foundation Trust

The ISO 14001 Environmental Management System is designed for all businesses who demonstrate commitment to the environment and sustainability. It is regularly reviewed and audited by external auditors to ensure that compliance is maintained, and continuous improvement is delivered.

ISO 14001:2015 is broken down into 7 key areas:

- Context of the Organisation – scope of the organisation, interested parties
- Leadership – commitment, policy, roles & responsibilities
- Planning – risks and opportunities, environmental aspects, compliance, objectives
- Support – resources, competence, communication, documentation
- Operation – planning & control, emergency preparedness & response
- Performance Evaluation – monitoring, measurement, analysis & evaluation, internal audit, management review
- Improvement – nonconformity & corrective action, continuous improvement

Summary

South Tees Hospitals NHS Foundation Trust

This Green Plan is a live document and will be regularly reviewed for progress against the action plans. We will monitor, measure and show our green plan progress by meeting quarterly with sustainability leads for each focus area, reporting routinely to SMT / Boards.

Adequate budgets and resources will be needed to achieve our goals and deliver sustainable care.

Climate Change poses many threats to our care population and how we deliver care. This Green Plan will enable us to become an adaptable and resilient organisation.

We will continue an open dialogue with all stakeholders to improve our Green Plans and the care we deliver.


NHS
EMERGENCY AMBULANCE

University Hospitals Tees

Fit and Proper Person Test Annual Submission 2024/25

Meeting date: *3 July 2025*

Reporting to: *Group Board*

Agenda item No: 22

Report author: *Jackie White, Head of Governance/Company Secretary*

Executive director sponsor: *Stacey Hunter, Chief Executive*

Action required:
Assurance

Delegation status: Matter reserved to Unitary Board

Previously presented to: *Audit & Risk Committee, Nomination Committee and Council of Governors*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

There are no issues to alert the Board of Directors to in relation to fit and proper person requirements.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Ongoing monitoring of the fit and proper person test will be undertaken through appraisals and 1:1 meetings. Nominations Committee and Remuneration Committee will have the oversight of any issues which may arise as appropriate within their remit.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The Group Board of Directors can be assured that a robust process has been undertaken and independently audited to ensure compliance with the fit and proper guidance.

Recommendations:

Group Board are asked to note the content of the report.

Group Board
3 July 2025
Fit & Proper Person Test Report – 2024/25

1. PURPOSE OF REPORT

The purpose of the report is to provide assurance to the Board of Directors regarding the implementation of the requirements for the Fit and Proper Person Test process for board members and the outcome of testing against the guidance that related to 2024/25.

2. RECOMMENDATIONS

It is recommended that Board of Directors note the contents of the report.

3. 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 was introduced, which sets out requirements both for new board appointments and annual review.

The purpose of strengthening the FPPT was to prioritise patient safety and good leadership within NHS organisations. A portfolio of evidence is required to 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 is held locally and entered onto ESR.

The Chair has overall accountability for the FPPT, supported by the Company Secretary and the HR Regulatory Manager to assist in carrying out and recording the outcome of the assessment for each board member against the FPPT requirements based upon the evidence collected.

The two Trusts are required to make an annual submission to NHS England confirming the outcome of FPPT for their board members.

4. DETAILS

The Board of Directors for North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust have applied the F&PPT guidance to voting and non-voting Non-Executive Directors and Executive Directors.

Reported Outcomes

The two Trusts have completed the testing relating to the new F&PPT guidance. The individuals that were tested as part of Phase 1 are listed below;

Employees of North Tees & Hartlepool NHS Trust

- Professor Derek Bell
- Ms Stacey Hunter
- Mr Matt Neligan
- Mr Neil Atkinson
- Ms Maurya Cushlow (interim)
- Mrs Ruth Dalton
- Mr Steven Taylor
- Mr Ken Anderson
- Ms Rowena Dean
- Mr Stuart Irvine
- Mr Chris Macklin
- Ms Fay Scullion
- Professor Elizabeth Barnes
- Ms Ann Baxter
- Ms Alison Fellows

Employees of South Tees Hospitals NHS Trust

- Mr Chris Hand
- Dr Hilary Lloyd (left)
- Dr Michael Stewart
- Mrs Rachael Metcalf
- Mr Sam Peate
- Mrs Jackie White
- Professor Rudy Bilous (left)
- Ms Ada Burns
- Ms Ali Wilson
- Mr David Redpath
- Ms Miriam Davidson
- Mr Ken Readshaw
- Mr Mark Dias
- Ms Alison Gerner (left)

Self-Attestation Forms

Self-attestation forms were issued and have been signed and returned by individuals.

F&PPT Checklists

A F&PPT checklist was completed to evidence the checks performed for each individual. This included checks on being disqualified from being a charity trustee, 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 and social media checks.

ESR Recording

A summary of the checks and declarations have been collated and are being entered onto the respective Trust ESR system for the mandatory fields to record F&PPT outcomes.

Outcome Validation

In order to ensure appropriate and independent checks were performed in relation to individual outcomes, the following approach was undertaken;

- Results for **Directors** of the Trusts – a summary of the outcomes, supporting evidence was provided to the **Chief Executive**.
- Results for the **Chief Executive** of the Trusts – a summary of the outcomes, and supporting evidence was provided to the **Chair.**
- **Senior Independent Directors** (Ada Burns and Chris Macklin) – a summary of the outcomes, and supporting evidence was provided to the **Chair**.
- Results for the **Non-Executive Directors** of the Trusts – a summary of the outcomes, and supporting evidence was provided to the **Chair**.
- Results for the **Chair** of the Trust – a summary of the outcomes, including the ESR dashboard and supporting evidence will be provided to the **Senior Independent Director** (Ada Burns).

Key issues, significant risks and mitigations

The risk relating to this paper is the potential breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 - people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The two Trusts have undertaken a thorough and comprehensive process to apply the F&PPT guidance and independent checks have been performed in relating to the outcomes and this can be evidenced by a robust audit trail.

Internal audit processes have been undertaken. For colleagues employed by North Tees & Hartlepool NHS Trust, Internal Audit partner Audit One completed the audit and provided Good Assurance. The report is anticipated to be received this month.

For colleagues employed by South Tees Hospitals NHS Trust, Internal Audit partner PWC completed the audit in May 2025 and was identified as Low Risk.

5. CONCLUSION

The two Trusts have strictly followed the new F&PPT guidance and applied this to members of staff.

In accordance with the new Fit and Proper Person Test Framework requirements, the Board of Directors of North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Foundation Trust and additional staff who were included in testing are compliant with the new guidance.

This evidences that the two Trusts are compliant with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 - people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The two Trusts have prepared the documentation that is required to be signed by the Chair in preparation to return to NHSE to confirm the outcomes of the F&PPT guidance for 2024/25 and is subject to formal sign off by the Chair.

APPENDICES

Appendix 5: Annual NHS FPPT submission reporting template – NTH
Appendix 5: Annual NHS FPPT submission reporting template - ST

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
North Tees & Hartlepool NHS Foundation Trust	Professor Derek Bell	2024/2025

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	7			0	0	0
Executive board members	9			0	2	2
Partner members (ICBs)	N/A	N/A		N/A	N/A	N/A
Total	16			0	2	2

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Internal Audit (AuditOne)	2024/25	The audit fieldwork of the internal audit on F&PPT (NHSE guidance) has been completed with a draft report received with Good assurance.	The draft report has 2 low priority actions. The management action plan is currently being drafted.	All actions to be completed by 31 December 2025
Internal Audit (AuditOne)	2023/24	Audit on F&PPT (old guidance). Reasonable assurance: compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.	Management action plan in place with 4 medium risk actions and 4 low risk actions.	All actions to be completed by 31 December 2025

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Group Chairman	Professor Derek Bell	29-04-2025	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	There are no adverse findings to report. The outcome has been reported to the Audit Committee, Council of Governors and will be retrospectively presented to Board of Directors 3 July 2025.
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	There are no details to report.
As Chair of North Tees and Hartlepool NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Chair signature:		
Date signed:		
For the regional director to complete:		
Name:		
Signature:		
Date:		

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
South Tees Hospitals NHS Foundation Trust	Professor Derek Bell	2024/2025

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	6		0	2	0
Executive board members	6	6		0	1	1
Partner members (ICBs)	N/A	N/A		N/A	N/A	N/A
Total	12	12		0	3	1

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
PWC Audit	May 2025	Audit on F&PPT (NHSE guidance). Report classification: Low Risk	Within this report, there are four current year findings with 2 medium risk actions and 1 low risk actions and a management action plan is in place.	All actions to be completed by 31 December 2025

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Group Chairman	Professor Derek Bell	29-04-2025	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	There are no adverse findings to report. The outcome has been reported to the Audit Committee, Council of Governors and will be retrospectively presented to Board of Directors 3 July 2025.
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	There are no details to report.

As Chair of South Tees Hospitals NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Audit & Risk Committee

20 May 2025

Connecting to: South Tees Hospitals NHS Trust Board, Chair Ken Readshaw

Key topics discussed in the meeting:

- **Counter fraud**

Counter fraud policy approved

2025/6 Work plan approved (9 month period)

- **External Audit**

Good progress. Timetable expected to be met.

- **Internal Audit**

3 internal audits received

- Board assurance framework- medium risk
- Fuller inquiry – Medium risk
- Fit and proper person arrangements – Low risk

Head of internal audit opinion – Limited assurance. (Omnicell audit - critical risk and high risk weaknesses found in Recruitment, Fuller inquiry and Maternity). However risks identified in 24/25 are not pervasive across the trust.

Actions:

- none

Escalated items:

- Committee responsibilities for IPR

- Terms of reference recommended for approval
- Good progress with annual filings
- Provider license statement recommended for approval
- Head of internal audit opinion – Limited assurance

Risks (Include ID if currently on risk register):

- No new Risks identified

NHS
University Hospitals Tees

Audit Committee – NTHFT

21 May 2025
Connecting to: North Tees & Hartlepool Trust Board

Key topics discussed in the meeting:

- Review of Committee's Terms of Reference – minor amendments discussed, to be reviewed at the next Committee meeting prior to submission to Board.
- Committee Effectiveness Review – Committee members had completed checklists and the majority of responses agreed strongly or agreed with themes and elements within the checklist. The Committee is aware of key sources of assurance. A gap in membership is being addressed. The Committee gives appropriate time for quality and finance information. Decisions and actions have been implemented in terms of timescales, recognising slippage in actions. Members confirmed agreement with the Effectiveness Review.
- Annual Report of the Committee - The Committee considered the draft report, and agreed to delegate responsibility for agreeing and signing the report to the Committee chair.
- Annual Report of declarations of interest and gifts & hospitality – the Committee noted the report and the assurance it provided, and the development and introduction of revised Standards for Business Conduct that will be common to both Trusts.
- Annual Governance Statement – this was in draft format, with some areas to be updated/completed, including the final Head of Audit opinion. It was noted that the Trust was not reporting any significant control issues. Progress on the AGS was noted and the Committee agreed to delegate final approval to the Committee chair.
- Trust's Provider Licence – the Committee noted that the Trust is operating in line with its Provider Licence and resolved to approve the Provider Licence declaration and support the annual self-certification by the Board of Directors.
- Review of Annual Accounts and Financial Statements - the draft annual accounts were submitted on 30th April 2025, following virtual approval by the Audit Committee. The external audit process was now in progress and going well and the final accounts would be submitted to an extra-ordinary Audit Committee in June. Resolved that the

Caring Better Together

Annual Accounts and Financial Statement would be finalised prior to submission to Board.

- Review of Tender Waivers – this report was discussed and a number of comments were noted; work is ongoing to rationalise and improve the processes and reporting. An audit will be completed in June and this is also in the annual audit plan, so additional assurance will be provided in due course.
- Draft Head of Internal Audit Opinion - the final Head of Internal Audit Opinion for 2024/25 will be incorporated into the Internal Audit Annual Report which is due to be presented to the Audit Committee meeting scheduled for 30th July 2025. No significant control weaknesses had been identified from work concluded to date.
- Internal Audit Progress Report - the Committee noted that there was one audit remaining in the 2023/24 audit plan, the draft report for which has been issued.
- Draft Annual Internal Audit Plan 2025/2026 - there is no H&S audit in the current plan for next year, but there are 13 days' contingency, so H&S can be added if desired. The plan does include a Fire Audit and its was agreed that those Audit ToR would come to the July Audit Committee for review. The Committee approved the Plan.
- 2025/2026 Internal Audit Charter and Protocol - the format had not changed from previous years. The Committee resolved to approve the Internal Audit Charter and Protocol.
- External Audit progress Report and Technical Update – progress was discussed and noted by the Committee.
- Counter Fraud Progress Report, including recommendations tracker and 2025/2026 Counter fraud work plan, annual counter fraud staff survey report, fraud awareness presentation summary report, NHSCFA local proactive exercise, NHSCFA quarterly performance statistics and Investigation Report. The Committee discussed and approved the report, and noted the assurance it provided.
- Annual Review of Effectiveness of Internal Audit – various points were discussed (including interface with the LLP), with feedback to be provided to AuditOne ahead of the next Committee meeting.
- Horizon scanning – no issues raised for discussion at this meeting.

Actions:

- Committee Effectiveness Review to be highlighted to the Board
- JW to carry out further analysis on the rate of response in respect of declarations of interest and gifts & hospitality and recommend escalation to Board.
- Fire Audit and Fire Safety to be reviewed to allow a decision to be made regarding whether an independent review is needed, ahead of next Committee meeting - SI.
- Annual review of the effectiveness of Internal Audit - SI to provide feedback to AuditOne prior to the next Committee meeting.
- SI to review the BAF risk relating to the years of life remaining for the Trust's buildings at North Tees

Escalated items:

- External Audit update.
- Items to ratify: Provider Licence, annual filings.
- Committee ToR.
- Declarations of Interest and Hospitality (rate of returns) – see above.

Risks (Include ID if currently on risk register):

- Committee discussed the BAF risk on North Tees buildings and the issue of the number of years of life remaining – SI to review.
- Also discussed the need to continue to monitor the care home sector (local authority scrutiny committees have a role here).

University Hospitals Tees

Good Governance Institute – Report Update (NTHFT)

Meeting date: *3 July 2025*

Reporting to: *Unitary Board*

Agenda item No: 25

Report author: *Stuart Irvine Director of Risk, Assurance & Compliance*

Executive director sponsor: *Stuart Irvine Director of Risk, Assurance & Compliance*

Action required:
Assurance

Delegation status: Matter reserved to Unitary Board

Previously presented to: *N/A*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF Domains

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Final Update on the Good Governance Institute Report

North Tees & Hartlepool NHS Foundation Trust commissioned a governance review in December 2022, following a period of change at Board level, including the appointment of a number of new Non-Executive Directors and changes to the portfolios of Executive Directors.

The governance review complied with the requirement of the NHS England Well-Led Framework Guidance, to undertake an external and independent governance review every 3-5 years.

The governance review was undertaken by the Good Governance Institute (GGI) and there was a clear focus on the governance system and processes that were in place across the Trust and assess whether they were fit for purpose.

The final report was issued in July 2023 and contained 24 recommendations. The Board have received two previous progress updates to implement the recommendations. This is the final update to Board, specifically relating to this report.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Group Governance Work Stream

Under Group arrangements, a comprehensive governance work stream has been completed by the Company Secretaries of each Trust and the recommendations in the GGI report were addressed as part of that work stream. Regular updates on the governance arrangements were presented to the Group Board, underpinned by legal advice. The governance arrangements of the Group (and each unitary Trust) will remain under regular review to ensure they remain robust and compliant with legal and regulatory requirements.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Reported Position

All recommendations contained in the GGI report are confirmed as implemented, with supporting details provided in the report. This report provides assurance to the Board that a legacy report on governance arrangements from the Good Governance Institute has been robustly received, considered and responsibly acted upon.

External Assurance

During 2024/25, University Hospitals Tees commissioned an internal audit to provide an independent and objective opinion on Group Governance arrangements. The review focused on the new group governance framework, roles and responsibilities of the Group Board and its sub-committees, whether the extent and authority that can be jointly exercised is clearly set out regarding group functions and to evaluate whether the current group governance framework will support the delivery of future ambitions of the Group.

The draft report was presented at a Board Seminar on 5th June 2025 for information and discussion prior to being finalised. All recommendations in the report were agreed and work is progressing towards implementation and oversight will be provided by respective Audit Committees.

Recommendations:

The Unitary Board (NTHFT) are asked to;

- Receive the report and note the content.
- Take assurance from the confirmation that all recommendations in the Good Governance Institute report have been implemented.
- Note the 2024/25 internal audit on Group Governance arrangements that provides further assurance regarding governance arrangements.
- Advise if any further assurance is required.

Group Board

3 July 2025

North Tees & Hartlepool NHS Foundation Trust

Good Governance Institute Report Update

1. Background

1.1 North Tees & Hartlepool NHS Foundation Trust commissioned a governance review in December 2022, following a period of change at Board level, including the appointment of a number of new Non-Executive Directors and changes to the portfolios of Executive Directors.

1.2 The governance review complies with the requirement of the NHS England Well-Led Framework Guidance, to undertake an external and independent governance review every 3-5 years (see section 4.3 for the most recent governance review).

1.3 The governance review was undertaken by the Good Governance Institute (GGI) and there was a clear focus on the governance system and processes that were in place across the Trust and assess whether they were fit for purpose.

1.4 The governance review focused on seven key themes;

- Board Membership & Profile
- Governance Structures
- Board and Committee Business
- Assurance and Reporting
- Risk Management
- Accountability
- Communications and Stakeholder Engagement

1.5 GGI undertook the governance review between March and May 2023 and a final report was issued in July 2023. The final report contained 24 recommendations that were agreed by the Trust and a work plan was developed to support and evidence the implementation of the recommendations.

1.6 At the Board of Directors meeting on 5th October 2023, a representative from GGI attended the meeting and presented the findings, ensuring a robust governance process was followed to conclude the commissioned review. Feedback from the GGI representative was that the findings in the report are broadly consistent with other NHS Foundation Trusts and the recommendations contained in the final report were made to strengthen existing governance systems and processes.

1.7 Immediately following the presentation from GGI, the Board were provided with an update on the progress of implementing the recommendations. To support robust oversight and challenge to the governance work plan, a Non-Executive Director was assigned to liaise with Trust staff during the period of implementation.

1.8 A further update on progress was provided to the Board on 1st February 2024, which reported that 13 out of 24 recommendations had been implemented, that are detailed below;

- **GWP02** – The Board Seminar programme should include content on the corporate governance requirements of NHS foundation trusts.
- **GWP03** – The Board should consider how it can raise the profile of its members, both executives and non-executives, within the organisation, including by means of more frequent site visits to different trust premises and departments.
- **GWP06** – The Board should consider rationalising its committee structure through the merger or disbandment of some committees.
- **GWP07** – Committees should adopt cycles of business where they do not have them already.
- **GWP08** – The Trust should continue its efforts to standardise governance processes through the implementation of common templates for terms of reference, agendas, minutes, etc.
- **GWP10** – The Board Seminar programme should include developmental work around scrutiny, questioning and constructive challenge.
- **GWP11** – Meeting agendas should include indicative timings for each agenda item.
- **GWP12** – The Trust should adopt a template for chair's reports whereby groups or committees can report to the next level up in the governance structure.
- **GWP13** – The Trust should consider establishing a central secretariat to support corporate governance at board and committee level.
- **GWP16** – As a general rule, Board Committees should receive information which is less granular, and more exception-based, than that reported at lower levels of the governance structure.
- **GWP17** – Cover sheets should be used more effectively to summarise the content of papers and direct readers to the most important issues.
- **GWP19** – The format and content of the Board Assurance Framework should be comprehensively reviewed in the same way that the Trust has done with the Integrated Performance Report. This should be done in partnership with the Board through a Board Seminar.
- **GWP24** – The Trust should review its approach to internal communication with its own staff, and in doing so should obtain feedback from them about current communication mechanisms and what would work best for them.

1.9 Two recommendations were proposed to be paused, linked to imminent Group arrangements that were due to commence.

- **GWP01** – The Trust should formalise the induction process to be applied for new non-executive directors in future.
- **GWP04** – The Trust should develop more formal succession planning arrangements for board-level roles.

2. Purpose

2.1 The purpose of this report is to provide the Board with assurance regarding the remaining 11 recommendations and to ensure openness and transparency with a legacy governance report, which maintains good governance standards.

3. Report Detail

Remaining Recommendations

For completeness, the 11 recommendations are set out in full below and a status position and update is provided.

Recommendation	Status/Update
GWP01 – The Trust should formalise the induction process to be applied for new non-executive directors in future.	**Complete.** The Group has a formal induction process for all newly appointed Non-Executive Directors.
GWP04 – The Trust should develop more formal succession planning arrangements for board-level roles.	**Complete.** Formal succession planning arrangements ate in place for Board level roles across University Hospitals Tees.
GWP05 – The Trust should ensure that it follows national guidance and the requirements of its constitution regarding the maximum terms of office for non-executive directors.	**Complete.** The Trust's Constitution was updated and approved in 2024, which states that the maximum term for Non-Executive Directors is 9 years. This also applies to Governors. This is aligned with the Constitution of South Tees Hospitals NHS Foundation Trust.
GWP09 – The Trust should consider undertaking a comprehensive review of its operational committees and management groups to ensure that they work efficiently and consistently across different executive portfolios and care groups.	**Complete.** New governance structures at Board and committee level have been implemented across University Hospitals Tees. Governance arrangements below committee were also reviewed.
GWP14 – Training should be provided for those who take minutes of committees and other formal meetings.	**Complete.** Training has been provided to staff across UHT for minute taking. This will be repeated again in 2025.
GWP15 – Training should be provided for those who write reports, which go before the Board or its Committees, with an emphasis on writing for assurance, and on the information needs of the Board.	**Complete.** Training has been provided to staff across UHT for report writing. The training was delivered by NHS Providers. This will be repeated again in 2025.
GWP18 – Management should consult widely on the format and content of the new draft Integrated Performance Report, and once this has been agreed, should then 'lock down' the report design and data set, so that the same information is reported each month.	**Complete.** A comprehensive review was undertaken on the IPR in 2024 to implement a consistent and standardised IPR across UHT. This included a working group with Non-Executive Director representation and a Board Development session to obtain feedback. The exercise was supported by benchmarking from NHS organisations nationally. The IPR is reported monthly on a fully validated basis and is formally signed off.

Recommendation	Status/Update
GWP20 – The Risk Management Policy should be updated to reflect improvements which have been made to the process, such as the establishment of a Risk Committee.	**Complete.** A Risk Management Policy has been reviewed and updated for use across UHT and was approved in June 2025. The Policy reflects operational processes that are in place.
GWP21 – The Trust should proceed with implementing a training programme for risk management, to reach staff at all levels.	**Complete.** Risk Management training is provided at all levels across UHT. This includes annual Board level training on the Board Assurance Framework and Risk Appetite. Below Board, monthly risk management training is provided to staff at the four main sites across UHT, weekly TEAMS drop in sessions are held by the Risk Management Team and ad hoc training is available upon request.
GWP22 – The Trust should ensure that its approach to management accountability for operational performance and quality is documented and understood as clearly as its approach to accountability for financial performance.	**Complete.** Quarterly performance reviews are held across UHT and are based on the Oversight Framework. The meetings are chaired by the Managing Director, focus upon performance against submitted annual plans and improvement actions.
GWP23 – The Board should consider how it can communicate better with its public sector partners in the region and build closer relationships, for example by inviting them to participate in Board Seminars.	**Completed.** The Trust / Group has nominated executive directors who take responsibility for assigned local authorities, attending meetings and engagement sessions as required. The directors work to support ongoing updates and discussions pertaining to services and communities, and actively engage with appropriate committees to update progress and strategy development. UHT also benefits from a dedicated Director of Communications and more recently appointed a Chief Strategy Officer, who leads on our engagement as an anchor institution with our stakeholders. Additionally, our public sector partners receive our regular stakeholder bulletins, trust magazines and other bulletins to support further insight into the ongoing work and ambitions of the Trust / Group.

4. Conclusion/Summary

4.1 This report provides assurance to the Board that a legacy report on governance arrangements from the Good Governance Institute has been robustly received, considered and responsibly acted upon. It is recognised that there is a time delay in the last formal update to the Board (February 2024) and the final update report being presented to the Board in July 2025.

4.2 The delay was due to the implementation of Group arrangements that were approved by the unitary Board of North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. As part of implementing Group arrangements, leading to the establishment of UHT, a comprehensive governance work stream was completed by the Company Secretaries of each Trust and the recommendations in the GGI report were addressed as part of that work stream.

4.3 During 2024/25, UHT commissioned an internal audit to provide an independent and objective opinion on Group Governance arrangements. The review focused on the new group governance framework, roles and responsibilities of the Group Board and its sub-committees, whether the extent and authority that can be jointly exercised is clearly set out regarding group functions and to evaluate whether the current group governance framework will support the delivery of future ambitions of the Group. The draft report was presented at a Board Seminar on 5th June 2025 for information and discussion prior to being finalised. All recommendations in the report were agreed and work is progressing towards implementation and oversight will be provided by respective Audit Committees.

5. Recommendation

5.1 The Unitary Board should;

- Receive the report and note the content.
- Take assurance from the confirmation that all recommendations in the Good Governance Institute report have been implemented.
- Note the 2024/25 internal audit on Group Governance arrangements that provides further assurance regarding governance arrangements.
- Advise if any further assurance is required.