NHS
University Hospitals Tees

Group Board Meeting

Thursday, 6 November 2025 at 13:00

Boardroom, 2nd Floor, Murray Building, James Cook University Hospital

Caring Better Together

University Hospitals Tees

MEETING OF THE BOARD TO BE HELD IN PUBLIC
ON THURSDAY 6 NOVEMBER 2025 AT 1:00pm
BOARDROOM, 2ND FLOOR, MURRAY BUILDING, JAMES COOK UNIVERSITY HOSPITAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
1. CHAIR'S BUSINESS					
1.1	Patient/Staff Story	Information	Chair	Verbal	13:00
1.2	Welcome and Introductions	Information	Chair	Verbal	13:20
1.3	Apologies for Absence	Information	Chair	Verbal	
1.4	Quorum and Declarations of Interest	Information	Chair	ENC	
1.5	Minutes of the last meeting held on 4 September 2025	Approval	Chair	ENC	13:20
1.6	Matters Arising and Action Log	Information	Chair	ENC	13:25
1.7	Chair's Report	Information	Chair	ENC	13:30
1.8	Chief Executive's Report	Information	Chief Executive	ENC	13:40
1.9	Group Management Team Chairs Log: 21 August & 18 September 2025	Information	Chief Executive	ENC	13:55
1.10	Board Assurance Framework	Assurance	Director of Risk, Assurance & Compliance	ENC	14:00
2. QUALITY AND SAFETY					
2.1	Quality Committee Chairs Log: 22 September & 27 October 2025	Assurance	Chair of Committee	ENC	14:10

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
2.2	Perinatal Quality and Safety Report Quarter 2: 2025/26	Assurance	Group Director of Midwifery	ENC	14:20
2.3	Perinatal Staffing Report Quarter 2: 2025/26	Assurance	Group Director of Midwifery	ENC	14:30
2.4	NTHFT Critical Care Service Delivery Model	Approval	Chief Nursing Officer	ENC	14:40
3. PEOPLE					
3.1	People Committee Chairs Log: 23 September & 28 October 2025	Assurance	Chair of Committee	ENC	14:55
3.2	Nurse Safer Staffing Report	Assurance	Chief Nursing Officer	ENC	15:05
3.3	Freedom to Speak Up Report Quarters 1&2: 2025/26	Assurance	Freedom to Speak Up Guardians	ENC	15:15
3.4	Guardian of Safe Working Report	Assurance	Chief Medical Officer	ENC	15:25
3.5	General Medical Council (GMC) Survey 2025 Report	Assurance	Chief Medical Officer	ENC	15:35
3.6	Medical Revalidation Report	Assurance	Chief Medical Officer	ENC	15:45
4. FINANCE & PERFORMANCE					
4.1	Resources Committee Chairs Log: 24 September & 29 October 2025	Assurance	Chair of Committee	ENC	15:55
4.2	Finance Report Month 6: 2025/26	Assurance	Chief Finance Officer	ENC	16:05
4.3	Integrated Performance Report	Assurance	Chief Delivery Officer	ENC	16:15
4.4	Academic Committee Chairs Log: 18 September 2025	Assurance	Chair of Committee	ENC	16:25

	ITEM	PURPOSE	LEAD	FORMAT	TIME
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Board of Directors will take place on Thursday 8 January 2026 in Rooms 3 & 4, STRIVE, Friarage Hospital, Northallerton				

University Hospitals Tees

Register of members interests

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 1.4

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

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
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	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
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

Board Member	Position	Relevant Dates From	to	Declaration Details
		14 August 2025	Ongoing	Director of Optimus Health Limited – Company Number 07415246
		1 October 2025	Ongoing	Chair on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
Emma Nunez	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	Director of Corporate Affairs & 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	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	Deputy Chief Executive / 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	Non-Executive Director	20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		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	Chair of Board of Nicholas Postgate Catholic Academy Trust

Board Member	Position	Relevant Dates From	to	Declaration Details
Michael Stewart	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	Chief Delivery Officer	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
		1 November 2025	Ongoing	Trustee, Age UK
		October 2025	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
Derek Bell	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	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
Ruth Dalton	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	1 April 2021	Ongoing	None
Stacey Hunter	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)
		Aug 2025	Ongoing	Lead, Leadership of Planned Care, Provider Leadership Board
		Aug 2025	Ongoing	Supporting national programme regarding neighbourhood health & review of secondary care
Steven Taylor	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

Minutes of a meeting of the University Hospitals Tees Board held in Public at 1:00pm on Thursday, 4 September 2025 in the Boardroom, 2nd floor, Murray Building James Cook University Hospital

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

Directors – non-voting:
Ken Anderson, Chief Information Officer
Steve Taylor, Estates Director
Ruth Dalton, 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, Director of Corporate Affairs/Company Secretary

In Attendance:
Mel Cambage, Group Deputy Director of Patient Experience and Involvement (for item 1 only)
Rebecca Denton-Smith, Associate Director of Nursing, NTHFT (for item 1 only)
Sarah Hutt, Assistant Company Secretary (note taker)
Gareth Lightfoot, Local Democracy Reporter, Gazette

GB25/100 Patient Story

Mel Cambage, Group Deputy Director of Patient Experience and Involvement and Rebecca Denton-Smith, Associate Director of Nursing, NTHFT presented a story regarding the experience of a North Tees patient called Alan, who had been admitted during the second wave of Covid in December 2021 and February 2022 on a number of occasions. The story had been developed with the patient's family, who had kept a diary. The patient was initially admitted following a fall at home, and had subsequent falls whilst in hospital resulting in injury and a significant wound. Some basic care needs were not met and there was a break-down in communication between teams with some missed opportunities throughout his stays in hospital. It was reported that the patient was isolated for long periods of time due to the restrictions of covid. The family noticing the deterioration in the patient asked whether they were at end of life and were told no. Unfortunately, the patient died a few days later.

The feedback from the family had been taken on board, particularly regarding the importance of listening to family members raising concerns about loved ones. It was noted that Phase 2 of Martha's Rule was being embedded across the sites and different strands and styles of training had been carried out with staff to improve communication and preparing staff to have difficult and appropriate conversations with families and patients regarding end of life. John's campaign continued to be promoted across the organisation and a carers' charter was now in place.

Emma Nunez, Chief Nurse highlighted the poignancy of the story with the announcement that day that it was NHSE's directive to roll out Martha's Rule to all acute hospitals and sought to understand whether there was anything specific the team wanted to flag regarding communication, as it was a recurring theme. It was noted that a lot of focused work regarding communication had been undertaken with teams and during huddles, in addition during ward rounds, any key information for each patient that day was shared so all staff were on the same page.

It was agreed it would be helpful for the Board to see what thematic actions are taken in relation to individual patient stories in order to close the loop and gain assurance regarding the lessons learnt.

A number of board members raised comments and questions and asked the team to thank the family for bravely sharing Alan's story as a point of learning.

Resolved: that, the Board be presented with thematic actions going forward in relation to individual patient stories in order to close the loop and gain assurance regarding lessons learnt.

GB25/101 Welcome and Introductions

The Chair welcomed everyone to the meeting and wished the Board to acknowledge the contribution of Janet Crampton, Lead Governor for STHFT and Ada Burns, Non-Executive Director / Senior Independent Director as their terms of office were coming to an end and they were stepping down.

GB25/102 Apologies for Absence

Apologies for absence were reported from Ken Readshaw, Group Non-Executive Director, Professor Chris Day, Group Non-Executive Director and Ada Burns, Group Non-Executive Director / Senior Independent Director.

GB25/103 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

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

There were 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.

GB25/104 Minutes of the last meeting held on, 3 July 2025

The minutes of the last meeting held on, 3 July 2025 were accepted as a true and accurate record, subject to a minor amendment.

Resolved: that, the minutes of the meeting held on, 3 July 2025 be confirmed as a true and accurate record subject to a minor amendment.

GB25/105 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.

GB25/106 Group Chair's Report

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

- NHS England (NHSE) had requested organisations undertook a self-assessment regarding provider capability by October, following which the findings would be shared. In addition, NHSE had invited expressions of interest for a board development programme, limited information was currently available, however, it was agreed to submit an interest.
- UHT was holding an Anti-Racism Day on 7 November 2025, with a number of key speakers organised. Board members were invited to attend the event.
- The quarterly armed forces and veteran's coffee morning was held at the North Tees site on 10 July 2025, which was well attended. Work was progressing in readiness for a joint accreditation submission on behalf of UHT for the Armed Forces Covenant towards the end of 2025.
- All Non-Executive Director appraisals were now complete and the outcome of the appraisals would be reported to the Nominations Committee.
- Had a positive meeting with Christopher Akers Belcher, Appointed Governor for Healthwatch and colleagues to discuss the implication of the ten-year health plan for Healthwatch going forward.
- The first joint Annual General Meeting for University Hospitals Tees (UHT) was taking place on Thursday, 11 September 2025 at Teesside University. All were welcome.

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

GB25/107 Group Chief Executive's Report

Stacey Hunter, Chief Executive highlighted the key points of the Group Chief Executive's Report, taking the report as read, noting no significant issues for alert and acknowledging it had been a busy period since the last meeting following the launch of the ten-year plan for health.

- Expressions of interest were invited to take part in the National Neighbourhood Health Implementation Programme (NNHIP), noting bids had been developed jointly with partners across councils, primary care, the community and voluntary sector and mental health in four places: Stockton-On-Tees, Hartlepool, South Tees (a joint bid as a single place across Middlesbrough and Redcar & Cleveland) and North Yorkshire. The outcome of the initial round of bids was scheduled to be announced on 5 September 2025.
- NTHFT had been part of the National Maternity Safety Support Programme (MSSP) for two years and following a review meeting in July 2025 were advised the service could enter the sustainable phase due to excellent work. Subsequently notification had been received that a further review meeting would take place in October 2025 to consider progression to the exit phase of the programme. It was noted that STHFT had now entered the programme. Assurance was provided to board members that a detailed discussion had taken place in the private board meeting regarding Quarter 1: 2025/26 maternity data.
- Thanks were placed on record to the Clinical Boards for laying the foundations for the reforms of clinical services going forward to help shape the UHT Strategy and entering into new arrangements as part of the transition to Clinical Service Units (CSUs). An evaluation and feedback session took place on 22 August 2025 celebrating the work undertaken together with lessons learned in developing a plan for the future.

Ali Wilson, Vice Chair / Non-Executive Director commended submission of the bids for the NNHIP and sought to understand the level of involvement from primary care partners. The Chief Executive explained that all partners agreed the bids and that the enthusiasm for the programme which did not have resource was very positive, placing neighbourhood support front and centre.

The Chair sought to understand what additional pressure the organisation was facing from additional patient referrals following the review into breast services at County Durham and Darlington NHS Foundation Trust (CDDFT). Rowena Dean, Site Chief Operating Officer, NTHFT reported that there had been a system wide impact to screening units and more locally in relation to cancer performance. The Cancer Care Alliance were looking at alternative operating models going forward across the system building in some standardisation. The organisation was working collaboratively with CDDFT to manage the pressures particularly around cellular pathology and surgery, with additional sessions being arranged.

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

GB25/108 Chair's Log – Group Management Team Meeting

The Chief Executive presented the Chair's Logs for the meetings of the Group Management Team (GMT) held in June and July 2025 for noting.

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

GB25/109 University Hospital Tees (UHT) Strategy Update

Matt Neligan, Group Deputy Chief Executive/Chief Strategy Officer provided an update regarding implementation of the UHT Strategy, with work continuing at pace.

A more user-friendly format of the Strategy was being developed by the Communications and Engagement team, along with a full engagement plan for stakeholders and staff. Small amendments to the content of the Strategy following feedback included emphasis on the ten-year plan for health, focus on the neighbourhood health systems, stronger reference to regional and tertiary services and clear timescales regarding horizontal integration of services.

Increased engagement with the ICB was ongoing regarding the process of approval for changes that would be required with the interdependency of major service changes and estate changes. Development of the Strategic Outline Case was in its final stages, with the expectation this would be brought to Board in November 2025 for consideration. It was noted that the final version of the Strategy would be complete by end of September 2025 and it was agreed going forward that quarterly implementation updates to Board would be sufficient.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Strategic Outline Case be presented to Board in November 2025; and
(iii) that, quarterly implementation updates be provided to Board going forward.

GB25/110 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) Update to the period 30 June 2025 and highlighted the key points noting that continuous review and refresh was undertaken as required.

For NTHFT:

- 30 strategic risks
- 10 strategic risks outside the approved risk appetite, with 7 red/high risks
- No changes to risk appetite
- Two changes to current risk scores: patient safety risk increased 9 to 12 due to prevalence of IPC cases and diagnostic score reduced 9 to 6 due to improved performance reporting
- 107 planned mitigating actions
- 5 actions marked as complete

For STHFT:

- 30 strategic risks

- No changes to risk appetite
- 11 strategic risks outside the approved risk appetite, with 8 red/high risks
- One change to current risk score: patient safety risk increased 9 to 12 due to prevalence of IPC cases
- 111 planned mitigating actions
- 4 actions marked as complete

The Chief Executive suggested the high strategic risk scores in the research and innovation BAF domain be reviewed comparatively against the threshold that was required nationally, for example delivery against 18 weeks RTT seeking alignment where possible.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the high strategic risk scores in the research and innovation BAF domain be reviewed comparatively against national targets for delivery seeking alignment where possible.

GB25/111 Quality Assurance Committee Chairs Log

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

From an alert perspective, the BAF demonstrated there was an increased risk to patient safety scores due to HCAI and some high operational risks, which would be included in the dashboard to assist with monitoring. Infection control remained a key focus with cases of C Diff continuing to rise and an incidence of MRSA in Neonates having been reported.

Clinical Effectiveness continued to be an issue across UHT, which was discussed at length in the private board meeting earlier that day and would be presented again at QAC in September for oversight and a way forward.

Two Maternity and Neonates Serious Incidents were reported and two never events, the action plans would be presented at the next QAC meeting to understand the learning and any required changes to practice. Cancer standards remained a concern and it was requested that potential harm be investigated and reported back to the Committee.

The Terms of Reference and Cycle of Business were agreed across all Committees, with evidence of good joint working and combined reports being presented. Jackie White, Director of Corporate Affairs / Company Secretary reported as a post meeting note, that from an advise perspective as part of the external evaluation of PSIRF, it was identified that Board member training was reporting at 36% and was not currently included as part of mandatory training on ESR, which was being addressed. It was noted that a refresher training session was planned for early 2026.

The Chair sought clarity regarding the £300k funding secured for mental health, it was linked to perinatal mental health supported by specialist mental health midwives.

Resolved: (i) that, the content of the report be noted; and
(ii) that, Board member PSIRF refresher training was being arranged for early 2026.

GB25/112 Perinatal Quality and Safety Report

Steph Worn, Group Director of Midwifery presented the Perinatal Quality and Safety Report for Quarter 1: 2025/26 and highlighted the key points.

A Hypoxic Ischaemic Encephalopathy (HIE) incident at NTHFT had been reported to the Maternity and Neonatal Safety Investigations (MNSI). The Perinatal Leadership Team had undertaken a review to examine contributing factors and the details of the HIE referrals had been shared with the North East

and North Cumbria Local Maternity and Neonatal System (LMNS). In response, the LMNS were also undertaking a comprehensive review and an action plan would be developed.

The Intrapartum Service at the University Hospital of Hartlepool remained temporarily suspended due to workforce pressures.

STHFT had undertaken a review to address the Care Quality Commission (CQC) actions in relation to estate management, with some issues still to resolve. A revised model of care was also being developed for the Friarage Hospital site.

Confirmation had been received from NHS Resolution Maternity Incentive Scheme (MIS) that NTHFT and STHFT had achieved compliance against all ten safety actions, which was really positive. It was noted that the year 7 requirements were published on 2 April 2025, ten safety actions remained and there were four safety actions that would require external oversight for approval. The current in-quarter position was that both services were on track for compliance.

Both services were collaborating on a quality improvement project to improve the rate of antenatal bookings prior to the 10th week of pregnancy. In addition, work was ongoing with the ICB to develop a maternal mental health service. It was noted both services continued to meet the perinatal safety champions required standards; meetings and engagement sessions.

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

GB25/113 Perinatal Staffing Report

Steph Worn, Group Director of Midwifery presented the Perinatal Staffing Report for Quarter 1: 2025/26 and highlighted the key points.

NTHFT was actively monitoring progress against BAPM compliance for neonatal nursing staff, which was recorded on the risk register. There had been sustained periods of pressure in the obstetric workforce, with gaps in the consultant workforce available for emergency obstetric work. This was also recorded on the risk register and a recruitment plan was in place. It was noted that both services were however compliant with the Royal College of Obstetrics and Gynaecology for attendance at obstetric emergencies, following a local audit.

The midwifery workforce had seen strong recruitment and retention trends, with projections that full establishment would be achieved within the next three months. It was noted that the Neonatal Workforce action plan agreed at Trust Board was reviewed regularly with progress noted against each of the actions and oversight from the LMNS and Neonatal Operational Delivery Network (ODN) on a quarterly basis.

Stacey Hunter, Chief Executive acknowledged NTHFT achieving the sustainable phase of the National Maternity Safety Support Programme and thanked the Group Director of Midwifery for her contribution.

Miriam Davidson, Non-Executive Director / Maternity Champion commended the triangulation of the reports being presented through the committee structure and to board providing assurance, and sought to understand when the next BirthRate+ review was due. It was expected to be October or November 2025 for both trusts.

It was noted that a new Maternity Voices Partnership chair had been recruited, which was positive.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the NTHFT and STHFT Transitional Care Action Plans be noted;
(iii) that, the NTHFT Maternity Survey Action Plan be noted; and
(iv) that, the NTHFT and STHFT SCORE Action Plans be noted; and
(v) that, NTHFT and STHFT neonatal workforce action plans be noted and approved.

GB25/114 People Committee Chairs Log

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Log for the meeting held on 29 July 2025 and highlighted the key points.

Areas of alert including commending the coordination across the organisation during the recent industrial action. An improving positive trend for key metrics in the IPR was noted for sickness absence, turnover, appraisals and mandatory training.

There was a lack of improvement identified regarding the treatment of global majority staff who had experienced discrimination, bullying and harassment, with more work required across the organisation.

For advise, progress had been made regarding medical job planning to achieve full compliance against the 95% national target. An updated position would be reported to Committee in September. It was noted those individuals who did not currently have job plans were in a formal mediation process.

Overpayments at STHFT continued to be an issue, the Committee requested that a strategy to rectify the situation be presented in three months' time and escalated the issue to Resources Committee, prompting a brief discussion. It was agreed the data would be presented to the Group Management Team to review and increase the level of scrutiny.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the data regarding STHFT overpayments be presented to Group Management Team to review and increase the level of scrutiny.

GB25/115 Nurse Safer Staffing Report

Emma Nunez, Group Chief Nurse presented the Nurse Safer Staffing Report for the period June 2025 and highlighted the key points.

It was noted that the latest bi-annual nursing establishment review would be presented to Board at the next meeting. It will include a review of the nursing establishment at NTHFT and the requirement for investment into a number of workforce models, highlighted in the 2024/25 establishment review.

From an advise perspective, overall good fill rates were reported with information by department provided. Those areas below the fill rate were reviewed daily with mitigation and check and challenge meetings were embedded to ensure compliance with rostering and safer staffing key performance indicators. A centralised recruitment process for Health Care Support Workers (HCSWs) was approved with interviews taking place during July 2025. In addition, a recruitment plan for newly qualified nurses was approved to over recruit a total of 90wte Band 5 newly qualified nurses (NQN), to support the reduction in reliance on bank/agency staff to fill unfilled shifts due to maternity leave and long-term absence.

Recruitment centres continued on a monthly basis alternating the recruitment of HCSW and RN posts. To provide further assurance regarding safer nurse staffing at NTHFT, a Safer staffing, Timely care, Enhanced care, Planned discharge (STEP) week was taking place in September and would specifically review patient acuity and dependency data. A review of the enhanced care team was also in progress at NTHFT and STEP week would be used to collect and collate data sets linked to the provision of enhanced care. There remained a reliance on the team to provide 1:1 care to patients across a number of wards particularly during the night, resulting in the use of temporary staffing to safely staff in patient areas.

Stacey Hunter, Chief Executive sought to understand where the reduction in recourse to bank agency spend would take place following the decision to recruit up to 90 NQNs to support this, prompting discussion. It was agreed that some time should be secured during October for the Board to stand back at the midway point in the year and review the outputs, to identify where the risks were to deliver against plan and whether the actions were sufficient. It was highlighted, that it was harder to deliver

against plan at the back end of the year and should therefore ensure there was sufficient time on each board agenda so respective committee chairs and members had sufficient times to debate such issues, recognising that the current year was particularly challenging from a financial perspective.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the latest bi-annual nursing establishment review be presented at the next meeting including the review of establishment at NTHFT.

GB25/116 WRES Report

Rachael Metcalf, Group Chief People Officer presented the Workforce Race Equality Standard (WRES) 2025 Report, highlighting the standards had been place since 2015 and that a separate report was required for each trust.

The majority of the responses were from the NHS annual staff survey and key issues highlighted for NTHFT included an increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public and experiencing discrimination from a manager/team leader. For STHFT key issues included an increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public and a disproportionate number of Global Majority employees entering a formal disciplinary process. There were plans to introduce cultural ambassadors to mirror the approach at NTHFT to support future disciplinary panels involving Global Majority staff.

In addition, at NTHFT the number of Global Majority staff employed within the Trust had increased each year since 2021, representing 16.06% of the workforce and these employees were well represented in the organisation when compared to the BAME population in the North East, which was reported as 7%. There was a decreased likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting and a decrease of these staff believing the Trust provided equal opportunities for career progression.

For STHFT, there was also a decreased likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting. This was being reviewed as a priority area across the group looking at the whole recruitment journey and consideration given to what changes could be made.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Workforce Race Equality Standards (WRES) results for both trusts be acknowledged.

GB25/117 WDES Report

Rachael Metcalf, Group Chief People Officer presented the Workforce Disability Equality (WDES) 2025 report and highlighted the local population for NTHFT and STHFT had a higher percentage of disabled population in all areas except Hambleton and Richmondshire.

For NTHFT, there was a negative increase in the number of disabled staff who experienced bullying, harassment or abuse from their manager and felt pressure to attend work when not feeling well enough to do so. In addition, there was a negative decrease in the number of disabled staff who believe the Trust provided equal opportunities for career progression, felt valued and had reasonable adjustments in place to enable them to carry out their work.

For STHFT, disabled applicants were less likely to be appointed than non-disabled applicants following shortlisting. There had been an increase in the number of capability cases involving staff with a disability or long-term condition. There had been a negative increase in the number of disabled staff who had experienced bullying, harassment/abuse from patients, relatives, the public, their manager or other colleagues. There had been a negative decrease in the number of disabled staff who believe the Trust provided equal opportunities for career progression.

The organisation had strong staff networks representing Global Majority groups of staff who would be involved in the development of action plans. It was noted that an anti-racism conference was taking place in November and a request had been made from a network to hold a disability awareness day.

A discussion ensued regarding the interpretation of the data presented when recorded as a percentage for example in order to understand the significance of the information and the actions being taken.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Workforce Disability Equality Standards (WDES) results for both trusts be acknowledged.

GB25/118 Resources Committee Chairs Log

The Resources Committee Chairs Logs for the meetings held on 30 July and 27 August 2025 were presented.

Key areas included the continued focus to delivery against the financial plan, delivering recurrent efficiency plans and continued reductions in WTE to ensure achieving the financial control total. A useful report was received on productivity, identifying areas of lower quartile performance, enabling good discussion at speciality level and providing assurance to the Committee. Positive progress continued to be made in the development of the CIP programme since it was submitted. Approval of the Critical Care Service Delivery Model for NTHFT had been escalated to Board and a full discussion took place at the private board meeting earlier that day.

Further information was requested in respect of future provision and costs for gas and electric brokerage at NTHFT. Further work was requested in respect of the UHT Winter Plan, providing clarity around the risks and mitigating actions prior to approval by the Board.

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

GB25/119 Finance Report: Month 4, 2025/26

Chris Hand, Group Chief Finance Officer presented the Finance Report for Month 4: 2025/26 and highlighted the key issues, taking the report as read.

The Group plan for 2025/26 was to deliver an overall deficit control total of £9.1m, with a break-even plan for NTHFT and £9.1m deficit for STHFT. At Month 4, a deficit of £4.1m for the Group was reported, which was a favourable variance of £22k against the year-to-date plan. The reported position included over performance of Elective Recovery Fund (ERF) income and other non-recurrent measures. There was a continued focus on de-risking and delivery of recurrent efficiency plans, along with continued reductions in WTE to ensure delivery of the financial control total. NHS England (NHSE) were expecting a strong board focus on delivery of agreed financial plans.

There were pay and non-pay pressures, in relation to increased demand for enhanced care, industrial action, pay award shortfall and slippage on CIP delivery. The focus to reduce bank and agency spend remained. The 2025/26 planning guidance included requirements to reduce agency spend by at least 30% and bank by at least 10%. Total agency expenditure across the group at Month 4 was £2.5m, this was 21% less than the same period the previous year and total bank expenditure was £9.2m, which was 15% less than the same period the previous year.

An overall increase of 45.84 WTE was reported compared to the previous month largely relating to bank staff at STH. This was 142.77 more than the same period the previous year and remained a key area of focus.

The Group's capital plan for 2025/26 was £66.8m and the spend at Month 4 was £8.5m, which was behind plan, however, it was anticipated the plan would be achieved at the end of the year. The Group's cash position was £114.6m.

A discussion ensued led by Stacey Hunter, Chief Executive regarding the increased usage of bank staff, particularly in the Allied Health Professional (AHP) category, which was significant. A review had been requested regarding the additional spend. It was reiterated that 2025/26 would be a difficult year financially with both palatable and unpalatable schemes to consider in order achieve against plan. A greater level of granular detail had been obtained from the bottom up to be able to fully compare and analyse ways of working across the sites.

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

GB25/120 Integrated Performance Report

Neil Atkinson, Group Managing Director Group presented the Integrated Performance Report (IPR) for the reporting period June 2025 and highlighted the key points, noting a detailed review of the IPR had been undertaken through the Board Committees and updates had been provided in earlier agenda items.

In respect of the items in the Alert category, there were four metrics remaining for NTHFT, including E. coli infections, Klebsiella infections, Pseudomonas infections and mandatory training. A further five metrics had been regraded to Alert, breast feeding at first feed, readmission rate, 4-hour A&E standard, RTT 52-week waiters and sickness absence.

For STHFT, there were six metrics remaining in the Alert category, Pseudomonas infections, breast feeding at first feed, cancelled operations not rebooked in 28 days, diagnostic 6-week standard, sickness absence and mandatory training. A further two metrics had been regraded to Alert, E. coli infections and MRSA infections. Five metrics reduced from Alert to Advise, MRSA infections, cancer 31-day standard, cancer 62-day standard, RTT incomplete and complaints closed within target %.

The cancer 31-day standard was regraded from alert to advise for STHFT and the still birth rate was regraded from alert to advise for NTHFT. There were two new metrics reported, neonatal mortality rate (rolling 12 months, per 1,000 births) and ambulance handovers within 45 minutes, previously 1 hour.

Assurance was provided that the Group Management Team closely monitor performance and delivery against the operational plan.

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

GB25/121 UHT Winter Preparedness Plan 2025/26

Rowena Dean, Site Chief Operating Officer, NTHFT and Sam Peate, Site Chief Operating Officer, STHFT presented the UHT Winter Preparedness Plan for 2025/26. The plan sets out the processes in place to manage the season increases in demand across the organisation. It included escalation processes at a system level to addresses wider pressures in the system. Part of planning included a reflection on the previous winter to identify what went well and what could be improved.

The plan was built upon the National Urgent and Emergency Care Plan, which was published on 6 June 2025 and identified 7 key priorities. A new innovative group care coordination centre pilot had been introduced to further support the organisation's community response, in line with the focus on community in the ten-year plan for health. It was anticipated this would support a reduction in patients being admitted into hospital. The pilot would run for 12 weeks from mid-November 2025.

It was presented to Resources Committee in August with members of the Quality Assurance Committee in attendance for oversight. The plan was discussed in detail including the testing arrangements, the QEIA and system wide engagement which was ongoing. The plan well received, however, more clarity regarding risk was requested to be included, which was being reviewed, prior to sign off of the Board Assurance Statements by the CEO.

A brief discussion ensued regarding this year's flu vaccination campaign, which was anticipated to commence at the end of September.

Resolved: that, the UHT Winter Preparedness Plan 2025/26 be approved.

GB25/122 Appointment of Senior Independent Director

Jackie White, Director of Corporate Affairs/Company Secretary presented a proposal to appoint a new Group Senior Independent Director as the current incumbent Ada Burns' term of office ended on 30 September 2025 and would be standing down.

It was noted that it was the duty of the Board to recommend to the Council of Governors that one of the existing Non-Executive Directors be appointed as Senior Independent Director. It was proposed that Ken Readshaw be appointed, having sought his prior acceptance, which would be presented to the Council of Governors on 11 September 2025.

Resolved: that, the proposal to appoint Ken Readshaw as Group Senior Independent Director with effect from 1 October 2025 be approved and presented to the Council of Governors on 11 September 2025.

GB25/123 Board Committee Terms of Reference Update

Jackie White, Director of Corporate Affairs/Company Secretary presented updated Terms of Reference for each of the Board Committees following a review into the new governance arrangements for the group and a number of recommendations for inclusion in the terms of reference were made. It was noted that each Committee had agreed the revised Terms of Reference, subject to ratification by the Board.

Resolved: that, the updated Terms of Reference for each of the Board Committees be ratified.

South Tees Hospitals NHS Foundation Trust Unitary Board items only:

GB25/124 Maggie's Trinity Holistic Centre Board Update

Neil Atkinson, Group Managing Director presented an update regarding the handover of the Trinity Holistic Centre at STHFT to Maggie's Cancer Care Charity which was scheduled to take place on 15 September 2025. The Board agreed a grant of £450,000 over a two-year period as part of the transition process. A manager been appointed and four WTE members of staff would be TUPE transferred on 14 September 2025. Work was ongoing reviewing the compatibility of digital systems. A grand opening was being held on 1 October 2025, which the Chair and Chief Executive had been invited to attend.

The Chair commended those involved for the work undertaken to reach this point, which was shared by other board members.

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

GB25/125 Audit and Risk Committee Chairs Log

Jackie White, Director of Corporate Affairs/Company Secretary presented the STHFT Audit and Risk Committee Chairs Logs for the meetings held on 23 June and 30 July 2025 on behalf of Ken Readshaw, Group Non-Executive Director.

The external audit value for money (VFM) opinion identified a significant weakness due the underlying deficit position, this had been discussed with the Chief Executive and Chief Finance Officer and included in the Annual Governance Statement. The Head of internal audit opinion was limited assurance based on the audits completed, which was also reflected in the Annual Governance Statement.

Two high risk internal audit reports were received regarding cancer pathways data management and the data security and protection toolkit (DSPT), with oversight of the agreed action plans for both to the Group Management Team.

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

GB25/126 Annual Members Meeting Minutes 2024

Jackie White, Director of Corporate Affairs/Company Secretary presented the minutes from the STHFT Annual Members Meeting held on 17 September 2024.

Resolved: that, the minutes of the Annual Members Meeting held on 17 September 2024 be approved.

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

GB25/127 Audit Committee Chairs Log

Alison Fellows, Group Non-Executive Director presented the NTHFT Audit Committee Chairs Log for the meeting held on 30 July 2025.

The Committee received an update regarding the annual filings, with a slight delay on the External Auditor's Opinion Report, due to some wording changes required to the Report. It was noted that this had now been finalised and the Annual Report and Accounts were ready for submission to Parliament.

The Internal Audit Progress Report was presented and the Committee emphasised the requirement to escalate recommendations overdue for more than 12 months or that had been extended three times. An update was requested at the next meeting for the five recommendations that had exceeded their due date by 12 months.

The Annual Internal Audit Report for 2024/25 including the final Head of Audit Opinion was presented, with an overall opinion level of 'good assurance'. It was noted that there were three audits still in progress, however, these would be completed by the date of the next Committee.

The Annual Counter Fraud 2024/25 Report and the Trust's Annual Counter Fraud Functional Standard Return for 2024/25 were presented and the Trust was rated green in all the NHS required categories with the exception of category 12, conflicts of interest policy and registers.

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

GB25/128 NTHFT Annual General Meeting Minutes 2024

Jackie White, Director of Corporate Affairs/Company Secretary presented the minutes from the NTHFT Annual General Meeting held on 19 September 2024.

Resolved: that, the minutes of the Annual Members Meeting held on 19 September 2024 be approved.

GB25/129 Any Other Business

The Chief Executive reported that the staff listening event on Monday, 8 September 2025 had a theme of sharing better together, with a number of suggestions already put forward by members of staff. Board members were invited to join the events.

GB25/130 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 6 November 2025 in the Boardroom, 2nd floor, Murray Building, James Cook University Hospital.

The meeting closed at 15:50

Signed:  Date: 6 November 2025

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	05 March 2026	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 linked to the UHT Strategy. MS and JW to agree arrangements. An update was provided at the September meeting, the likely timescale would be 2026.	
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 March 2026	Completed	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. JW & EN to agree arrangements. Update was provided at September meeting, the session would take place once the move to single services was complete.	
03 July 2025	GB25/068	***Board Assurance Framework*** A Board session to be arranged to review risk appetite in relation to delivery of the organisation's strategic objectives.	Stuart Irvine	30 September 2025	Open	Following discussion regarding the risk appetite for each of the domains in the refreshed BAF it was agreed to have a session to fully review risk appetite to ensure it accurately reflected the ambitions and delivery of the UHT Strategy. An update was provided at September meeting, SH requested item remain open until a review of the mid-year position after Month 5 had taken place.	
03 July 2025	GB25/080	***Audit Committee Chairs Log*** A review to be undertaken of Gifts and Hospitality and Declaration of Interest Registers	Jackie White	04 September 2025	Completed	It was agreed Executives would review the registers and processes for Gifts and Hospitality and Declarations of Interest for oversight. An update was provided at the September meeting, consideration was being given to use ESR going forward to replace the current manual process, a project plan was being worked up.	
04 September 2025	GB25/100	***Patient Story*** The Board to be presented with thematic actions going forward in relation to individual patient stories in order to close the loop and gain assurance regarding lessons learnt.	Emma Nunez	06 November 2025	Open	It was agreed it would be helpful for the Board to understand the thematic actions taken in relation to the individual patient stories.	
04 September 2025	GB25/109	***University Hospital Tees (UHT) Strategy Update*** The UHT Strategic Outline Case be presented to Board in November 2025	Matt Neligan	06 November 2025	Open	Development of the Strategic Outline Case was in its final stages, with the expectation this would be brought to Board in November 2025 for consideration.	
04 September 2025	GB25/110	***Board Assurance Framework*** The high strategic risk scores in the research and innovation BAF domain be reviewed comparatively against national targets for delivery, for example delivery against 18 weeks RTT	Stuart Irvine	06 November 2025	Open	It was agreed to pick up outside of the meeting to review the higher rated strategic risks in the research and innovation domain to consider bringing them into alignment with national expectations and realistic targets e.g. delivery against 18 weeks RTT.	
04 September 2025	GB25/114	***People Committee Chairs Log*** Data in relation to the STHFT overpayment issue to be presented to Group Management Team for oversight and scrutiny	Rachael Metcalf	30 September 2025	Open	The issue regarding STHFT payroll overpayments was being monitored by People Committee and escalated to Resources Committee. SH agreed to review the information at the Group Management Team to better understand the position and increase the level of scrutiny.	

University Hospitals Tees

Chairman's Report

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 1.7

Report author: Jackie White, Company Secretary

Executive director sponsor: Derek Bell, Chairman

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 framework references this paper relates to:

Add in BAF reference.

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 Board of Directors are asked to note the report.

Chairman's Report

1. PURPOSE OF REPORT

The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.

2. RECOMMENDATIONS

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

3. DETAIL

3.1 NHS UHT - Anti Racism Day

I am really pleased to be able to promote our 'This is our conversation - what does Anti Racism mean to me' day which takes please on Friday 7 November 2025.

As previous mentioned Joy Warmington (Author of Too Hot to Handle) will be speaking in the morning on racism as a social construct and Windrush colleagues on their experience of whether things have moved forwards, then we welcome back the police and crime commissioner who has done recent focus groups with our staff one year post-riot and also are exploring intersectionality and allyship with the Chief pharmacist from Sheffield.

The afternoon will focus on local experience with a refugee charity speaking, lived experience- stories from colleagues and from the riots, information from our networks and the plan for what we do going forwards - what do we need to do differently as an organisation.

It would be great for Board members to join us on the day.

3.2 NHS Chairs and CEO Meeting

The main topic of discussion was integration and Integrated Health Organisations (IHO). Interestingly, the conversation evolved much more into the importance of progressing partnership working and collaboration across the patient/population journey(s). Discussions focussed on the need for a clear strategy and implementation plan plus the importance of Boards empowering staff to progress with the appropriate assurance structures in place.

The NENC regular chairs meeting is due to be held on 4 November, and a verbal update will be provided.

3.3 Armed Forces and Veterans Coffee Session – 10 July 2025

University Hospitals Tees (UHT) continues to demonstrate its commitment to the Armed Forces Covenant. Our Help for Heroes Nurse who works across UHT, continues to proactively make positive contacts with patients who are members of the armed forces community. We held our most recent quarterly armed forces coffee morning at the Friarage Hospital site on 28th October 2025, with lots of engagement, resulting in an increase in our

database of veterans working for UHT and patients who are veterans. UHT will be coordinating a series of events in November, including raising of the remembrance flags, attendance at Remembrance Sunday events of our five Local Authorities and UHT Armistice Day ceremonies at each of our four main sites on Tuesday 11th November 2025. We continue to positively engage with our stakeholders with the aim of ensuring primary and secondary healthcare services are working jointly and collaboratively for the benefit of our Armed Forces Community.

A joint accreditation submission on behalf of UHT for the Armed Forces Covenant was made in September 2025 and the outcome is expected at the end of October 2025. Further updates will continue to be provided to the Board.

3.4 Arts Council

The James Cook and Friarage Hospitals Covid memorial art competition supported through South Tees charitable funds will close at the end of November 2025. To date, eight schools have confirmed they will be submitting artwork to the judging panel on 9 December, the launch event is planned for 7 April 2026 in line with world health day.

A University Hospital Tees Arts Council was established in February of this year continues to deliver a wide range of initiatives that support staff, patients and community wellbeing through arts. Following the installation of the Covid Memorial at North Tees and Hartlepool funded through charitable donations, the remaining funds have been used to create a memory wall for dementia and delirium patients on wards 41 and 42 supported by Stockton Camera Club and the Globe Theatre, the development of a Writers Nook in Café Wilbur at North Tees which will serve as a reflective space and as a base to strengthen links with our local community to support adult literacy in partnership with the Group education team. In addition, the funding will support the framing of artwork supplied by Yarm School across North Tees. Currently, the Council is working with Hartlepool Museums and Art Gallery to run a 'time for tea' health and wellbeing initiative giving staff, patients and visitors a moment of calm while learning more about the history of tea making and the history of Hartlepool. This has been positively received with over 50 participants sharing their memories. Work continues with Hartlepool art gallery to showcase artwork by regional painter John Wilson McCraken (who resided in Peterlee) which will be displayed at Peterlee Community Hospital prior to the end of the year

Finally, a memorandum of understanding has been developed which will be shared with Middlesbrough Institute of Modern Art (MiMA) and the Bowes Museum, both of whom are keen to explore partnership opportunities with the group to showcase some of their museum pieces as well as offering preferential rates for exhibitions etc.

3.5 Visits by Sir David Bell and Professor Sheree Smith

Sir David Bell, Vice Chancellor of Sunderland University met attended the James Cook site and visited facilities for undergraduate students and further discussions are ongoing around developing stronger links with our local universities.

Professor Sheree Smith visited Teesside University and UHT to explore potential collaboration with Australia including peer support and potential exchange programmes in relation to nurse and allied health professional research and education.

3.6 AGM / AMM and Council of Governors

We held our AGM/AMM and Council of Governor meetings at Teesside University on 11 September 2025 in their new Digital Centre. We had a great turn out of members, stakeholders and members of the public who were able to visit a number of market stalls and to hear about the work we have been doing over the last year. Thanks to those who attended, presented and organised the events.

3.7 COG Election

We have just recently undertaken our autumn round of elections for both South Tees and North Tees & Hartlepool Foundation Trusts Councils of Governors. Notice of appointments will be posted later in November.

3.8 Board Development

The Board met on 2 October 2025 for its Board Development / Seminar programme. The Board were pleased to be able to visit some of the nominations for the Love Admin Awards who were based at James Cook. Neil Atkinson, Chief Delivery Officer discussed the new Accountability Framework which has been developed to ensure delivery of the annual plan through the new CSUs and Lucy Tulloch, Director of Planning attended with her team and provided an interactive session on the oversight framework for the two Trusts exploring opportunities for development. Finally, Jackie White, Company Secretary took the Board through a workshop session on the new self-assessment process for Trust capability.

Derek Bell
Chairman

University Hospitals Tees

Chief Executive Officer Report

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 1.8

Report authors: Stacey Hunter CEO / 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:

N/A

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 Board are alerted to the forthcoming resident doctor strikes. I will ask the CMO to provide an update in respect of covering the strikes when we meet in November.

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 will note and discuss our performance against the 25-26 plan and whilst there are areas of good progress, cancer and RTT remain under plan. This report highlights this and some further actions and the IPR plus the Board committee reports will provide the details.

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 the H2 stage of the year we are delivering the overall requirements we committed to in our financial plan. Whilst this includes non-recurrent support the quantity of recurrent savings has been increasing and now benchmarks well compared to the other providers in NENC.

The ongoing activities all of our teams support in relation to events like the Love Admin awards and the AHP event are well received by our colleagues. They also provide some counterbalance to the day to day demands and I am grateful to everyone who helps organise, promote and deliver this.

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. It covers the period since our last Board meeting on 4 September 2025.

2. National Priorities

2.1. Fuller Enquiry – Trust Response Update

The Board will be aware that the Government-commissioned the Fuller Inquiry into the safeguarding of deceased individuals in healthcare settings which has now completed both of the planned phases. University Hospitals Tees has undertaken a structured response to both the Phase 1 Report (published November 2023) and Phase 2 Report (published July 2025). A Multi-Disciplinary Team is leading the review and implementation of actions aligned to the inquiry's recommendations. Progress is being monitored through the Executive Team and Quality Assurance Committee, with a full update scheduled for presentation to the Trust Board in February 2025. This may include capital investment which will need to considered as part of our overall plan for 26-27.

2.2. Planning 2026/27

In September 2025, NHS England published an overview of the approach to annual planning for 2026/27. This was followed by planning guidance which was received on the 24th October 2025. At the time of writing this report the guidance is being reviewed with further details due to be released during November.

We are required to submit financial plans and operational trajectories providing assurance of sustainability and improved performance over the next three years (it is 4 years for capital). This includes a minimum of a 2 percent increase in productivity relative to this year and a significant CIP plan. The details of this plus the required increases in performance across urgent and emergency care, diagnostics, electives in both acute and community services and cancer are being worked through. The planning timeline has reduced significantly this year, with plan submission due by December 2025 (3 months earlier than previous years). CIP planning has commenced, with a current internal planning assumption that the target requirement will be at broadly the same level as the current year, pending the agreement of the full financial plan. Initial focus is prioritised on the schemes where there is the most significant level of opportunity, such as Group wide cross cutting schemes, transformation schemes and material productivity and efficiency improvements.

Planning work will also commence with the new CSUs in early November 2025. This planning process is alongside a continued focus on in-year delivery and the work continues to be overseen by the Financial Recovery Oversight Group. Clinical leadership and actions at the level of service and specific care pathways are critical to delivering this safely and effectively.

We will also submit a narrative integrated delivery plan looking ahead over the next five years, drawing on our UHT clinical strategy, digital strategy and people plan. It will reflect the work of the clinical boards and our ambition for neighbourhood health services and sustainable models of care outside the hospital setting. Alongside demonstrating progress to returning the constitutional standards to the national targets over this period we will need to demonstrate progress against the national 10 year focused on the 3 big shifts (which as Board are aware are inherent in our UHT strategy).

2.3. National Neighbourhood Implementation Programme

We are delighted that Stockton is one of 43 places to be selected to join Wave 1 of the National Neighbourhood Health Implementation Programme. This will test a new model of joined up care to support people with long term conditions and rising risk, starting in the Central Stockton and Portrack neighbourhoods and then looking to spread the learning to the rest of Stockton. It provides a great opportunity to develop services in line with our strategy, shifting more resource into the community and putting in place the most appropriate support and interventions for patients from our collective resources across partner organisations. We will also look to work with the ICB to spread the learning across the system and into the other places in the Tees Valley as we develop joined up care models in neighbourhoods for the whole population that we serve.

2.4. National Investigation into Maternity and Neonatal Services

The national investigation into maternity and neonatal services was launched by the Health Secretary Wes Streeting in response to systemic failures in NHS Maternity care and neonatal services. The investigation aims to understand the experiences of affected families, identify lessons learned and drive improvements to ensure high quality and safe maternity and neonatal care across the country.

The investigation will focus on a range of services across the whole of the maternity system. It will look at the quality and safety of services and the impact of inequalities. The findings from the investigation will inform a new national maternity and neonatal action plan. The following 12 trusts in focus are;

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bradford Teaching Hospitals Foundation NHS Trust
- East Kent Hospitals Foundation NHS Trust
- Gloucestershire Hospitals Foundation NHS Trust
- Oxford University Hospital NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospitals Sussex NHS Foundation Trust
- Somerset NHS Foundation Trust

Although UHT is not part of key focus, we do want to ensure any broader recommendations are understood and acted upon as required. The review is due to

report by Christmas 2025. At South Tees the team are receiving support from the national maternity team responding to the areas that need further improvement following the diagnostic report we received earlier this year.

2.5. ICB and NHSE Changes

We are working with colleagues locally and nationally to understand and plan for the changes to NHS England and ICB roles and responsibilities. In July the Government's 10 Year Health Plan for England announced plans to devolve power from the centre to the frontline. This includes the merger of NHS England into the DHSC (with a 50% reduction in headcount), maintaining seven regions, and reducing the number of ICBs and their headcount. Earlier in the year the Model ICB blueprint set out the revised future strategic commissioning role for ICBs, and this has now been followed by the Model Region. This describes the future role for regions as the "system facing arm of the centre" that will focus on strategic leadership, performance management, and improvement and intervention. The implementation timetable for the merger of NHS England into DHSC was initially two years, and while we understand that this relies on an ambitious timetable for the passage of a health bill through parliament, the DHSC has recently reasserted that it expects to meet this target timeline.

2.6. National Oversight Framework – Organisational Capability Self-Assessment

As part of the National Oversight Framework (NOF), NHS England requires provider trusts to complete a self-assessment of organisational capability, aligned to the six domains of the *Insightful Provider Board* framework:

1. Strategy, leadership, and planning
2. Quality of care
3. People and culture
4. Access and delivery of services
5. Productivity and value for money
6. Financial performance and oversight

The Board undertook a structured review of each domain during a development session held on 2 October 2025, using a range of internal and external evidence including audit findings and regulatory assessments. Working in small groups, Board members assessed each criterion and proposed compliance levels, which were then discussed and agreed collectively.

A follow-up session on 7 October 2025 enabled further triangulation of the initial assessments. The final submission was agreed by the Chief Executive and Chairman on behalf of the Board. The completed and Board-approved self-assessment template, along with supporting evidence, was submitted to the NHSE regional oversight team on 22 October 2025. This has been shared with Board members and will be put in the Board's reading room.

The regional oversight team will now review the submission alongside other contextual factors, including the Trust's historical performance, regulatory history, and third-party intelligence, before determining and communicating the Trust's capability rating.

2.7 Industrial action

The BMA resident doctors committee have announced further strike action which will run for 5 days from 7am on the 14th November. This is despite efforts to bring this prolonged period of industrial unrest to an end. Our Chief Delivery Officer & Chief Medical Officer will work with our clinical and operational teams to plan for the strikes. Whilst we will do everything feasible to continue to provide as many of our planned services it is likely we will have to cancel and rearrange some activity.

3. Regional Update

3.1. ICB NENC Mid-Year Finance and Performance Delivery Workshop

Myself and several members of the executive team attended the mid-year finance and performance delivery workshop on Monday 6 October 2025. The event was held in Newcastle and primary focus was to review the progress of trusts financial and performance and recovery plans.

3.1.1. H2 Review

We have had confirmation that our H2 review will be undertaken with the ICB rather than escalated for review by the regional or national team. At the time of writing this report we have not yet had any feedback from the H2 review. We will provide a verbal update to the Board on anything material.

3.2. NENC ICB System Recovery Board

This month the SRB focused on the Elective Workstream continues to show progress across several key areas. The shared visible PTL was approved at Provider Leadership Board in October, enabling real-time data sharing across NENC trusts to support proactive demand management. Theatre utilisation has improved from 76.3% in March to 84% in September, driven by embedded practices such as 6-4-2 scheduling and “no TCI before green.” Mutual support across the ICS has enabled quicker access to care for 533 patients year-to-date. The Gynaecology Clinical Alliance’s Health & Growth Accelerator bid was approved, aiming to deliver 2,247 new appointments by March 2026, benefiting over 2,000 working-age women. However, affordability remains a concern, with most trusts overperforming against ERF income targets and ISP activity rising to 12% (above the 8% target). HRG-level reviews are planned to address this. While the system has achieved a 2.3% reduction in the waiting list over two years, recent data shows an upward trend due to rising demand. RTT performance is mixed, with NENC ranking 2nd nationally at 70.2% Elective hubs show strong performance, with 50% of providers meeting or exceeding 85% theatre utilisation. Strategic optimisation recommendations are expected later this year. Key risks include affordability, Independent Sector reliance, and RTT performance, with mitigation plans in place and enhanced governance underway.

The planned care board has reviewed its programme of work and agreed to prioritise further work focused on reductions in outpatient follow up appointments in two key specialities (ENT and Gynaecology). The system level work will enhance the work individual providers are doing with a particular focus on enabling digital solutions.

The other programmes all provided an update to SRB with a further focus on the workforce programme due.

3.3. NENC Provider Collaborative Leadership Board (PLB)

It was confirmed that there will be a national rollout of the Target Operating Model (TOM) for people services, with strong backing from the NHSE Executive and a clear expectation for increased collaboration across systems. A digital solution is being developed to support the TOM, with several components of the operating model to be integrated over time. The Workforce Board has given its support to progress this as a scoping opportunity to the Provider Leadership Board (PLB), noting that this remains an outline plan rather than a formal proposal. While regional implementation is preferred, the North region is considered too large, and the North East region has been identified as a more viable option, with support for this approach. PLB endorsed the direction of travel and principles, and a workshop involving CPOs, DoFs, CEOs, and NHSE representatives will be convened to further explore the opportunity and refine the case. Tom Simons and members of the national team will facilitate this session. Time pressures were noted, along with the need to consider team capacity for implementation, the potential benefits of the digital solution, applicability to local authority partners, financial liabilities, local considerations such as subsidiaries, and any capital/CDEL implications. Collaboration and digital infrastructure will be central to successful delivery.

3.3.1. NENC Provider Collaborative Strategic Approach to Clinical Services

The SACS Board met on 10th October 2025 and confirmed several strategic developments. The SACS Framework has now been formally signed off by FT CEOs via the NENC Provider Leadership Board, with communications to FT Executive and Board teams expected by the end of October. The framework will also be discussed at the NENC ICB Board Development session on 21st October. The Board agreed to explore alignment between SACS and ICB-led diabetes work, particularly where long-term hospital service implications are relevant. Continued emphasis was placed on embedding a realistic medicine approach within SACS documentation. Assurance was provided that the framework is being integrated into five-year strategic planning across commissioners, providers, and the wider system, with supporting data and narrative to follow. Medical Directors were asked to consider informal peer support mechanisms to address short-term service quality challenges. The Board also discussed the SACS programme's role in supporting Cancer Alliance work on breast cancer pathways and agreed to ensure strategic coherence and learning from current service pressures. Further work will be undertaken to address ophthalmology concerns through appropriate system forums, noting broader sustainability and equity issues. A clinical engagement report was received from senior paediatric leaders to inform collaborative priorities for sustainable children and young people's hospital services. Finally, SACS clinical delivery groups will be asked to identify opportunities for digital diagnostic innovation as part of the NENC capital bidding process. Our CMO is our representative on this Board. I anticipate that this programme of work will gather momentum and priority as part of the 3-5 plans all providers are embarking on.

with forthcoming national guidance on cancer pathway improvement. A 10-year national cancer plan is expected to be published in November, which may carry further strategic implications for the system.

4. Local update

4.1. Management and Leadership Restructure / New Accountability Framework

The majority of the restructure process is now complete with the exception of recruitment to Clinical Director roles which will happen over the coming weeks. The majority of existing CDs will remain in their roles to provide continuity until the roles have been appointed too and colleagues confirmed their start dates.

We have published the new structures internally and will share with our partners over the coming weeks. I would like to thank the executives and our HR team who have held in excess of 220 interviews as part of this process and provided advice, information and support to colleagues. I would also like to thank all of those colleagues in scope of this review for their patience and professional behaviours throughout this period.

We are now focused on securing a smooth transition from the beginning of November with weekly operational oversight and weekly all staff briefings for the first 8 weeks to support staff during a time of transition. There is a detailed accountability framework that sets out the expectations and ways of working and a detailed transition plan to minimise the risks associated with such a significant change. Board members have had an opportunity to comment on this as it was developed and I will ask that the final documents are made available in our reading room for further information.

4.2. Performance Against Plan

The IPR and the exception reports from the Board committees highlight areas of progress against our 25/26 plan and also those areas which are behind plan and need further focus. The relevant Board committees will report on this so I won't duplicate the information.
Our progress against both the cancer standards in both trusts is below the plan as is the position for patients waiting over 52 and 65 weeks at South Tees. I have recently agreed with the Chief Delivery Officer that we will commence a Cancer Recovery Board and an Elective Recovery Board to provide additional oversight and actions as part of our efforts. They will be held on alternate months and commence in November 2025.

4.3. Staff Targeted Racism

Last month I wrote to our workforce following two separate incidents of racism against our staff. We have worked with our staff network and workforce teams to support these staff, as well as so many others who have sadly suffered similar abuse during their day-to-day lives.

We have also worked with our media partners to highlight this with our communities – raising awareness of how much richer we are as an organisation for the diversity we have in our workforce and population. We also continue to work with our partners at Cleveland Police to get those messages across to our community.

I assured colleagues they are not alone and encourage staff to report any incident. I made sure staff know I will be available to talk to should they need to talk along with our colleagues in workforce who are also encouraging staff to contact them.

Whilst colleagues appreciate, we are not always able to influence the external factors they do welcome our support and that they receive from their colleagues.

4.4. Flu Campaign

We've had a reasonable response to our staff flu vaccine programme so far, our vaccination rates are exceeding this time last year, but there is still a long way to go to get herd immunity against this potentially deadly virus.

Thank you to everyone who has taken up the offer and got their flu vaccine- your dedication to patient safety hasn't gone un-notice. I am extremely grateful to our colleagues who are delivering the flu campaign and the volunteer flu champions who are going above and beyond to make it as accessible as possible.

4.5. NTH Solutions LLP

NTH Solutions LLP have received a grievance from Unison regarding what they describe as a two tier workforce in relation to Agenda For Change and non Agenda For Change terms and conditions. I will provide an update in the private session when we meet.

5. In other news!

5.1. Maggie's Centre Launch

In February 2025, Her Majesty visited Middlesbrough Town Hall to announce that cancer charity Maggie's, of which she is President, would be establishing a presence in Middlesbrough. This followed an invitation from University Hospitals Tees to Maggie's to collaborate with the Trinity Holistic Centre at The James Cook University Hospital, which has faced ongoing funding challenges.

On 15 September 2025, Trinity Holistic Centre officially transitioned to become Maggie's Middlesbrough, now offering expert, holistic support to people with cancer, their families, and friends across the University Hospitals Tees footprint. Support includes help with emotional wellbeing, financial concerns, managing treatment side effects, and navigating daily life with cancer.

This transformation has been made possible through grant funding provided by Our Hospitals Charity, which is supporting the service transition for an initial two-year period. We warmly welcome Maggie's to Middlesbrough and look forward to the positive impact this partnership will have on patient experience and support services across the region.

5.2. University Hospitals Tees Stroke Conference – 9 September 2025

I was delighted to join more than 200 delegates at a University Hospitals Tees stroke conference which was organised by our AHP Stroke Consultant Kirsty Jones. The day focused on how stroke impacts our patients, communities and the NHS. Throughout the day we heard from colleagues across our hospital and community services, partner organisations, as well as the national NHSE Clinical Director for stroke.

We heard about the challenges that the Tees and surrounding areas face with regards to stroke, and how the service has improved because of NHS investment. This highlighted the priority of communication in patients after a stroke and developing a stroke education programme for non-medical practitioners. Thank you to consultant therapist Kirsty Jones who, with the support of others, delivered an excellent educational and networking day.

5.3. Allied Healthcare Professionals Celebration

We held a special AHP Day Awards recently to celebrate allied healthcare professionals across the organisation who go above and beyond their roles. Our AHPs, who are healthcare professionals providing things like diagnostic, therapeutic, and rehabilitative services in various healthcare settings, are vital to the care we give our patients. More than 100 nominations were received for a diverse range of award categories showing what an impact, these individuals and team have made.

Congratulations to everyone nominated and recognised with awards and thank you to the leaders in the team who organised the event which was well attended and received great feedback.

5.4. Love Admin Awards

We also recently celebrated colleagues at our first University Hospitals Tees Love Admin awards. Across our hospital group, we value and recognise their contributions to patient care services both in back and front office settings. The event gave us an opportunity to put a spotlight on our unsung heroes who always go above and beyond.

6. Conclusion

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

University Hospitals Tees

Chair's Log of the Group Management Team Meeting on 21 August 2025

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 1.9

Report author: Stacey Hunter, CEO & Abigail Smith, Executive Assistant to the CEO and Chair

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:

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.

Nothing to alert

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.

Significant focus on continued strengthening of CIP delivery including reducing the high-risk schemes, substitution of schemes that are not delivering and increasing the recurrent reductions in run rate.

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

Nothing specific to identify.

Site Leadership Team Reports

North Tees and Hartlepool NHS FT

- Weekly Response Planning MDT meetings have been utilised to review individual safety events and consider any apparent themes that may be emerging.
- The Clinical Quality Audit Programme has successfully been relaunched with good engagement from clinical teams.
- Successful recruited into the 65 WTE band 2 Healthcare Support Worker roles, with a view to commence employment from October 2025.
- Specific work is taking place with Stockton LA with a joint bid being submitted to the Better Care Fund for increased care hours, following a joint review of delays demonstrated a 7- day delay in starting packages of care in some instances. The bid was approved on Friday 15th August and will start to be put in place from Monday 18th August.
- In May the Trust has bid for additional capital relating to constitutional standards totalling £2.94m - it has yet to be notified of an outcome, although it is acknowledged that bids were oversubscribed when compared to the allocation received by the ICB. The Trust has however been successful in its bids for funding from the CDC Pathway Development Fund for Liver Disease £0.2m, Estates £0.224m and the Constitutional

bids for Physiological Sciences £0.077m and Spirometry £0.011m. The additional approved bids, along with UEC £4million will increase the initial allocation of £23.065m to £27.296m.

South Tees Hospitals NHS FT

- Cancer 62-day standard is highlighted as a strategic risk in the Board Assurance Framework (BAF) as the Trust benchmarks poorly against the national picture. While prostate pathway changes present the biggest opportunity to improve performance, performance in other pathways will need to be delivered for the Trust to surpass 70% consistently.
- Cancer 31-day standard has been variable since January 2025 but now demonstrating general sustained deterioration with 7 consecutive months below the previous average performance, driven by increasing radiotherapy waits for subsequent treatments. 31-day performance improved to 87% in June against the plan of 91.1% and 96% standard.
- A&E standards on 4 hours wait (76.5% for June 2025), 12-hour ED breaches (3.2% for June) and ambulance handover delays are showing improvement.

Planned Additional Elective Activity Policy

Policy developed to introduce transparency on when enhanced rates are used across UHT. Steps are in place to minimise the use of additional elective activity. It was agreed the Chief Delivery Officer will hold accountability for this policy going forward.

Lead Health Scientist Role

It was agreed that a Lead Healthcare Scientist role should be established across both organisations, as neither currently has this in place. This role will provide professional leadership and recognition for healthcare scientists, many of whom feel their contribution is not sufficiently acknowledged and are keen to play a more active role. The position will carry responsibility rather than operational management, and will mirror roles for both pathology and non-clinical pathology healthcare scientists, with alignment to the pathology clinical director role to ensure cross-specialty collaboration. A responsibility payment will be associated with the role. Discussions have taken place with the Lead AHP to ensure awareness and alignment, and the new role will offer support and visibility to healthcare scientists as part of ongoing improvement work.

Continuous Improvement

A strategic initiative is underway to streamline the approach to improvement across the group, aiming to make it more systematic and aligned. Currently, over 100 individuals across various teams hold responsibility for improvement, resulting in variability and fragmentation. A comprehensive strategy has been developed, encompassing transformation, operational improvement, and day-to-day quality improvement, with a focus on aligning these efforts. A high-level proposal has been put forward, supported by a partner organisation, to lead this work across the group. Executives will visit Harrogate Trust next week to learn from their development journey, which will help inform Board-level discussions. A draft business case has been prepared, with cost implications requiring Committee and Board approval. The procurement process has reviewed several potential support providers. Timescales include market testing and presentation to the Resource Committee, with plans to socialise the

proposal with the Board in September ahead of finalising the business case. A separate PMO will be established for CIP delivery during the first two years, with a focus on consolidating resources to effectively support the programme.

Board Assurance Framework

Planned internal audits will take place on the Board Assurance Framework and Risk Management processes in 2025/26 and will be reported in due course.

Recommendations:

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

NHS
University Hospitals Tees

Chair's Log of the Group Management Team Meeting on 18 September 2025

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 1.9

Report author: Stacey Hunter, CEO & Abigail Smith, Executive Assistant to the CEO and Chair

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:

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.

Nothing to alert

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 are advised to note the information provided in respect of the performance standards which are covered in the IPR.

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 site leadership teams and corporate teams provided comprehensive updates against their priorities which are highlighted in the report.

Site Leadership Team Reports

North Tees and Hartlepool NHS FT

Ambulance handover performance is now measured against a 45-minute standard, with 98.71% compliance in August. A&E performance remains above the national recovery standard at 84.62%, though below the planned trajectory of 89.64%.

Cancer performance shows mixed results: the 28-day faster diagnosis standard was 78.43% in July, above trajectory but below the 80% target; the 31-day standard was 92.45%, and the 62-day standard was 52.3%, both below target and trajectory, with sustained pressure from breast symptomatic referrals and delays in urology, gynae, and respiratory pathways. RTT performance was 72.68% in August, slightly below trajectory but strong regionally and nationally, with 52-week waits reduced to 157, meeting trajectory.

Financially, the Trust reported a £417k surplus in month 5 and £833k YTD, both ahead of plan. CIP delivery stands at £9.219m (94% of target), with no unidentified CIP in the NHSE submission, though £2.9m remains high risk. SQAS will conduct a QA visit on 9th October following prioritisation, focusing on leadership, governance, and radiology at North Tees. Pre-visit documentation has been submitted, and actions are in place to address concerns, with KPIs showing improvement.

South Tees Hospitals NHS FT

The Cancer 62-day standard remains a strategic risk on the Board Assurance Framework, with the Trust benchmarking poorly nationally. However, changes to the prostate pathway have shown early impact, making it the best-performing pathway regionally and improving the Trust's overall position to 67.2% in July. Sustained improvement beyond 70% will require progress across other pathways, particularly urology, gynae, and respiratory. Urology. A&E performance continues to improve, with a 4-hour wait performance of 78.0% in August, and 12-hour breaches at 2.8% in July, placing the Trust in the upper national quartile. Ambulance handover delays are also showing positive trends. This will require consistent attention as we progress into the winter months to ensure the winter plan for the JC site is effective and the improvements are sustained.

Continuous Improvement

Myself and several members of the Executive Team made a recent visit to Harrogate District Hospital to assess their implementation of the continuous improvement model, with lessons learnt. The visit was positive with some really good feedback, highlighting key priorities of focus to support a smoother implementation of the continuous improvement model. Following the visit, the team have collated feedback and continue to develop the CI business case.

Digital Strategy

Pre-marketing engagement documentation for the single Electronic Patient Record (EPR) has now been published, with supplier demonstrations scheduled for the week commencing 20th October. Deployment of respective EPRs across both organisations continues, with clarity provided around training and clinical sign-off to ensure readiness. Progress is also being made on the Windows 11 and Office 16 upgrade, which remains on track for completion within the October deadline. However, some systems are unable to transition to Windows 11 due to supplier non-compliance, which is being actively managed.

Estates Strategy

A number of key activities have been completed and further actions are planned to support delivery of the estates savings target. A five-year capital backlog maintenance plan is being developed for both NTHFT and STHFT estates, aligning with future allocation processes through the Integrated Care Board (ICB) and wider system. The Premises Assurance Model submissions for both Trusts are complete and ready for submission ahead of the 30th September 2025 deadline. The staff sign-up process for ANPR is scheduled to commence on 16th September 2025. Additionally, the exit/entry time period for the Marton Road traffic lights has been extended to improve site access during peak times.

Finance Strategy

Annual planning working groups will be established and meet regularly throughout the planning period, to bring together the relevant leads from each relevant functional area (People, BI, Finance) and to support early engagement with CSU and directorate leadership teams.

NENC ICS and NEY NHSE have established a regional planning forum to bring together the planning leads from each organisation, with the first meeting to be held on 23rd September 2025.

Learning Disability & Autism Training Update

Work is underway across UHT to assess training need and resource implications of implementing the Oliver McGowan Training programme. An understanding of the regional picture has been sought and there is ongoing engagement with the ICB in relation to this topic.

Green Plan Progress Update

NTHFT are compliant with regards to the legislative requirements of food waste.
At STHFT a range of initiatives have been rolled out across procurement and food services to reduce waste and carbon emissions.

NHS England published new statutory green plan guidance to support NHS organisations develop robust plans to improve health outcomes, reduce costs, and minimise waste – continuing the NHS' journey to achieving net zero. Refreshed Green Plans have been approved by the UHT board and published in an accessible location on the Trust websites and shared with NHS England.

Job Planning Assurance

The team continue to work with staff and are committed to supporting staff through process, as per policy, to improve this further. This next year needs to focus on job plan accuracy and consistency; ensuring that the information within job plans is meaningful.

Improving Resident Doctors Working Lives Programme (10 Point Plan) September Submission

The Chief Medical Officer and Team provided assurance the trusts are being assessed positively by resident grade BMA reps. Collaborative working already in place offers a good platform to improve compliance towards improving resident doctors working lives programme to make us an employer of choice. The team continue to work through this process.

Health and Safety Update

Health and Safety inspections at NTHFT during Q1 identified 92% compliance across 49 inspections (target 100%), while 18 Fire Safety inspections in Q4 showed 95% compliance. No improvement or prohibition notices were issued in Q1, and the Trust remains below the threshold for Fire Brigade attendance over the past 12 months. At STHFT, sharps injury reports have reduced from 65 in Q1 2024 to 50 in Q1 2025, reflecting progress under the sharps reduction plan. This improvement is attributed to targeted training and awareness sessions delivered by the Health and Safety Team, Sharp Smart, and the Waste and Sustainability Manager. Risk assessments for safe sharps usage have been completed. Collaboration with the STAQ team has introduced additional health and safety questions to ensure staff awareness and effective communication across the organisation.

Board Assurance Framework Update

At NTHFT, there has been no change in the red and high risks, which remain static. Positive progress is being seen in the completion of actions, particularly within the People and Estates domains. At STHFT, an additional strategic risk has been identified relating to digital and data protection. This is flagged as a red risk within the Board Assurance Framework under the digital board assurance domain which the Board will want to review. A mitigation and action plan are in place, with a review scheduled for December/January. Both the Resource and Audit Committees are sighted on this issue. Financial strategy readiness risks remain stable. An update was provided on the capital replacement position, with approximately £7 million of end-of-life equipment now identified, prompting discussion around the associated level of risk within the BAF.

Policies Position Update

The clinical governance team & the quality governance and compliance team are working closely to ensure policy authors are supported to align policies across University Hospitals Tees. We will provide oversight to this and ensure that out of date policies are renewed over the coming months.

Armed Forces Reaccreditation

Positive progress has been and continues to be made regarding our commitment to the Armed Forces Community (AFC) covenant across University Hospitals Tees, particularly achieving consistency and standardisation of each Trust. Over the next year, four specific work streams will be progressed.

Recommendations:

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

University Hospitals Tees

Board Assurance Framework Report 2025/26 (reporting to 31st August 2025) NTHFT/STHFT

Meeting date: Thursday 6th November 2025

Reporting to: Group Board

Agenda item No: 1.11

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

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

Action required:
Assurance

Delegation status: 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 sections of the Board Assurance Framework for each Trust.

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.

Headlines

NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 9 strategic risks are outside of approved risk appetite, of which there are 6 red/high strategic risks outside of approved risk appetite. This is a reduction from 7 previously reported.
- Reduction of an R&I red strategic risk relating to over-reliance on external income which is now amber (reduction from 16 to 12) following review.
- Mitigating actions are in place to address all strategic risks.
- There are 104 planned mitigating actions within the BAF across the 8 domains.
- There are no reported completed actions.
- 6 action timescale extension requests (People (3) and R&I (3)).
- Planned action timescale range – September 2025 – October 2027.

STHFT

- There are 31 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. This is a reduction from 9 previously reported.
- This included an increase in one strategic risk relating to Digital (improved alignment across UHT) which is a red rated risk (data protection – DSPT Report), which identified improvement opportunities in policies, processes and controls. An action plan is in place and will be completed by December 2025. The current risk score will be reassessed in December 2025.
- Reduction of an R&I red strategic risk relating to over-reliance on external income which is now amber (reduction from 16 to 12) following review.
- Mitigating actions are in place to address all strategic risks.
- 114 planned mitigating actions.
- 5 actions reported as completed (P&C (1), Digital (2), Trust Estate (2)).
- 12 action timescale extension requests (Q&S (1), P&C (5), People (3), R&I (3)).
- Planned action timescale range is August 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.

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 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 each Trust's Board Assurance Framework has been reviewed and 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

Planned internal audits will take place on the Board Assurance Framework and Risk Management processes in 2025/26 and will be reported in due course.

Recommendations:

Group Board is asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 31st August 2025.
- Note the 6 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the update to the STHFT Digital BAF strategic risk and the reduction of the R&I strategic risk (red to amber) relating to external income funding, which applies to both Trusts.
- Advise on any further actions to be taken.

North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 31st August 2025)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 6 red/high strategic risks are outside of approved risk appetite (previously 7). • One step from approved risk appetite. • Reduction of an R&I red strategic risk relating to over-reliance on external income which is now amber (reduction from 16 to 12) following review. • 104 planned mitigating actions. • No reported completed actions. • 6 action timescale extension requests (People (3) and R&I (3)). • Planned action timescale range – September 2025 – October 2027.	• 31 identified strategic risks. • 8 red/high strategic risks are outside of approved risk appetite (previously 9). • One step from approved risk appetite. • This included an increase in one strategic risk relating to Digital (improved alignment) and is a red rated risk (data protection – DSPT Report). • Reduction of an R&I red strategic risk relating to over-reliance on external income which is now amber (reduction from 16 to 12) following review. • 114 planned mitigating actions. • 5 actions reported as completed (P&C (1), Digital (2), Trust Estate (2)). • 12 action timescale extension requests (Q&S (1), P&C (5), People (3), R&I (3)). • Planned action timescale range – August 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.

BAF Format

University Hospitals Tees has 6 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 are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

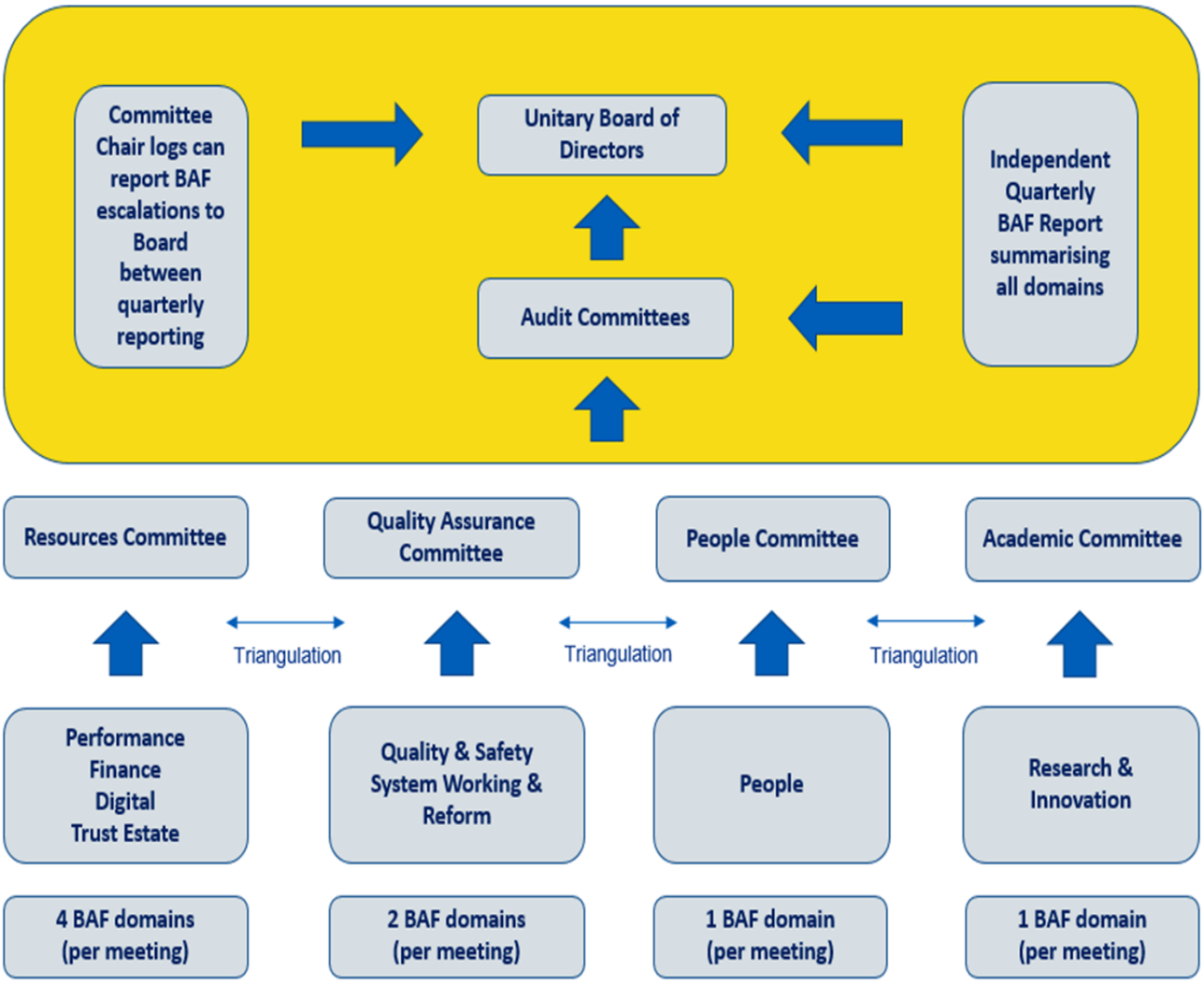
BAF Domains

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

BAF Domain	Responsible Director	BAF Author	Committee oversight
Research & Innovation	Group Medical Director	Associate Director, TVRA/Director of Innovation	Quality Assurance Committee

For continued illustration purposes, the reporting arrangements for the BAF are set out below, with the addition of the Academic Committee, which has now been established and meets on a quarterly basis. The benefit of this approach allow Board Committees to receive BAF reports at each meeting, to focus on their areas of expertise and 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 has been presented to the Board that confirms the strategic risks are linked to the BAF and are relevant for each organisation.

Risk Appetite

The approved risk appetites for the BAF domains for each Trust are set out in this report and 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.

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	12
Digital	4	4	0	**1**	0	1	17	16
People	4	4	0	0	0	0	14	14
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	16	22

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
System Working & Reform	2	2	0	0	0	0	22	22
Research & Innovation	5	5	**2**	**2**	1	1	13	14
Total Number	**30**	**31**	**9**	**11**			**104**	**114**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 9 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 September 2025 – October 2027.	• The Trust has 31 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 August 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 6 strategic risks that are red/high and are outside of approved risk appetite, which is a reduction from 7 in the previous reporting period (linked to external R&D income). 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**	4	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Insufficient capital funding to maintain Trust estate.	Trust Estate	**5 x 4 = 20**	2	Resources Committee
Reduction of system capacity if the Trust is unable to provide services.	Trust Estate	**5 x 3 = 15**	3	Resources 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**	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 31 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, which is a reduction from 9 in the previous reporting period (linked to external R&D income). 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
Failure to protect information/data we hold as a result of non-compliance with legislation/policy	Digital	**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**	5	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
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
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

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025.

External Assurance

Planned internal audits will take place on the Board Assurance Framework and Risk Management processes in 2025/26 and will be reported in due course.

4. Conclusion/Summary

The BAF continues to be regularly reported for each Trust and incorporates;

- The requirement to maintain separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF domains to the relevant Group strategic objectives.
- Approved risk appetites 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 and Board.
- Board Committees to escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Escalation Reports.
- 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.
- The learning from internal audit report findings.
- There are 30 strategic risks relating to NTHFT and there are 6 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- There are 31 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 is an increase of one red strategic risk relating to Digital (improved alignment) and is a red rated risk (linked to the data protection – DSPT Report). An action plan is in place.
- A red strategic risk (current risk score of 16) within Research & Innovation has been reduced to amber (current risk score of 12), following review and links to external income funding.
- This report is also presented to respective Audit Committees.

Assurance Statement

This report provides assurance that each Trust's Board Assurance Framework has been reviewed and 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.

5. Recommendation

The Group Board is asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 31st August 2025.
- Note the 6 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the update to the STHFT Digital BAF strategic risk and the reduction of the R&I strategic risk (red to amber) relating to external income funding, which applies to both Trusts.
- Advise on any further actions to be taken.

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 & Reform** 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

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

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)

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
- Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleagues ability to deliver quality patient care
- 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

- 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

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

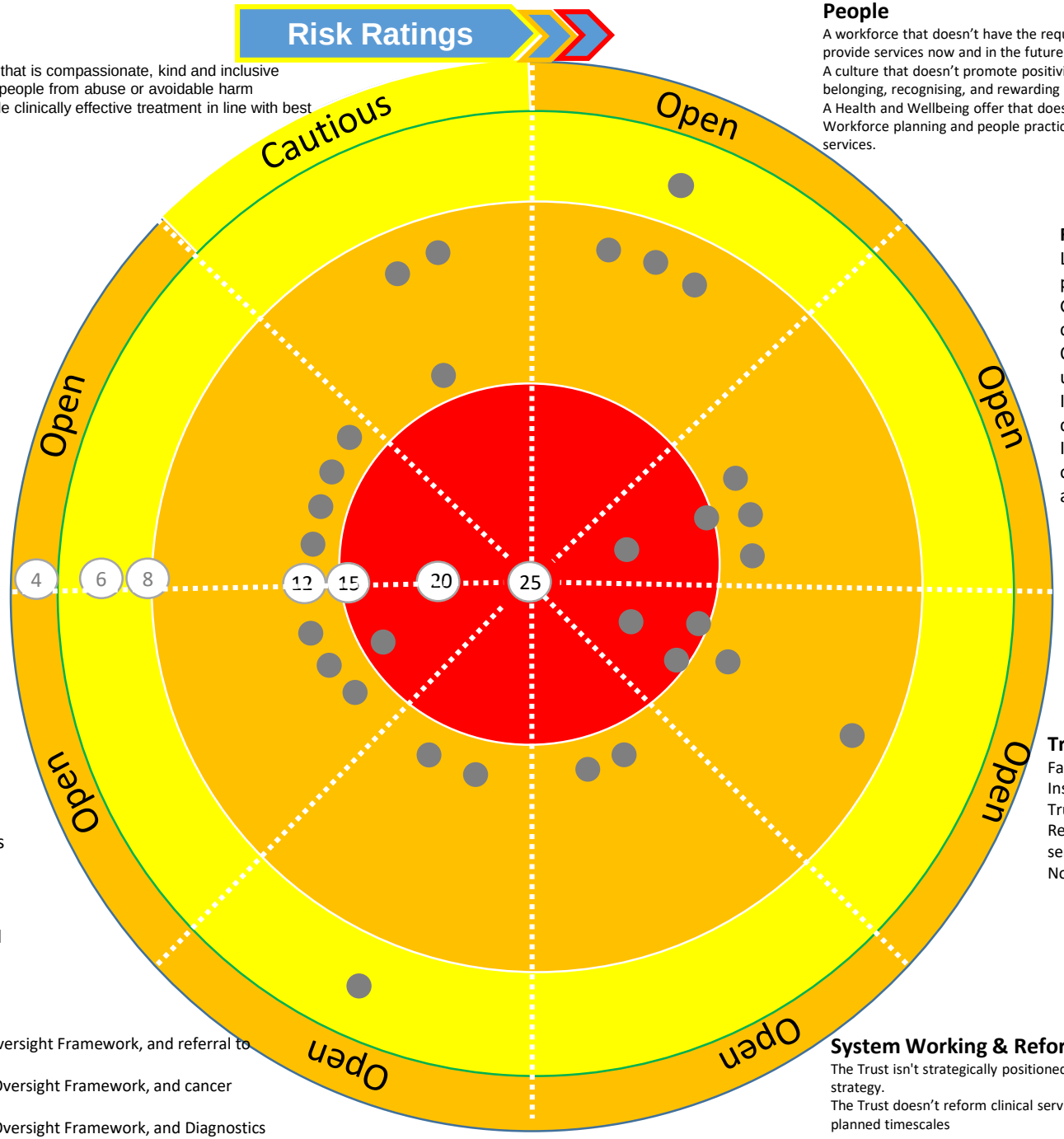
Strategic Risks

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

31st August 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 adequately maintain and upgrade current hardware and software systems and implement planned digital programmes and infrastructure projects through lack of adequate funding
- Failure to prevent a cyber-attack or data breach
- Failure to protect information / data we hold as a result of non-compliance with legislation and / or non-compliance with Trust policy
- Conflicting demands of maintaining BAU and supporting new programmes within Digital teams poses a risk to the timely and effective delivery of the digital strategy

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
- Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleague's ability to delivery quality patient care
- 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

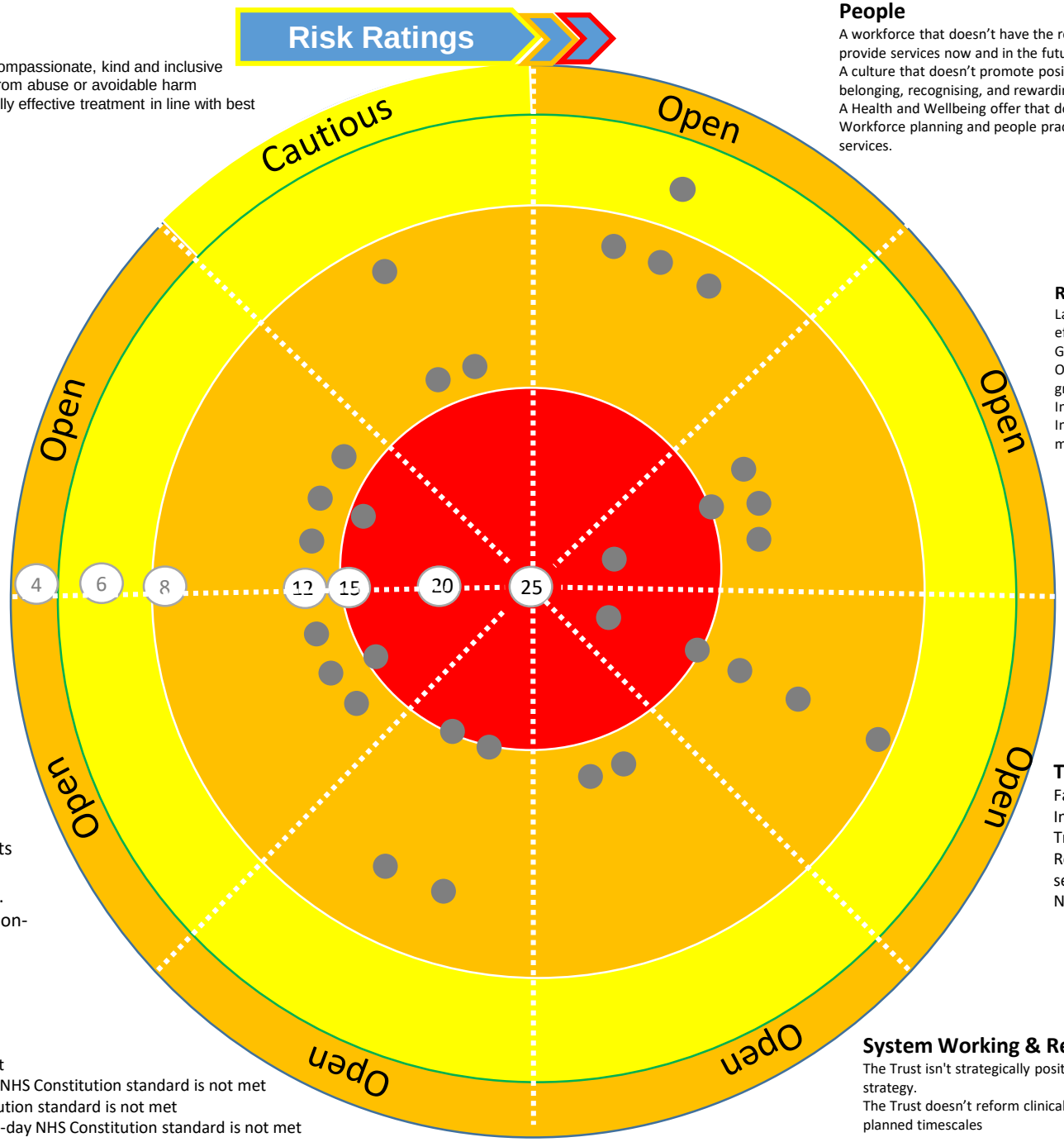
Strategic Risks

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

Appendix E

NHS South Tees Hospitals NHS Foundation Trust

31st August 2025 BAF Risk Radar



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

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 & 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

Appendix F

North Tees and Hartlepool
NHS Foundation Trust

Top 10 Operational Risks (31 August 2025)

InPhase Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
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	Corporate	Emma Roberts	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	Corporate	Andy Brown	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.	Corporate	Kerry McLean	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.	Corporate	Stephen Cuthbert	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	12
223	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton	Healthy Lives	Fiona Hardie	12
230	Due to high level of Dentist absence there is inadequate clinical staffing capacity to deliver the commissioned work plan impacting on patient waiting time and experience	Healthy Lives	Wendy McGee	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	Corporate	Stephen Cuthbert	12

244	Due to increased number of referrals received and vacant posts, there are longer waits for Under 5 Multi-agency autism team (MAAT) assessments resulting in possible reputational damage, possible suboptimal care and unmet health needs	Healthy Lives	Leanne Boyd-Smith	12
256	Lack of a dedicated maternity triage service increasing risk of deterioration of women and babies causing sub optimal outcomes	Healthy Lives	Gemma Gordon	12
267	Due to insufficient FIT Testing provision, there is a number of staff non compliant with HSE FIT testing legislation impacting on staff and patient safety	Corporate	Victoria Hancock	12
271	workforce and skill mix deficit in critical care impacting on service delivery and patient safety	Collaborative Care	Tom Bingham	12
280	Delivery of Aseptic Services to the Trust are at risk due to current estate provision	Healthy Lives	Marco Picone	12
30	Fragility of Infection Prevention and Control Workforce can lead to a loss of service and affect patient outcomes	Corporate	Victoria Hancock	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	Corporate	Rachel Desilva	12
6404	Risk to service delivery due to ICT Staffing Levels and BAU	Corporate	Mick Fox	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway	Collaborative Care	Steve Heavisides	12
246	Due increased demand there is a lack of available elective caesarean capacity to ensure timely access to theatres therefore increasing the likelihood of morbidity and mortality of the mother and fetus	Healthy Lives	Gemma Gordon	12

Appendix G

South Tees Hospitals NHS Foundation Trust

Top 10 Operational Risks (31 August 2025)*

InPhase Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
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	Estates	Paul Swansbury	20
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	Sharon Pooley	20
279	Provision of critical care follow up is non compliant with the adult critical care service specification leading to a risk of patient physical and psychological harm and a proven risk of readmission to hospital because there is no dedicated critical	Critical Care medicine	Michelle Carey	16
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neurorehabilitation outpatients	Neurorehabilitation	Jenna Moffitt	16
857	Risk that patient privacy and dignity is compromised when trying to deliver rehabilitation psychology treatment to patients on ward 26	Neurorehabilitation	Glynis Peat	16
866	Risk that complex cognitive patients on Ward 26 may come to harm and have poorer experience as they are not receiving appropriate standards of psychological specialist care according to Neurorehabilitation Standards due to a lack of funding for requi	Neurorehabilitation	Glynis Peat	16
39	The trust is commissioned to deliver neurosurgical high dependency care, currently the service is not providing the required ICU consultant sessions in NHDU, the unit is non-compliant with the service specification.	Critical Care medicine	Michelle Carey	15
777	The Flouroscopy room at JCUH has been condemned reducing capacity, the single remaining equipment has significant downtime due to age, This in impacting on Patient flow and treatment therefore patients may experience sub optimal outcomes.	Radiology	Callum Pearce	15
278	The inability to isolate patients in a timely and effective manner, leading to potential onward transmission of infection leading to sub optimal outcomes.	Critical Care medicine	Karen Banks	15
809	MGH numbers created by the LIMS are re-used which is not compliant with BSH Blood Transfusion IT guidelines and can lead to two different patients having the same MGH number which could compromise care	Pathology	Andrew Roberts	15

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

Quality Assurance Committee

22 September 2025

Connecting to: UHT Trust Board

Chair of Committee: Fay Scullion

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 3 strategic risks related to the quality domain relating to Patient Experience and Involvement, Safety, and Clinical Effectiveness, resulting in the risk score being increased. This is specifically related to safety and healthcare acquired infections.

The Learning from Deaths Report has identified that a lack of resource within the mortality teams has resulted in the learning from deaths being delayed. There is a business case pending to train to facilitate a more robust and resilient Learning from Deaths process across UHT.

UHT has a total of 11 complaints which remain open longer than the legislated 6 months. There are actions of increased monitoring and escalation on a weekly basis to SLT. The importance of regular contact with the complainant has been instigated with communication and agreement on extensions when required to conclude the complaint.

5 Quality Priority workstreams have some actions that are off trajectory, affecting the overall outcome (medication safety, IPC, patient feedback, clinical outcomes, learning from deaths). However, some of the actions are small and there has been positive progress in each of the 9 quality priority areas.

IPC remains a concern with rates above the trajectory across UHT, with IPC being regraded from advise to alert. A dashboard is being developed to identify areas that need a more targeted approach, and fundamentals of handwashing and commode care are being reviewed at ward / department level.

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 Legal Services Annual Report highlighted differences across UHT and as a result a review of the legal services provision is underway. This will support the consistency of claim and inquest management, provide experienced support to the clinical teams and improve processes for learning and improvement. The improved quality of patient safety investigations is reducing the need for Trust witnesses to be called.

Due to the concern surrounding IPC, a new Quality Priority have been developed, in response to the increasing rates of healthcare associated infections. Aligned to this is the development of ICP dashboard to highlight areas of concern so targeted action can be taken.

Maternity services – North Tees service was unsuccessful in obtaining the Baby Friendly Initiative stage 2. Two standards out of nineteen did not achieve compliance, and there is a reassessment via an internal audit planned for November. HIE rates have decreased, and an external review of cases is in progress supported by LMS. ST estate plans are being progressed for the RAAC replacement build. An external peer review was sought to review the 7 still births reported in 2024, which included the perinatal mortality review tool process, individual case reviews, and grading of care. It was inclusive of a peer review, and the gradings of care did not change. The action plan will be monitored via the patient safety meeting, the directorate meeting, and the Perinatal Services Quality Assurance Council.

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

Complaint response timeframes remain below target of 80% across UHT, action is taken weekly to escalate to the SLT. Both trusts have achieved 100% target for acknowledging complaints.

Maternity services at North Tees have been successful in appointing a Maternity and Neonatal Voice Partnership Chair.

NHS
University Hospitals Tees

Quality Assurance Committee

27 October 2025

Connecting to: Trust Board

Chair of Committee: Fay Scullion

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.

For both North Tees and South Tees there remain a number of high operational risks linked to Quality and Safety that may impact the strategic objectives (patient safety, patient experience and clinical effectiveness). Work is underway to regularly review the risk and mitigations against UHT quality priorities.

PSIIs completion across UHT are taking longer than the NHSE Guidance of 6 months to complete and this is having an impact on the implementation of learning and on patient experience. 9 reported across UHT with 2 reported as Never Events.

UHT continues to see a rise in HCAIs which are above threshold, in particular C. difficile (now at 46 against a threshold of 45). NT is slightly below threshold and ST slightly above). MRSA has a threshold of zero and year to date total of 3 (1 at NT and 2 at ST). E Coli is at 80 cases against a threshold of 57. The reduction of cost for cleaning remains a concern and has identified additional costs when there is an outbreak at ST, this has been escalated.

Maternity services – UHT reported 6 events to Maternity and Newborn Safety Investigation (MNSI) with 3 events meeting the eligible criteria for investigation. All reporting standards for MIS compliance have been met.

Caring Better Together

NT reports a stillbirth rate higher than the published MBRRACE comparator and the service is being proactive in reviewing all cases for due diligence with peer colleagues.

The Health Inequalities projects have funding ending in March 2026 and concern was raised over the ending of these services which focus on preventative measures. Awaiting the detail on the Better Care Fund and other sources of funding support, and some decisions may need to be made on the prioritisation of service continuation.

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.

There are no risks within the System Working and Reform Domain that are outside the risk appetite, with planned mitigations. Work is underway to refresh the BAF with Executive sponsors to ensure better alignment and reporting.

PSIIs reporting – there are no open Legacy Serious Incidents, with only 3 actions to be closed and evidence being monitored through established governance structures.

IPC - The fit testing service at NT for NTH Solutions continues to experience concerns, and reporting seems an issue. Senior leadership is supporting to address these concerns. Flu vaccination rates are low at 27 %

Work has commenced on producing an improved dataset for monitoring NICE guidance across UHT which will harmonise the ease of ease of reporting. However, 10 national clinical audits currently pose a risk of non / reduced submission. Support is being given to ensure the risk is assessed and added to risk register as appropriate, and the consequence on UHT of non-compliance. Work is underway to scope a UHT Clinical Effectiveness Group, incorporating existing site based groups.

Maternity services – The Rowan Suite remains suspended with an extension of this to January 2026 due to workforce pressures. There is planned meaningful engagement with workforce and stakeholders. The Birth Centre at the Friarage Hospital has been closed 12 times due to staff pressures and there is planned engagement with workforce and stakeholders. Maternity Incentive Scheme year 7 continues to be monitored with both sites having action plans to recover the training trajectory, the medical staff change in August led to non-compliance.

The national rapid review of maternity services was published and UHT are not included in the 14, further information is awaited. The North East and Yorkshire regional team are being proactive and have developed a Heatmap tool to support the oversight of services. The ST site have voluntarily entered the Maternity Support Scheme with some of the actions already completed.
HIE for NT has decreased generally but the perinatal service reported a spike, placing it as an outlier. A proactive approach was taken to develop a singular HIE improvement plan, with a supportive external review on 7 November.

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

There are stronger systems in place for ongoing monitoring of patient safety activity, escalation of overdue incidents recorded and PSII reports are progressing through the Quality Oversight Group and being presented by the Medical Directors Team.

IPC – a designated decant ward has been identified which will have an impact on cleaning. The clinical leadership group is actively looking at antimicrobial processes and a Triumvirate has been developed including pharmacy representation with IPC team. The IPC dashboard development will allow areas of hotspots to be identified and then focused activity on addressing areas of concern.

The National Cancer Patient Experience Survey showed that UHT scored higher than average on a range of questions with significant improvement over time in some of the questions. The MDT has developed an action plan to look at specific areas where there can be service improvements. There is a continued focus on areas where there is an indication that scores are lowering over time.

The consultant obstetric medical workforce for North Tees and Hartlepool is in a recruitment process, and both sites employ locums and are compliant Royal College of Gynaecology and Obstetrics locum audit. UHT service has employed 14 wte newly qualified midwives. UHT on both sites are compliant with the reporting standards for all perinatal mortality reviews.

University Hospitals Tees

Perinatal Quality and Safety Report: Quarter 2, 2025/26

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 2.2

Report author: Stephanie Worn, Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Services Quality Assurance Council, Perinatal Safety Champions meeting and Quality Oversight Group

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.

Maternity Incentive scheme year 7 continues to be monitored during the reporting period. Both North Tees and South Tees have an action plan to recover the training trajectory, due to the medical staff rotation in August that led to new staff members coming out of compliance shortly after joining the teams.

North Tees and Hartlepool received a recommendation from the NHSE lead for the Maternity Safety Support Programme to facilitate a meeting in November, as it was evidenced in July of the good progress made against the exit criteria. South Tees Hospitals continued to progress towards the Maternity Safety Support Programme diagnostic opportunities since on-boarding onto the programme in May 2025.

Rowan suite birth availability temporary suspension has been extended to January 2026 as the workforce pressures remain. The team are to work through workforce options and engage with stakeholders. All other existing maternity services remain open at University Hospital of Hartlepool.

The Birth centre at Friarage is available, though through staffing pressures and acuity at the James Cook site, it has closed 12 times. The team are to work through workforce options and engage with stakeholders.

Within quarter 2, the national rapid review of maternity services was published, identifying 14 trusts that would be included. UHT maternity services are not included. Further information is awaited. The North East and Yorkshire regional midwifery team, launched a Heatmap tool to support oversight of all services.

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

Recommendations:

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

Group Board
6 November 2025
University Hospitals Tees
Perinatal Services Safety and Quality Report
Quarter 2, 2025/26

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Board of Director members that there is an effective system of clinical governance in place monitoring the safety of our perinatal services with clear direction for learning and improvement. The data within this report is for quarter 2 of 2025/26. This report contains the perinatal quality oversight model report for September and the dashboards (Appendix 1, 2 and 3). Where any data provided sits outside this reporting timeframe, this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHS England revised publication 'Perinatal Quality Oversight Model', previously known as Perinatal quality Surveillance Model.

University Hospitals Tees provides a comprehensive community and hospital based maternity and neonatal service. The service provision differs between the 2 main sites. North Tees and Hartlepool (NTHFT) provide a consultant and midwifery led care service with a maternal medicine service and a level one special care unit neonatal service. South Tees (STHFT) is a tertiary unit for neonatal care offering a level three neonatal intensive unit service. The obstetric service provides a consultant and midwifery led care service, maternal and fetal medicine

1.Maternity services overview

The activity for the maternity service is outlined in table 1.

Table 1 – Maternity activity

	University Hospitals Tees	North Tees & Hartlepool		South Tees	
		North Tees	University Hospital Hartlepool	James Cook	Friarage
Bookings	2032	533	389	874	236
All Births	1817	658	<5	1125	32
Home birth	5	<5	NA	<5	NA
Elective LSCS	310	115	NA	195	NA
Induction of labour	1421	316	NA	1105	NA

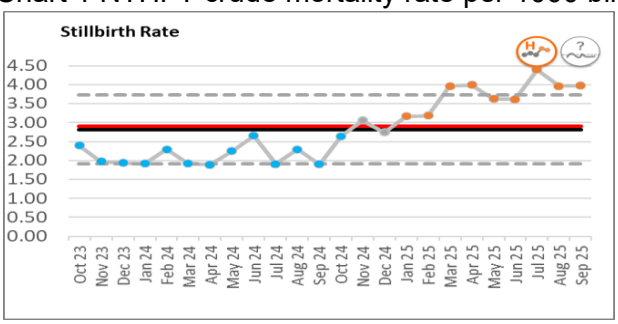
In May 2025, the intrapartum services provided by the Maternity Continuity of Care (MCoC) at University Hospital of Hartlepool (UHH) were temporarily suspended due to workforce challenges. A review is scheduled for January 2026. The Friarage Birth Centre experienced 12 service suspensions, with eight attributed to staffing shortages and high acuity at the

James Cook University Hospital (JCUH) site, and four due to staffing shortages at the Friarage Birth Centre.

2. Perinatal mortality rate

In quarter 2, the crude 12-month rolling annual stillbirth rate per 1000 births for NTHFT was 3.97 and STHFT rate was 3.52 (exclusive of medical termination of pregnancy). The crude12-month rolling neonatal death rate per 1000 births for NTHFT was 0.40 and STHFT was 1.32% (inclusive of early and late neonatal deaths) (Charts 1 and 2).

Chart 1 NTHFT crude mortality rate per 1000 births



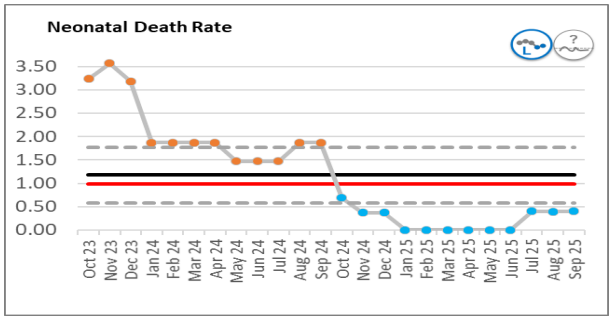
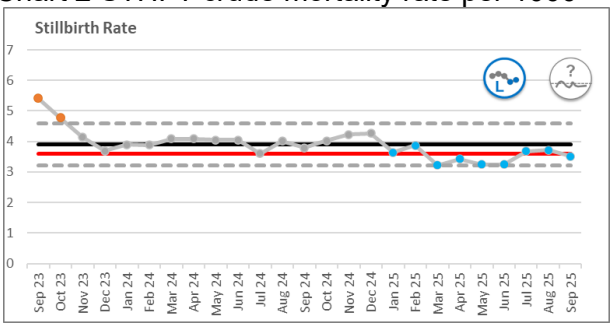
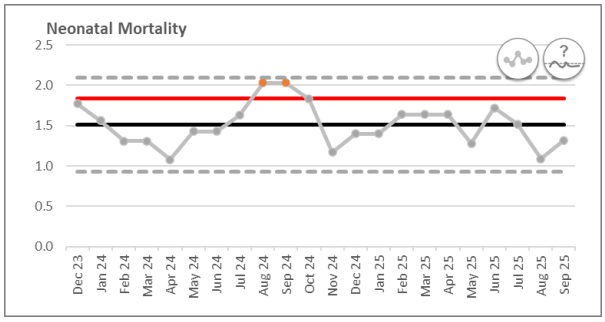


Chart 2 STHFT crude mortality rate per 1000





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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks' gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. The definition for Stillbirths is from 24 weeks. All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. On a monthly basis the number of cases and key learning points are reported to the Quality Committee and quarterly to the Group Board of Directors.

Learning from PMRT reviews in Quarter 2

Immediate learning is identified and acted upon pending completion of full PMRT reviews within the designated timeframe. Improvement plans have been established, with further details in the Quarter 2 perinatal morbidity and mortality report presented to the in-committee to protect patient confidentiality. Key learning points include:
Developing clear, accessible fetal medicine reports, distinct from routine scans and appointments.

Implementing digital communication for discharges across the group to prevent missed discharges.

3. Maternity and Neonatal Safety Investigation (MNSI)

MNSI teams conduct investigations per the Department of Health and Social Care's Maternity Case Directions (2018). Additionally, NHS Resolution's Early Notification (EN) scheme proactively investigates specific brain injuries to determine if negligence caused harm. Both MNSI and EN aim to identify learning, enhance transparency and candour, and address family needs in real time.

Reported and investigation progress update
University Hospitals Tees reported six events for MNSI triage, with fewer than five accepted. Reporting complies with Maternity Incentive Scheme Year 7 requirements. To minimise patient-identifiable details, limited information is included here, with a comprehensive report provided to the Group Board of Directors In-Committee.

Coroner Reg 28 made directly to the Trusts
No requests made in this reporting period.

4. Maternity and Neonatal events

All incidents graded as moderate harm or higher are reviewed at the trust's response-planning meeting, led by the patient safety operational lead and attended by the patient safety team. The total number and severity of reported events are detailed in Tables 2 and 3.

Table 2. Grading of events

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept	July	Aug	Sept
No Harm	169	115	145	76	45	61	93	70	84
Low Harm	84	60	67	23	19	23	61	41	44
Moderate and above	11	<5	8	11	<5	<5	0	<5	<5
PSII / MNSI	<5	0	<5	<5	0	0	<5	0	<5
Q2 Total	666			262			404		

Table 3.Moderate harm events

	University Hospitals Tees	North Tees & Hartlepool	South Tees
Postpartum Haemorrhage >1.5L	<5	0	<5
3/4th degree tear	<5	0	<5
Shoulder Dystocia	0	0	0

Readmission due to retained products and secondary PPH	0	0	0
Bladder injury at emergency Caesarean section	<5	0	<5
Admission to ITU	<5	<5	<5
Baby fall	<5	0	<5
HIE	<5	<5	<5
Eclamptic Fit	0	0	<5

Maternity and /or neonatal services suspension/divert/closure

North Tees and Hartlepool experienced one episode of high acuity that required the unit to go on divert for a short period of time, after mutual aid for elective work was unable to be supported by neighbouring trusts. No patients were diverted to surrounding maternity units during this period. No suspension/diverts or closures were experienced at South Tees.

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

North Tees and Hartlepool

Following a CQC review in October 2022, which rated Maternity Services as Requires Improvement, the service was enrolled in the Maternity Safety Support Programme (MSSP). The Trust is collaborating with Simon Mehigan, the designated Maternity Improvement Advisor. In May 2023, MSSP exit criteria were established by the Trust, Integrated Care Board (ICB), and NHS England, with an update in November 2023. The seven key elements are:

- Workforce
- Leadership
- Quality, Risk, and Safety
- Digital
- Improvement Plan
- Communications
- CQC

A July 2025 review by the Maternity Improvement Advisor confirmed significant progress, allowing the service to advance toward a sustainability phase. A follow-up meeting is planned before the end of Quarter 3 to assess the service's sustainability journey.

South Tees Hospitals

In April 2025, a diagnostic report on maternity culture prompted a rapid quality review, leading to the service's formal inclusion in the Maternity Services Safety Support Programme. The designated Maternity Improvement Advisor is focusing on the following themes from the initial report:

- Culture, leadership and governance
- Workforce development and efficiency

- Quality improvement and safety
- Communication, collaboration and experience

6. Three year delivery plan for maternity and neonatal services

The service continues to work towards requirements set out in the Maternity and Neonatal Three-year service delivery plan, with a 6 month review due at the end of quarter three. Governance is provided through the Perinatal Services Quality Assurance Committee and the Obstetric Directorate meetings.

7. NHS Resolution Maternity Incentive Scheme (MIS)

Both North Tees and Hartlepool and South Tees Hospitals have achieved full compliance with all ten safety actions of the NHS Resolution Maternity Incentive Scheme, marking a significant milestone for the teams involved. Year 7 of the scheme, launched on April 2, 2025, retains the ten safety actions with minor updates to the technical guidance. Four actions require external oversight for approval:

- Safety action 1 – MBRRACE-UK
- Safety action 2 - Maternity services Data Set (MSDS)
- Safety action 6 – Local Maternity and Neonatal System (LMNS) / ICB
- Safety action 10 – MNSI / EN/
- CQC sense check

Both services are on track for compliance with all ten safety actions in Quarter 2, as shown in Table 4. A RAGB (Red, Amber, Green, Blue) system is used to monitor progress at governance meetings

	Not started
	Partial compliance, work underway
	Compliant evidence not yet received
	Compliant evidence received

Table 4. MIS progress

Safety Action	NTHFT	comments	STHFT	comments
1				
2		Published result due 23rd October		Published result due 23rd October
3				
4				
5				
6		LMNS to confirm Q2 position		LMNS to confirm Q2 position

7				
8		Lower medical compliance. Action plan in place to achieve compliance		Lower medical compliance. Action plan in place to achieve compliance
9				
10				

8. Saving Babies Lives Care Bundle version 3.2

The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. In May 2025, NHSE published an updated version and monitoring towards compliance will be undertaken at Trust and ICB level. The quarter 2 position is to be reviewed by the LMNS in November for North Tees and December for South Tees.

9. Avoiding Term Admissions into Neonatal Unit (ATAIN) Rates

This is a programme of work to reduce avoidable admissions to a neonatal unit for infants born at term (over 37 weeks gestation) paralleled by reducing separation of mother and baby. The National ambition is a rate below 6%. The site service each have a quality improvement project to support a further reduction in ATAIN rates (table 5). Progress is reported at both Trust and ICB level.

Table 5. ATAIN quality improvement

North Tees & Hartlepool	
ATAIN rate July 4.8% August 5.3% September 6.7% Q2 = 5.6%	Quality improvement project: To reduce monthly term admissions by 1% • Teaching sessions commenced across labour and postnatal ward for intravenous antibiotic administration. • MDT review for respiratory admissions • Review of Tier 1 attendance at deliveries when escalated
South Tees	
ATAIN rate July 8.2% August 6.2% September 4.7% Q2 = 6.3%	Quality improvement project: Prevention and management of neonatal hypoglycaemia • Audit in progress • Teaching sessions and prompt aid commenced • Guideline review in progress

10. Transitional Care Service

The service continues to advance its action plan, previously approved by the Board of Directors, to provide transitional care for late preterm infants. An update will be included in the Quarter 3 report.

11. NENC Local Maternity and Neonatal System (LMNS)

Engagement with the LMNS contunies, sharing quality and safety intelligence that reaches regional oversight via:

- Quarter Perinatal Quality Surveillance Provider meeting

- LMNS Board
- LMNS Safety and Quality meeting
  LMNS Perinatal patient safety learning network

Quarter 2 Perinatal Quality Surveillance Provider meetings are scheduled for November 2025 for North Tees and Hartlepool and December 2025 for South Tees Hospitals.

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

In collaboration with the NENC Local Maternity and Neonatal System (LMNS), the service has developed a maternity training syllabus aligned with the Core Competency Framework v2 (CCFv2), promoting standardized training, service user involvement, and shared resources. Trust core 10 mandatory training compliance for obstetric and neonatal departments is detailed in Table 6, with ongoing monthly monitoring to support staff access to training.

MIS training compliance

STHFT have developed an action plan to support training compliance for the obstetric medical team. Following the August rotation, many resident doctors were out of compliance for STHFT and in response a training action plan was developed and is monitored monthly through local governance meetings.

Table 6. Perinatal workforce Trust Mandatory Core training

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept	July	Aug	Sept
Midwifery and support staff	85%	86%	85%	85%	86%	84%	84%	85%	83%
Medical (obstetrics/neonates)	85%	82%	89%	89%	88%	90%	81%	76%	75%
Neonatal Nursing and support staff	86%	90%	89%	93%	93%	95%	78%	87%	83%
Total	85%	86%	88%	89%	89%	90%	81%	82%	80%

Chart 3. NTHFT MIS training compliance

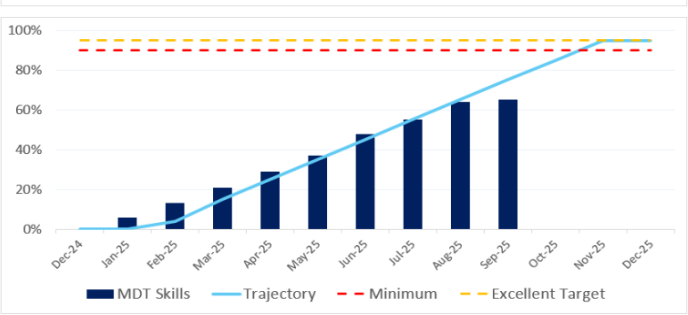
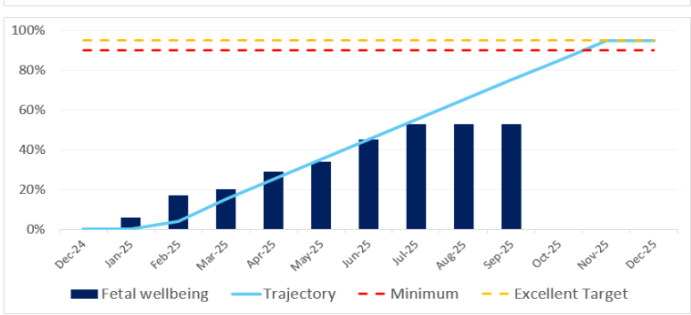
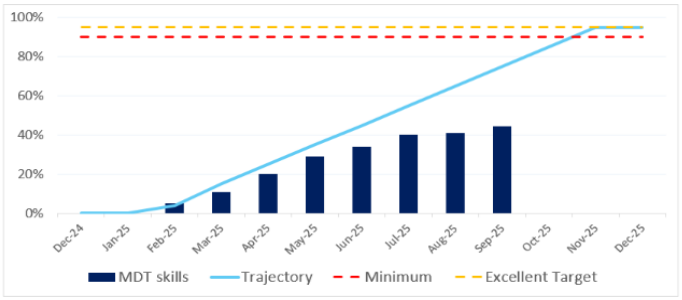
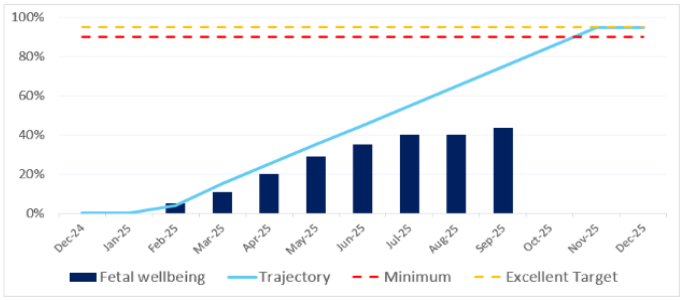


Chart 4. STHFT MIS training compliance







13. Insights from service users

Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in table 7 and table 8 formal complaints within quarter 2 related to:

- Care provided
- Lack of compassion
- Communication

The above has been communicated to maternity staff through mandatory training and ward meetings. Complaints are monitored via the trust complaints process.

Table 7. Complaints

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept	July	Aug	Sept
Stage 1	<5	11	7	<5	7	<5	<5	<5	5
Stage 2	0	0	<5	0	0	<5	0	0	<5
Stage 3	<5	0	<5	0	0	0	<5	0	<5
Total	8	11	13	<5	7	5	6	<5	8

Table 8. Compliments

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept	July	Aug	Sept
Communication	5	9	6	0	<5	0	5	7	6
Compassionate care	18	8	10	5	<5	<5	13	5	9
other	140	134	189	48	30	71	92	104	118
Total	163	151	205	53	35	72	110	116	133

13. Service user insights from Friends and Family Test (FFT)

The service continues to monitor friends and family test feedback, triangulating data with complaint themes. The latest results outlining positive feedback are presented in the table 9.

Table 9. FFT

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept	July	Aug	Sept
FFT %	85%	96%	95%	80%	100%	100%	90%	92%	90%

Trust Claims Scorecard

NHS resolution published the annual claims scorecard. The data was triangulated with local data to inform learning and if appropriate an action plan. The scorecard information for each service can be viewed in appendices 4 and 5.

Maternity and Neonatal Voice Partnership (MNVP)

In April 2025, Safety action 7 of the MIS year 7 requires trusts with an MNVP infrastructure in place, the MNVP chair to be a quorate member of the governance, quality and safety meetings. STHFT have an MNVP infrastructure in place however, the additional capacity required is not achievable nor sustainable. The concern has been escalated to the LMNS/ICB and in addition the Non-Executive Directors Maternity and Neonatal safety champions have written to the National and Regional maternity teams and NHS resolution.

North Tees and Hartlepool NHS Foundation Trust (NTHFT) appointed an MNVP lead in August 2025, who has made significant strides in developing a workplan, establishing a social media presence, and engaging with local stakeholders. The STHFT MNVP chair has provided support, with plans for further joint engagement. STHFT continues to advance projects focused on accessibility and bereavement support.

Service user insights taken from a recent CQC peer review

An update of progress towards the attainment of the CQC maternity survey for 2024 will be provided in the quarter three report.

14. Community midwifery services

Following the 2022 Ockenden report, the national target for Maternity Continuity of Carer (MCoC) was discontinued. At NTHFT, workforce challenges led to the suspension of the intrapartum service provided by the Rowan team in Hartlepool to ensure safe staffing levels. A workforce model review is underway, extending the suspension until January 2026. Similarly, STHFT disbanded its MCoC team, which offered antenatal and postnatal care, in June 2022 due to staffing pressures.

Enhanced Models of Maternity care (EMoMC)

Both NTHFT and STHFT offer tailored services for vulnerable women and families, supported by external funding. This funding has enabled the expansion of midwifery support, including roles like social prescribers. An outcome paper is being developed to demonstrate the impact of these specialised services.

15. Quality improvement and research

Research

NTHFT: The midwifery research team continue to recruit eligible women to several research studies. The team are the highest recruiting site for the iHOLDS Trial and the 3rd highest recruiter to the COPE trial.

STHFT: The service is currently involved in three research studies. The Obs UK obstetric bleeding study, INGR1D2 designed to identify infants with a genetic risk of type 1 diabetes and 'sonobreech' to determine the diagnostic accuracy of handheld ultrasound to determine fetal presentation.

Quality Improvement

NTHFT:

- PPH: Aim for major obstetric haemorrhage to less than 3.2% in line with the national average. The rates are showing continuous improvement.
- Each baby counts learn and support toolkit – to improve clinical escalation and in so doing so reduce incidence of intrapartum and neonatal morbidity. Diagnostics were ran as recommended by the RCOG toolkit to establish what the issues were. The staff survey around escalation was shared with the whole MDT. Following staff surveys the following working groups have been established to progress the project:
    - Working group to improving decision to birth for surgical to instrumental deliveries.
    - Working group established to look at a process for timely escalation.
    - Resources to identify and support team awareness of escalations.
- ATAIN – Data collection demonstrated a theme around less than 24 hours stay to reduce admissions. Work has been completed to support this including. IV antibiotics to be administered on the ward which is happening on ward 22 but to be rolled out on delivery suite. ANNP to be present at delivery within 5 minutes when baby is born in poor condition. Further data collection looking at respiratory admissions which are the leading cause for admission to establish if any improvements can be made.

- APGAR - data demonstrating this was a data entry error with regards to and work has begun to educate staff and the data continues to show improvement.
- Mechanical IOL – Patient feedback is positive and will be shared with staff. Delay in data collection due to sickness, with the expectation this will be completed by November.
- Implanon service - Now in a position to re commence this work as has been on hold due to tender.

STHFT:

- QI project to address compliance with booking by 9+6 weeks commenced in May 2025. Project improvement interventions are currently in progress.
- Prevention of neonatal hypoglycaemia commenced May 2025. PDSA cycles are being utilised to address six areas of focus with the aim for completion in January 2026.

Specialist Midwifery roles

A summary of the roles is provided in appendix 12. The Group service is collaborating with the ICB to fund a group service for Maternal Mental Health.

16. Culture and Leadership

Board level safety champion meetings

Board-level maternity safety champions serve as a link between the board and service-level champions. Both sites hold bi-monthly meetings at a minimum, with agendas covering national, regional, and system developments, alongside local feedback, performance, and service updates. Monthly perinatal walkabouts are conducted, with feedback shared across teams. Key insights from these walkabouts include:

North Tees & Hartlepool	
Areas visited: Delivery Suite UHH – Rowan suite	Feedback. Overall positive workarounds, good level of support identified by staff. Could be better use of support roles. Positive patient feedback. Frustrations around suspension of services at the Rowan suite though an understanding of reasons why to maintain safety.
South Tees	
Areas visited: Central delivery suite, Triage, Maternity Day Unit, Ward 19 and FHN birth centre	Feedback continued to centre around clinical environment and estate concerns with reference to upcoming changes on ward 16 to accommodate triage and the impact on the maternity outpatient clinic. Positive feedback was received about active birth workshops.

Perinatal Culture and Leadership Programme

The service has a perinatal leadership aligned to the 2 locations: NTHFT and STHFT. The culture improvement plan for the respective sites are monitored at the Safety Champion meetings, with escalation to Quality Committee. There are no escalations for the in quarter 2 position.

17. Risk register

There are twenty-three open risks across Maternity and Neonatal services, table 10 summaries the grading. In line with the Trust risk management process, risks raised by the service are developed by the service and are reviewed in the respective risk management and governance meetings.

Table 10 grading of risks

	North Tees & Hartlepool	**South Tees**

	Maternity	Neonates	Maternity	Neonates
High Graded risk	0	0	0	0
Moderate graded risk	3	0	11	4
Low graded risk	1	1	1	2
Very low graded risk	0	0	0	0
Within approval process	3	0	5	0

18. CQC action

Table 11 demonstrates the position for STHFT against the CQC must and should do's. The outstanding relate to estates, which are in progress.

Table 11. CQC actions progress

Maternity Actions	Total	Completed	In Progress
Must Do requirements	7	6	1
Should do recommendations	12	11	1

18. Key issues, updates, significant risks and mitigations

North Tees and Hartlepool

- Elective Caesarean Section Demand: Demand exceeds capacity. A time and motion study is planned to assess utilization, with an options paper to explore adding an additional weekly list.
- Consultant Antenatal Clinic Demand: Demand exceeds capacity. A working group is reviewing current practices and improvement opportunities. A pilot, supported by MDT and MIS funding, is proposed to increase capacity starting November/December 2025. Additional capacity is expected from January 2026 with the return of an obstetrician from maternity leave.
- Maternity Triage: A 24-hour triage service has launched, with an ongoing estates project to meet national standards. A workforce-proposed pilot will provide triage on the delivery suite to potentially reduce transfer delays from the current ground-floor location and optimize night shift staffing.

South Tees Hospitals

- Estates Issues: Challenges affecting patient flow and suitable environments for women and families are under review.
- Elective Caesarean Section Demand: Demand exceeds capacity. A business case has been prepared and will be submitted through appropriate governance channels.
- Consultant Antenatal Clinic Demand: A capacity and demand analysis is underway.

National/Regional/System updates

In September NHSE published the terms of reference for the national maternity and neonatal investigation. The interim report is expected in January 2026. UHT maternity and neonatal services are not one of the named fourteen Trusts included within the review.

The North East and Yorkshire regional midwifery team launched the Regional Heatmap tool to identify trusts early for support or intervention.

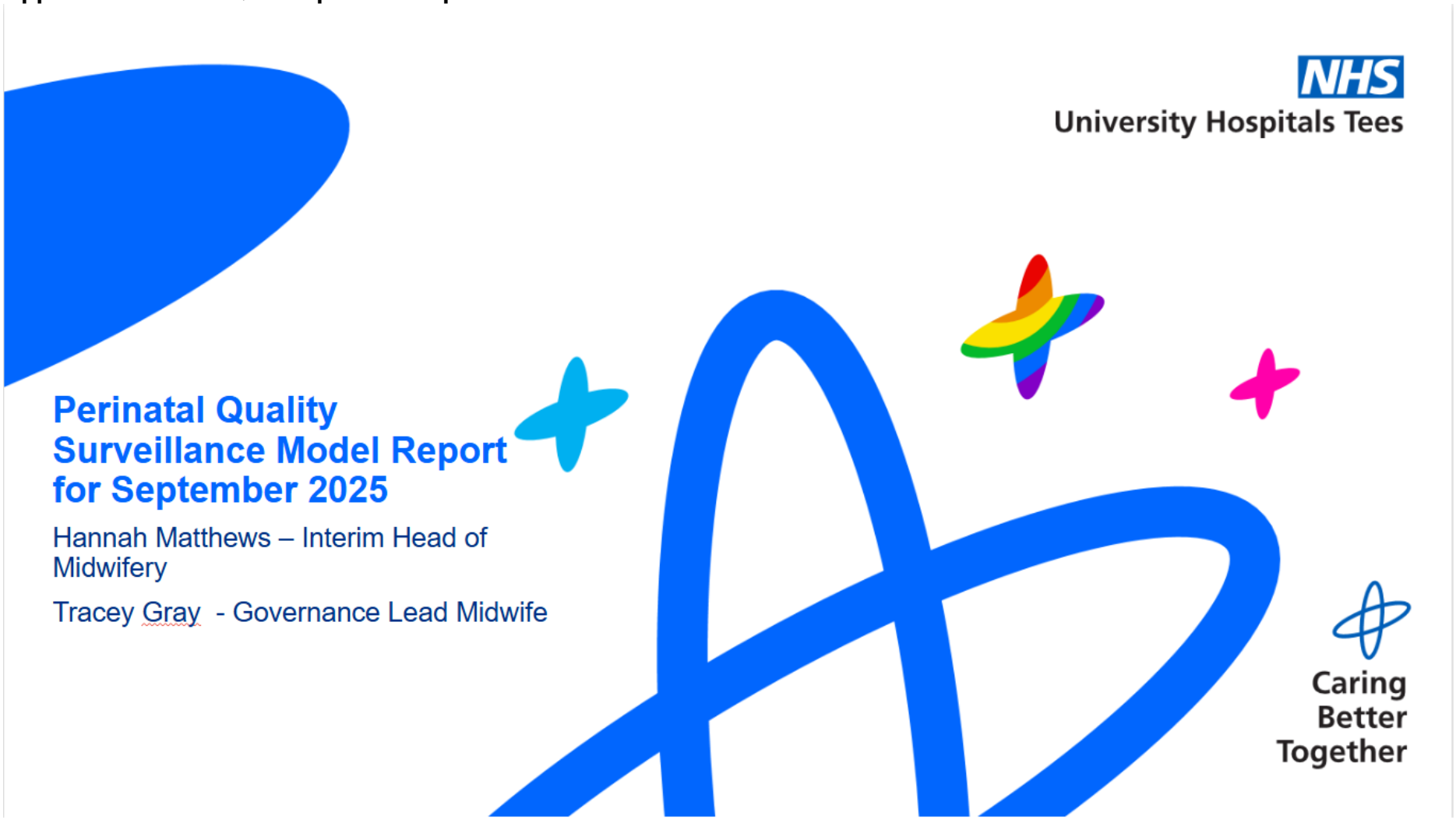
19. Assurance and Recommendations

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

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

Appendices
Appendix 1. PQOM September report
Appendix 2. PQOM dashboard NTHFT
Appendix 3. PQOM dashboard STHFT
Appendix 4. NTHFT NHSR claims scorecard
Appendix 5. STHFT NHSR claims scorecard
Appendix 6. UHT Specialist midwives summary

Appendix 1. UHT PQOM report for September



Key Performance Metrics

KPI	Unit	Standard	UHT			NTHFT			STHFT		
			Jul-25	Aug-25	Sep-25	Jul-25	Aug-25	Sep-25	Jul-25	Aug-25	Sep-25
Booking at 9+6	Percent	90%	63.86%	64.34%	65.15%	69.35%	64.87%	68.57%	60.10%	64.74%	62.20%
Smoking status at Booking	Percent	<10%	5.95%	8.87%	7.21%	4.96%	10.88%	9.84%	4.96%	7.23%	4.93%
Right Place of Birth	Percent	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births	Numeric		610	596	613	208	227	221	402	369	392
Preterm birth rate (22-36+6)	Percent	<7%	7.05%	9.23%	6.53%	3.85%	5.73%	6.33%	8.80%	11.50%	6.60%
Induction of Labour	Percent		48.33%	49.66%	46.59%	45.89%	48.00%	46.08%	49.62%	50.70%	46.88%
PPH >1.5L	Rate per 1000	31	23	22	25	19	13	18	25	28	29
3/4th degree tear	Percent	<3.5%	3.57%	2.29%	2.15%	8.91%	3.23%	0.99%	1.30%	1.78%	2.70%
Stillbirth rate	(12 mnth) Rate per 1000	North 2.91 South 3.60				4.40	3.97	3.97	3.68	3.72	3.52
Neonatal death rate	(12 mnth) Rate per 1000	North 0.99 South 1.84				0.40	0.40	0.40	1.52	1.09	1.32
Smoking status at Delivery	Percent	<6%	5.15%	6.67%	6.48%	7.66%	7.52%	5.96%	4.20%	6.13%	6.60%
Breastfeeding at first feed	Percent	74%	57.76%	56.59%	61.34%	49.51%	46.26%	47.51%	62.40%	63.45%	69.50%
VTE Score	Percent	95%	100%	100%	100%	100%	100%	100%	100%	100%	99%
ATAIN	Percent	6%				4.85%	5.73%	6.79%	8.20%	6.20%	4.70%
Apgar <7 at 5 mins	Rate per 1000	24	25	15	24	35	19	9	19	11	31
HIE Rate	12 mth - Rate per 1000					1.60	1.59	1.98	0.43	0.22	0.44

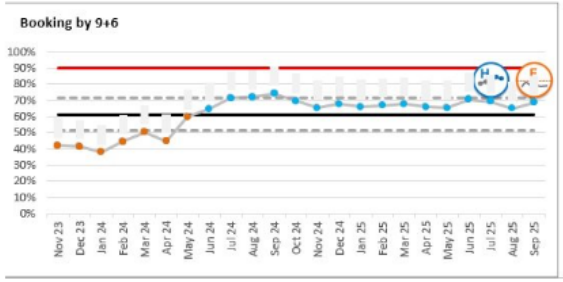
NB.
North Tees and Hartlepool provides a consultant and midwifery led care service with a maternal medicine service and a level one special care unit neonatal service. South Tees is a tertiary unit for neonatal care offering a level three neonatal intensive unit service. The obstetric service provides a consultant and midwifery led care service, maternal and fetal medicine

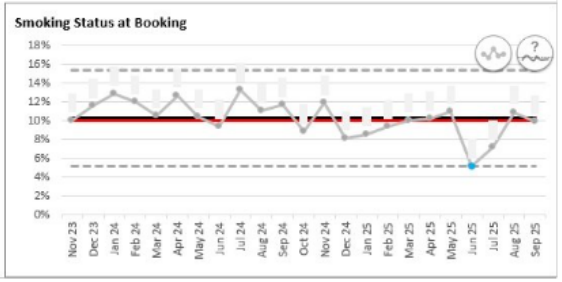
Caring Better Together

NTHFT KPI overview

3

Antenatal





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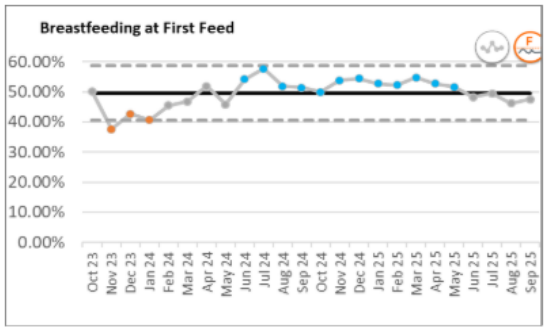

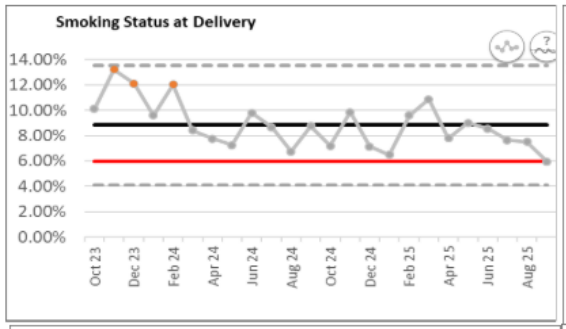

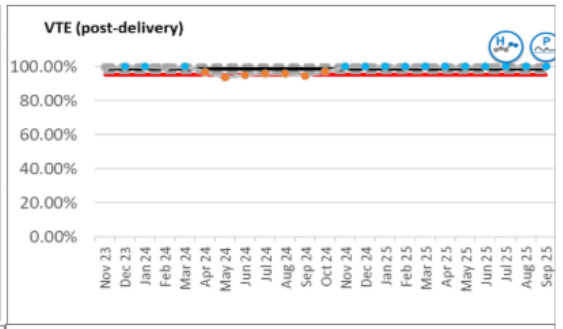

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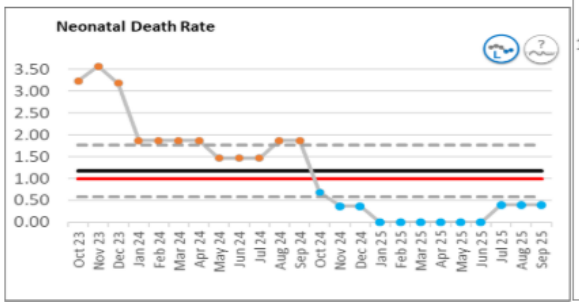
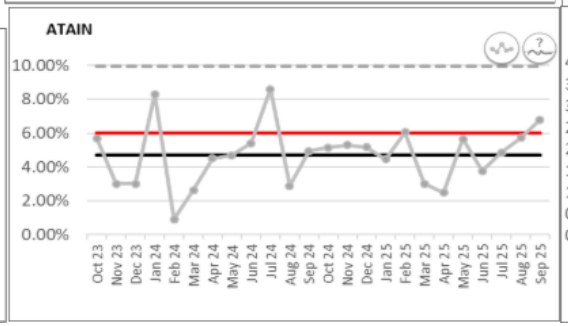
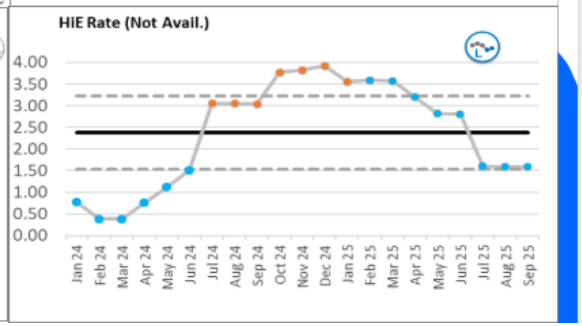
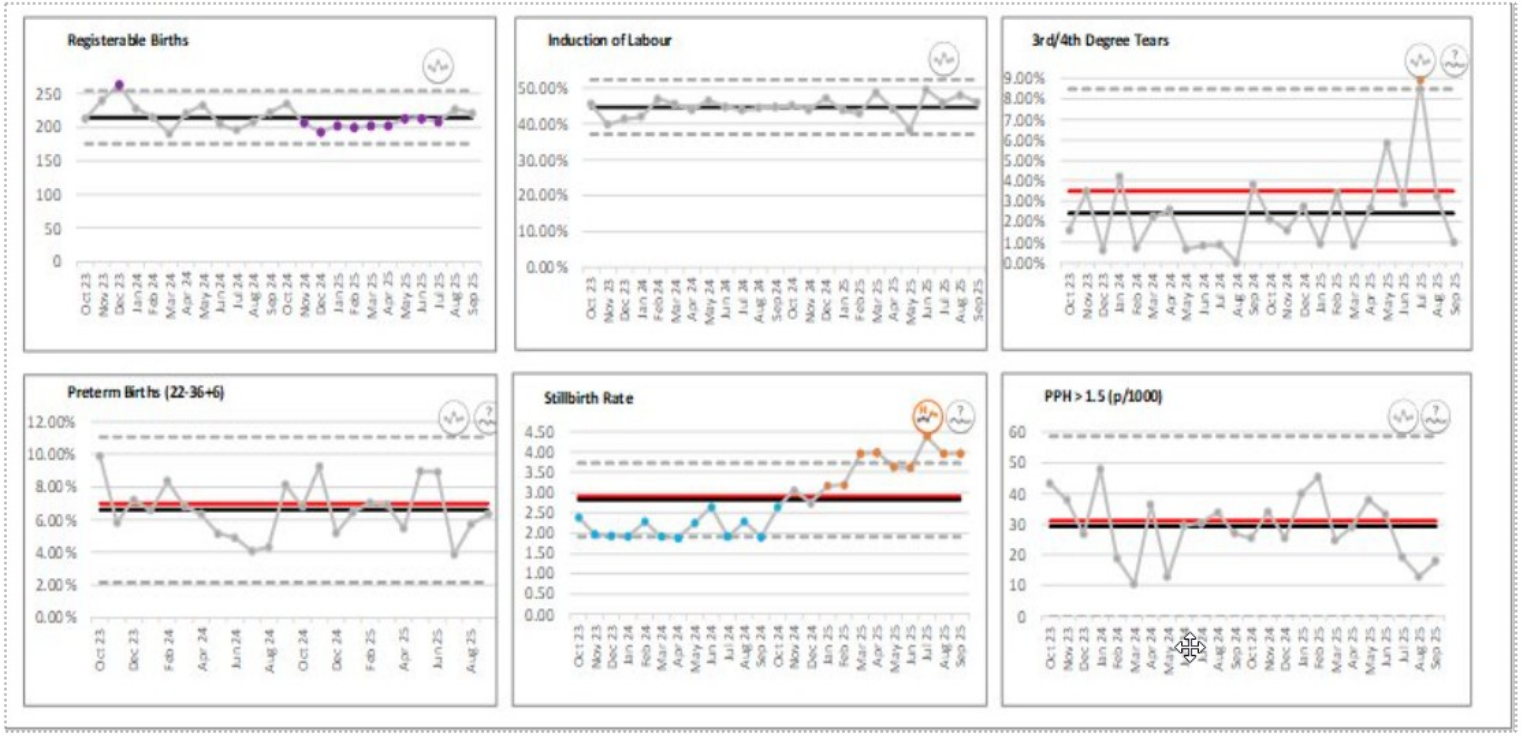






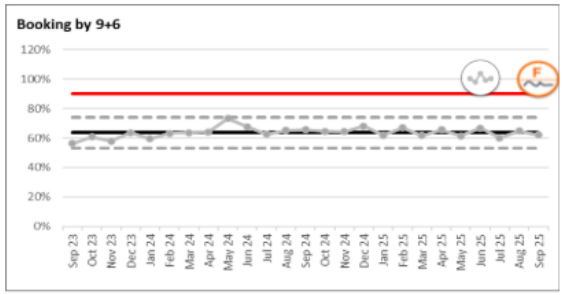
NTHFT KPI overview

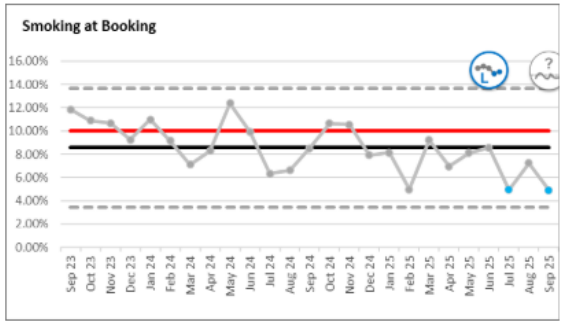
Birth



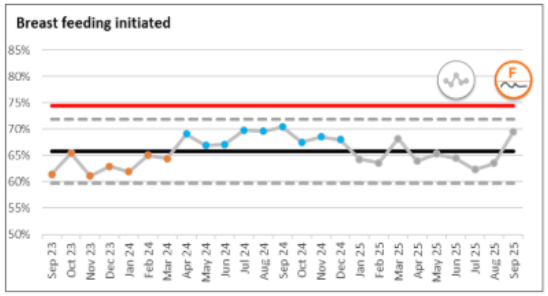
STHFT KPI overview

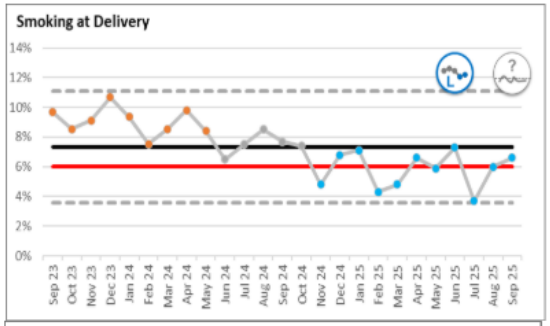
Antenatal

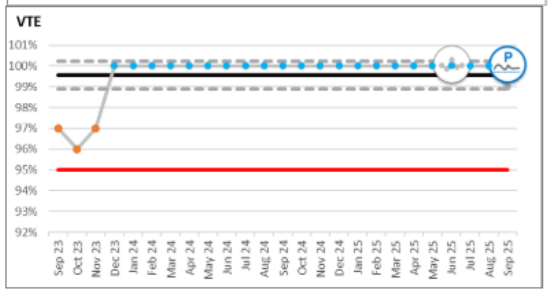




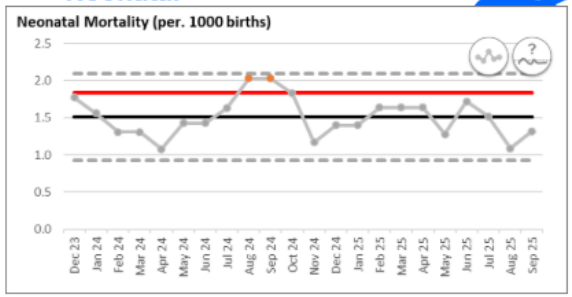
Postnatal

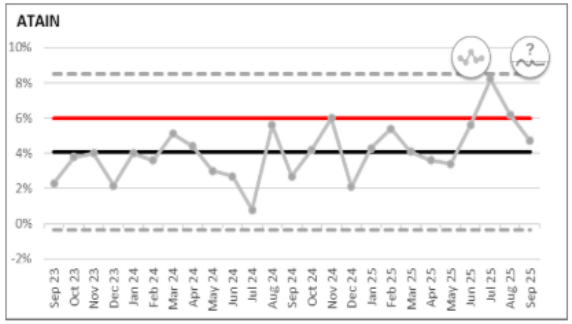






Neonatal





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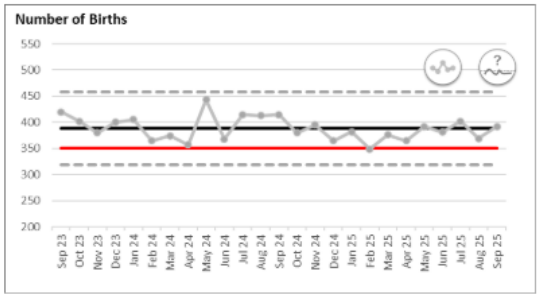
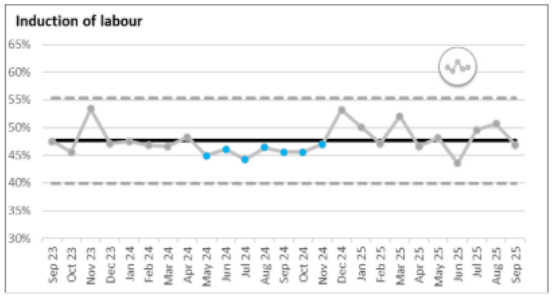
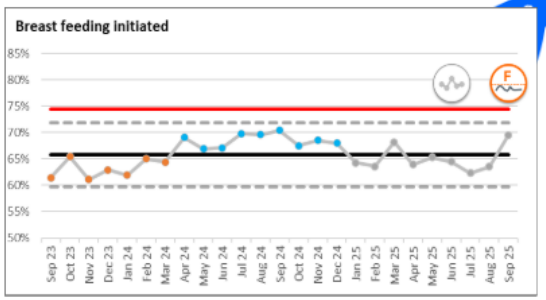
Caring Better Together

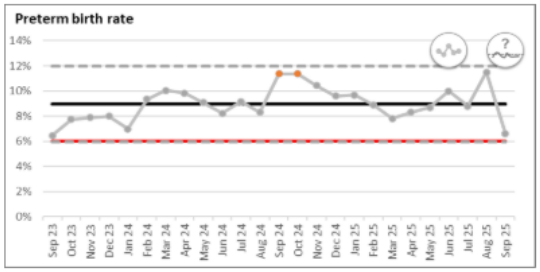
STHFT KPI overview

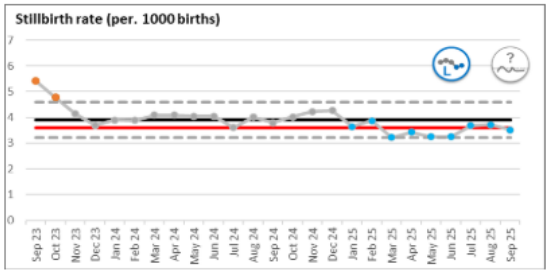
Birth

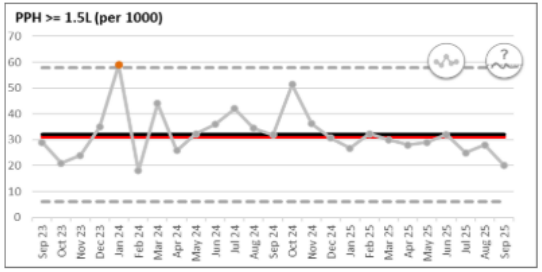


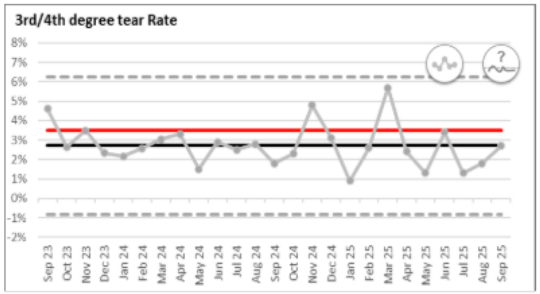












Caring Better Together

Insights for Safety, quality and learning

Theme	Insight	NTHFT	STHFT
Engagement	Friends & Family Test	100%	90.8%
	MNVP	New lead in post, commenced engagement with stakeholders, volunteers and service users. Workplan in progress – to be sent to LMNS board end of October.	New social media correspondent and equality and diversity sub-group chair have been recruited. Bereavement feedback event has been held and themes will be developed to provide a bereavement action plan
	Complaints	Stage 1 x 9 Stage 2 x 3 Stage 3 x 0. Themes remain communication and staff attitudes.	Stage 1 x 5 Stage 2 x 1 Stage 3 x 2. Themes are communication and place of birth
	Compliments	76	133
	FTSU	0 received	0 received
	Safety Champion engagement	Rowan Suite – Frustrations over current suspension but understanding of the quality and safety priority.	Ward 16, 19, triage and CDS- Feedback related to concerns around estate changes, lengthy procurement processes and the impact of support staff sickness on the service
	PCLP / SCORE Survey	Action plan developed and monitored via Board safety champion meeting	Action plan developed and monitored via Board safety champion meeting
	% midwives would recommend their Trust as a place to work or receive treatment	50% / 54%	60.5% / 70%
	%speciality trainees responding with excellent or good for clinical supervision out of hours	82%	86%
Safety and learning Regulatory	PMRT reportable and completed	0 Stillbirth reported. 0 Neonatal deaths reported	0 stillbirth and 2 neonatal deaths reported.
	MNSI / PSII	1 reported in month. 2 active MNSI/ 1 active PSII	1 eligible MNSI case parents declined consent for investigation, 0 reported in month. 2 active MNSI
	Moderate events	2	5 moderate events, 1 severe
	NHSR claims scorecard	Not reviewed in month	Not reviewed in month
	MIS compliance	On track	On track
	CQC rating & actions	Requires Improvement. Actions completed.	Require Improvement. 2 outstanding actions, estates related.
	MSSP	Commenced November 2022	Commenced May 2025
	Coroners Reg 28 request	NA	NA
	Safety signals	Stillbirth rate. External review in progress. HIE – Ongoing review in coordination with the LMNS.	NA
	Quality Improvement	PPH, ATAIN, APGAR Score	PPH, ATAIN

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Midwifery Workforce

Midwifery Establishment

	NTHFT					STHFT				
Budget	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (July 2025)	Projected 6 month (Oct 2025)	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (Dec 2025)	Projected 6 month (Mar 2026)
B5/B6 RN's/RM's	107.27	101.32 (98.14)	-5.95 (-9.13)	+1.69 (-5.11)	+5.15 (-3.65)	174.68	173.43	-1.25	175.82	175.82
B7 Clinical and Specialist Midwives	29.42	27.74 (26.74)	-1.68 (-2.68)	+0.16	+0.16	38.32	41.57	3.25	43.72	43.72
Grand Total	136.69	129.06 (124.88)	-7.63 (-11.81)	+1.85 (-4.95)	+5.31 (-3.49)	213.00	215.00	2.00	219.54	219.54

Workforce safe staffing metrics	NTHFT	STHFT
Obstetric labour ward cover	100%	100%
LWC Supernumerary LWC supernumerary start of shift	94% 100%	100% 100%
1-1 care in labour	100%	100%
Midwife to Birth ratio	1: 21	1:21
Registered midwife fill rate	83%	99%
BAPM compliance	95%	71%
Trust Core 10 (all staff)	87.15%	82.4%

(***) data includes maternity leave

Red Flags	NTHFT	STHFT	comments
1-1 care in labour	100%	100%	
Delay in IOL	3	12	
Time critical	9	16	NTHFT & STHFT - Awaiting regional prioritisation tool
Missed or delayed care	7	1	
Delays in Triage	0	0	

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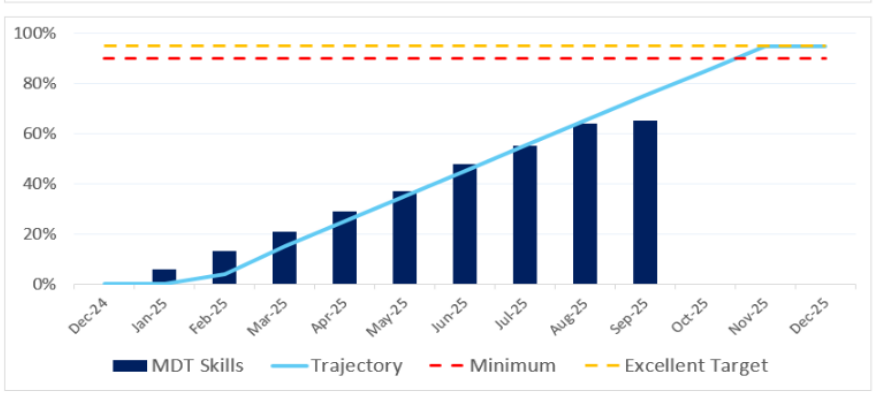
MIS training compliance

Chart 3. NTHFT MIS training compliance



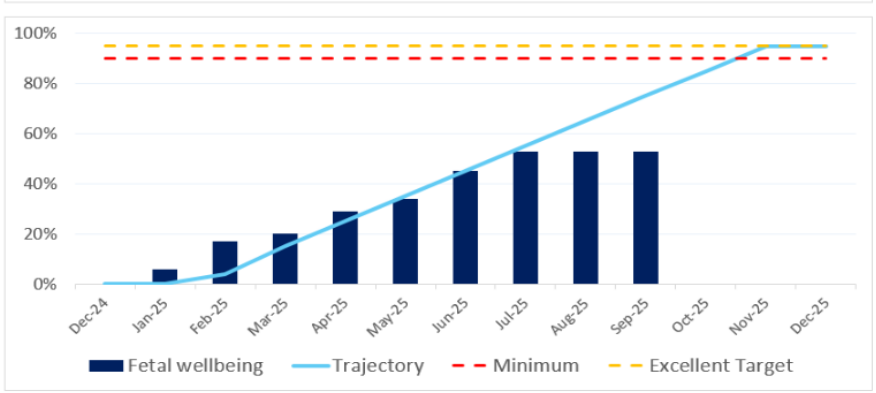
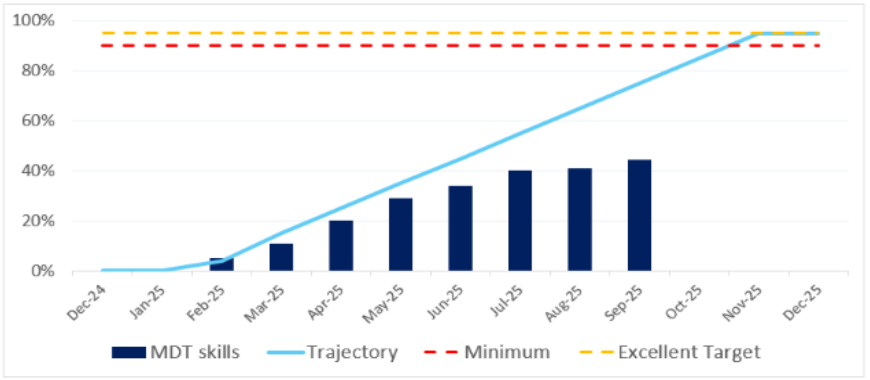
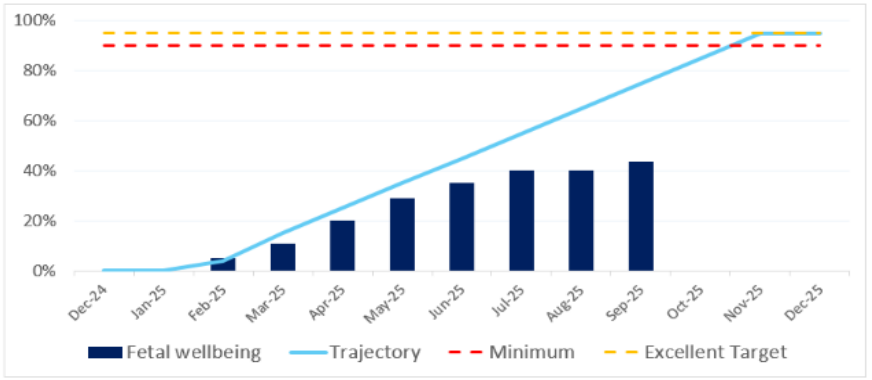


Chart 4. STHFT MIS training compliance





Key Updates

NTHFT

- Continue to work towards MIS SA8 Training compliance. September has seen a drop in compliance, with a robust action plan in place.
- Midwifery workforce staffing establishment utilising BirthRate+ tool in progress

STHFT

- Continue to work towards MIS SA8 Training compliance. September has seen a drop in compliance, with a robust action plan in place.
- Midwifery workforce staffing establishment utilising BirthRate+ tool in progress

National, Regional, System

- National maternity and neonatal investigation review published the terms of reference and named the 14 trusts included in the review.
- Maternity Outcomes Safety Signal (MOSS) live dashboard to be launched in November
- NEY heatmap launched in September:
  - Regional analytical tool that triangulates national and regional intelligence from a range of data sources.
  - Enables regional monthly oversight of the triangulated data and then scores each element to read the signs of trusts that require additional early intervention and support.
  - Enables systems to use the information to direct quality improvement work programmes and resources to the right areas.
  - Aligns to the Perinatal Quality Oversight Model (PQOM) and 3-year Maternity Single Delivery Plan (3YSDP) to support delivery of the national priorities

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Appendix 2. NTHFT PQOM dashboard

CQC Maternity Ratings RI	Effective: RI		Caring: Good		Well-Led: RI		Responsive: RI		Safe: RI		MSSP: YES	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	NA	I learning point	4 learning points	NA	NA						
2. Findings of review of all cases eligible for referral to MNSI	NA	3 reports - 10 actions	NA	NA	NA	1 report – 1 action						
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	<5	<5	<5	<5	<5	<5						
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	94%	94%	83%		95%	69%						
	95%	92%	93%		89%	56%						
2c. Minimum safe staffing in maternity services to include **Obstetric cover** on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively **(midwife V birth ratio, 1:19**)	100%	100%	100%	100%	100%	100%						
	1:18.4	1:25	1:19.7	1:19.7	1:19.9	1:21						
3.Service User Voice Feedback – positive %	100%	100%	80%	80%	100%	100%						
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Ward 22	Ward 22	SCBU	MDAU	DS	HPL						
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA	NA	NA	NA						
6.Coroner Reg 28 made directly to Trust	No	No	No	No	No	No						
7.Progress in achievement of CNST 10	Yr 7 - In progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress						
% midwives would recommend their Trust as a place to work or receive treatment 54%												
%speciality trainees responding with excellent or good for clinical supervision out of hours 70%												

Appendix 3. STHFT PQOM dashboard

CQC Maternity Ratings RI	Effective: Good		Caring: Good		Well-Led: RI		Responsive: RI		Safe: RI		MSSP: YES	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	2 learning point	1 learning point	1 learning point	NA	NA						
2. Findings of review of all cases eligible for referral to MNSI	NA	NA	NA	NA	NA	NA						
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	0	<5	<5	0	0	6						
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	78%	88%	88%	87%	79%	79%						
	83%	94%	95%	77%	77%	77%						
2c. Minimum safe staffing in maternity services to include **Obstetric cover** on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively **(midwife V birth ratio, 1:19**)	100%	100%	100%	100%	100%	100%						
	1:19.3	1:21.8	1:21.4	1:22	1:22	1:21						
3.Service User Voice Feedback – positive %	92.8%	92.5%	93.5%	91%	91%	90%						
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Inpatient maternity	Neonatal unit	Inpatient maternity	CDS & NNU	FHN centre	Inpatient maternity						
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA	NA	NA	NA						
6.Coroner Reg 28 made directly to Trust	No	No	No	No	No	No						
7.Progress in achievement of CNST 10	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress						

% midwives would recommend their Trust as a place to work or receive treatment 70%
%speciality trainees responding with excellent or good for clinical supervision out of hours 86%

Appendix 4. NTHFT NHSR claims scorecard

Claims Scorecard (10 years of claims) Quarter 2 2025 (July August September)

Top injuries by volume: • Stillborn (5) • Atdnl / Unnecessary operations (4) • Brain Damage (3) • Fatality (2) • Thrombosis/Embolism(2)	**Top injuries by value:** • Brain damage (3) • Cerebral Palsy (1) • Erbs's Palsy (1) • Fatality (1) • Bowel Injury (1)
Top causes by volume: • Fail/delay in treatment (7) • Fail to make resp to abnrm FHR (4) • Repeat attempt at forceps (2) • Fail to recognise. Complication of (2) • Fail to diagnose Pre-eclampsia ((2)	**Top causes by value:** • Fail/Delay in treatment (7) • Fail /Delay Admitting to hospital () • Birth Defects (1) • Inhosp Maternal Death post PPH () • Repeat attempt Forcep/Ventouse

Complaints Q2 25-26

Communication – staff attitude
Care Provided – related to decision making
Care related on the postnatal ward
Communication – decision related to
Disjointed appointments

Incidents Q2 25-26

PPH > 1.5litres (3&4th Degree Tears)
Timing of C sections
Apgars <6 at 6 minutes
Term admissions (Rolling increase in HIE)
Escalation (Staffing Issues) impacting on service provision

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS
North Tees and Hartlepool
NHS Foundation Trust

Themes Q2 25-26

- Escalation both staffing and escalation of care
- Communication
- Management of the perineum
- HIE

Learning Q2 25-26

Review of the recording of Apgar at time of birth
Effective communication between teams
Management of perineum
Escalation of CTG concerns

Action Plan Q2 25-26 Not started | In progress | Completed

Integration of data that is sent externally ((Namely HIE development of action plan)	By 30.9.25 (HM)
Review of the previous years complaints to identify any themes (Introduction of 24 hour triage)	30.09.25 (AS)
External Review of stillbirth Data	31.09.25 (AS)
Apgar Audit / CTG	31.03.25 (AST)
Implementation of Pelvic Health service (Include training re : management of perineum)	30.09.25 (KN)

Appendix 5. STHFT NHSR claims scorecard

Claims Scorecard (10 years of claims) Quarter 2 2025 (July Aug Sept)

Top injuries by volume: • Stillborn (7) • Loss of baby (7) • Adtnl/unnecessary operations (7) • Unnecessary pain (7) • Fatality (5)	**Top injuries by value:** • Brain damage (3) • Cerebral Palsy (4) • Psychiatric/psychological dmge (4) • Wrongful birth (1) • Erbs's Palsy (5)
Top causes by volume: • Fail/delay in treatment (23) • Intra-op problems (5) • Forceps delivery(4) • Fail to warn-informed consent (4) • Unexpected Death (3)	**Top causes by value:** • Fail /Delay in treatment (23) • Fail to warn-informed consent (4) • Delay in performing operation (2) • Fail to inform test results (1) • Fail to recog. Complication of (2)

Complaints Q2 25-26

Place of Birth
Communication – Lack of effective communication
Care provided – Infection control
Care provided –Pain management
Care provided- Bereavement

Incidents Q2 25-26

Term admissions to NNU over 37 weeks
Postnatal readmission
Apgars less than 7 at 5 minutes
Failure to follow local protocol
Failure to follow protocol-antenatal

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes Q2 25-26

- Postnatal readmission
- Apgars less than 7 at 5 minutes
- 3rd/4th degree tears
- Trust processes

Learning Q2 25-26

Management of readmission for RPOC, hypertension and infection
Management of perineum
Fresh eyes
Use of oxytocin

Action Plan Q2 24-25 Not started | In progress | Completed

Review of postnatal readmissions	By 30.9.25 (JL)	
Review of ATAIN cases	By 31.11.25 (TG)	
OASI care bundle relaunch	30.11.25 (RK)	
Review PPH cases	30.06.25 (SL)	

Appendix 6. Specialist Midwives summary

Specialist role	North Tees & Hartlepool	South Tees
Preterm birth	Detection of issues relating to data collection in relation to preterm optimisation. Progesterone 200mg at night to be offered to all women who have previously had a spontaneous preterm birth prior to 34 weeks. Actim Partus test now available.	Recent achievements include the introduction of midwife led postnatal debrief clinics for women who deliver before 34 weeks and sustained improvements for preterm early maternal breastmilk. The service has also recently increased the preterm birth midwife hours in line with funding received
Diabetes	N/A	1.64 WTE midwives in post for diabetes, currently managing care for women with gestational diabetes within MDT diabetes clinics.
Birth reflections	Birth Reflections had a soft re-launch in July. This involved meeting with Communications to share information on social media. New format designed for our information poster and staff newsletter. Gone live with an online referral form and QR stickers on 'Red Book' to encourage women to self-refer to reduce DNAs.	Currently there are 12 midwife hours per week allocated to this – 6 are externally funded. Birth Reflection clinics are currently at capacity.
Bereavement	Following a QI project completed in Scotland whereby they reduced their stillbirth rate by 45% a GAP analysis has been completed of our AN care provision, taking into consideration our smoking cessation provision, risk assessments for pre-eclampsia and aspirin, SGA detection and fetal movement education. Liaised with MNVP lead and completed some videos for social media to discuss bereavement support.	Bereavement spoke placement introduced for midwifery students. Training of 30 staff in postmortem and tissue sampling consent. Recruitment of band 4 bereavement counsellor/support worker funded for 12 months
Fetal wellbeing	Use of new LMNS SBL fetal monitoring review tool, learning identified via SEPIS model, hourly risk assessment undertaken 92% cases, hourly peer review undertaken in 95% of cases. Main themes of learning included; CTG not photographed from time in theatre to birth, obstetric documentation and clinical narrative, significantly improved midwifery documentation and clinical narrative, clear escalation and professional conflict discussions documented. All of these addressed via action plan, and learning shared in multiple platforms. Monthly oversight of all ATAIN/APGAR/Low cord pH/HIE cases via systematic audit process. MDT work to gain oversight and understanding of decision to birth interval and share learning weekly with MDT. This quatre I have had an increase in staff,	New LMNS saving babies lives process for audit in progress. 100% pass rate for competency assessment last quarter.

	both midwifery and medical asking me to review cases with them to widen their understanding, discuss the management of them.	
Recruitment & Retention	Supported all three internationally educated midwives out of supernumerary and onto the preceptorship programme. Organised and facilitated induction for 6 new band 5 midwives. Held successful team building/staff wellbeing event at Tees Barrage. Supported midwives returning to work after maternity leave and career breaks. Continued to focus on retention of staff through offering pastoral support.	Band 3 posts recruited to for the antenatal clinic. Challenges surrounding lack of midwifery hours to recruit to for new students
Practice Placement Facilitator	Continues to support students as they come through placements, new cohort of 1st year students starting soon. 3rd year students waiting to qualify and ongoing recruitment discussions.	Student padlet introduced to replace student boards in clinical areas, This includes lots of useful information and celebrates student achievements. Prep for review 2 sessions (one to one) in collaboration with HEI's identifies any cause for concern early and enables individualised programme planning. Reintroduced practice assessor/supervisor session into MMT
Digital	Implemented appointment books in BadgerNet for post natal appointments which enables oversight of postnatal workload. Data collection completed for Birthrate plus and working in collaboration with STees at producing a clinical safety case for BadgerNet Maternity.	Collaborative group working in progress to develop hazard log for digital. Clinical safety officer training completed to ensure there is a CSO for maternity systems. The service has volunteered to be early adopters of MEWS and NEWTT2.
Practice development Midwife / Clinical educator	Continuing to work towards MIS targets via mandatory training, whilst facilitating additional training to ensure that staff are confident and continue to work in a safe environment. We are also working on training passports for midwives to be rolled out in quarter 3.	Training compliance in target this quarter, new LMNS MMT programme in place. Practice Development Midwife on secondment currently working one day a week
Public Health	N/A	Poverty proofing conference attended and demonstrated areas of improvement. Conference highlighted lack of sustainability with this as services such as vulnerabilities team and bereavement counsellor are externally funded on a short-term basis.

Maternal mental Health	N/A	Continuing funding sourced for mental health midwife for women in Teesside, this does not cover North Yorkshire. Challenges associated with clinic capacity in which to provide care.
Infant Feeding	Unicef BFI assessment stage 2 completed in July with 2 standards to reassess internally in November. Plan in place to address uplift in the weaker areas of staff skill and knowledge. Documentation audit completed in August which highlights gaps in antenatal conversations, skin to skin contact and first feeds. Action plan completed to increase awareness and support increasing initiation.	BFI accreditation achieved last quarter. Working towards compliance for 2-day infant feeding training for staff

University Hospitals Tees

Perinatal Staffing Report: Quarter 2, 2025/26

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 5.2.2

Report author: Stephanie Worn; Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Services Quality Assurance Council and Perinatal Leadership Team meeting and Quality Oversight Group

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.

The maternity services for North Tees and Hartlepool and South Tees are having the recommended three year BirthRate+ reassessments undertaken. The report is expected in November. Each service is compliant for the perinatal workforce roles for preterm birth and fetal wellbeing.

The consultant obstetric medical workforce for North Tees and Hartlepool is in a recruitment process. Both North Tees and south tees employ locums and are compliant with Royal college of Gynaecology and Obstetrics locum audit.

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

Across the maternity service, there has been 14wte newly qualified midwives' employed.

Recommendations:

The Bord of Directors are asked to receive and note the content of the report.

University Hospitals Tees
Perinatal Staffing Report
Quarter 2, 2025/26

PURPOSE OF REPORT

The purpose of the report is to inform and provide assurance to the Group Board of Directors that there is an effective system for monitoring safety staffing within the maternity service.

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements. Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided.

2.Minimum safe staffing maternity services

Safe Maternity Staffing Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. In addition, the final Ockenden report (2022) states minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the Local Maternity and Neonatal System (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational MIS and CQC requirements.

3.Midwifery staffing

The midwifery service is compliant with the recommended funded midwifery establishment by BirthRate+ for North Tees and Hartlepool and South Tees Hospitals (Table 1). The percentage of specialist and, management is 11.7% for NTHFT. The percentage of specialist and management is 10.6% for STHFT. Appendix 1 outlines the actions and mitigations to minimise risks when the staffing levels are below template. The registered midwifery (RM) vacancy position at the end of quarter 2 is shown in table 2, and the rates are in table 3. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). In the event of a red flag (table 4), the labour ward co-ordinator along

with the obstetric consultant determines the appropriate action to maintain safety; clinical and management (appendix1, 2 and 3).

Perinatal staffing levels, including midwifery, nursing and medical as well as activity are monitored and reviewed through daily safety huddles, during which staff discuss current workload, patient acuity and staffing allocations. These huddles provide an opportunity for the team to identify potential risks, escalate concerns and implement appropriate actions to maintain safe staffing and quality care.

Table 1 Birthrate+ recommendations

	North Tees & Hartlepool	South Tees
Recommended establish received	January 2023	October 2022
Midwife to Birth ratio	1:19.5	1:22.6
Recommended funded establishment. Clinical and non-clinical	142.75	236.16

Table 2 Midwifery vacancy position (clinical)

	North Tees and Hartlepool						South Tees					
	Budget	July	Aug	Sept	**3month forecast**	**6month forecast**	**Budget**	July	Aug	Sept	**3month forecast**	**6month forecast**
B5/6	107.3	99.76	102.1	101.3	108.9	112.45	174.68	176.15	174.71	173.43	175.82	175.82
B7 incl Specialist	29.42	29.34	28.22	27.7	29.58	29.58	38.32	41.34	41.57	41.57	43.72	43.72
Total	**136.69**	**129.9**	**130.32**	**129.1**	**138.48**	**142.03**	**213.0**	**217.49**	**216.28**	**215.00**	**219.54**	**219.54**

Table 3. Midwifery fill rates

	North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept
Sickness rate	8.89%	8.07%	9.45%			
Maternity Leave rate (WTE)	3.96	5.72	4.72			
RM fill rate %	87%	83%	81%	102%	102%	99%
Midwife to birth ratio	1:19.7	1:19.9	1:21	1:22	1:20	1:21

Table 4 Red flags

	North Tees & Hartlepool			South Tees		
	July	Aug	Sept	July	Aug	Sept
Delayed or cancelled time critical activity	3	6	9	40	35	16
Delay between admission for induction and beginning of process.	0	0	3	28	22	12
Labour Ward Coordinator (LWC) not supernumerary.	0	0	1	0	0	0
One - one care in active labour	0	0	0	0	0	0
Delay in Triage	0	0	0	0	0	0

Missed or delayed care	7	0	7	0	0	1

Supernumerary Labour Ward Co-ordinator (LWC)

Availability of a supernumerary LWC is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. For the purpose of Maternity Incentive Scheme year 7, the LWC is to have supernumerary status at the start of every shift (table 5).

Table 5. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance North Tees and Hartlepool	Compliance South Tees
July	31	62	100%	100%
August	31	62	100%	100%
September	30	60	100%	100%

One to One in Established Labour

1:1 care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour” (NICE 2015). During this reporting period there were no occasions when 1:1 care was recorded as not being provided (table 6).

Table 6. 1-1 care in labour compliance

	July	Aug	Sept
North Tees	100%	100%	100%
South Tees	100%	100%	100%

4.Obstetric staffing

North Tees & Hartlepool

The service is at full establishment at consultant grade for Obstetrics and Gynaecology. The pressures within the consultant workforce relate to cover for the emergency work within obstetrics due to long term sickness absence, occupational health recommendations and maternity leave. This has resulted in the requirement for additional cover for one third of the emergency obstetrics and on-call sessions. The has been covered by the existing consultant workforce. Recruitment to a new consultant post advertised in quarter 2 was not successful and the recruitment plan is being reviewed. The department has not recruited any long-term locum consultants during 2025.

The departmental clinical session timetable ensures compliance with the compensatory rest recommendations with no clinical work scheduled for the day after a night on-call. There is a weekly safe staffing meeting coordinated by the operational manager, clinical director, rota administration team and the specialty training lead, to ensure safe medical staffing and to enable a schedule that meets the training needs of the resident doctors in the department. The departmental support for enhancing perinatal medical leadership has continued with job planned dedicated time for the preterm birth and fetal wellbeing consultant lead roles in place, in addition to the consultant lead for obstetrics and consultant lead for neonatology posts.

The quarter 2 sickness rate for medical staff in Obstetrics and Gynaecology was 8.27%. The Royal College of Obstetricians and Gynaecologists has published recommendations on standards when recruiting short term (less than 2 weeks) middle grade locum doctors. A six-month audit from February to July 2025 has reported 100% compliance (Appendix 5). There is on-going monitoring of consultant attendance for obstetric emergencies to ensure appropriate consultant attendance for complex obstetric emergency care in line with the national recommendations of Royal College of Obstetrics and Gynaecology. The quarter 2 audit demonstrates 100% compliance.

South Tees Hospitals
The service meets full requirement established at consultant grade. There has been some pressure within the consultant workforce since August, available for on call and elective obstetric work due to occupational health requirements and sabbatical leave.

This has led to 2 rota gaps in the consultant rota. The department has successfully recruited one Locum Consultant from April filling a vacant post from January. This post holder has increased his PAs from 7 to 10 from October to help with the vacant shifts.

In addition to this the existing Consultant workforce will be undertaking additional shifts to mitigate the current gaps in the rota. Another locum post has been advertised, and 2 eligible applicants have been shortlisted. Weekly obstetrics and gynaecology staffing is coordinated by the rota Consultant Rota Lead, rota administration team and the College tutor to ensure safe staffing and meeting the training needs of the doctors in training in the department. There is an emergency rota cover contact every day for resident doctor sickness and absence, reflected on the Medi rota.

There are twice daily multidisciplinary team handovers of care for obstetrics and twice daily consultant led multidisciplinary ward rounds taking place. There is on-going monitoring of consultant attendance for obstetric emergencies to ensure appropriate consultant attendance for complex obstetric emergency care in line with the national recommendations of Royal College of Obstetrics and Gynaecology. The quarter 2 audit demonstrates 100% compliance. The departmental support for enhancing perinatal medical leadership has continued with job planned dedicated time for the preterm birth and fetal monitoring consultant lead roles in place.

5.Neonatal nurse staffing

North Tees and Hartlepool
The staffing compliance rate over quarter 2 was 96 % in comparison to the national average for the quarter of 87% for SCBUs. The service used the National neonatal workforce calculator tool and have developed an action plan shared with the Neonatal Operational Delivery Network previously agreed by the Board of directors in quarter 1. Compliance is managed through escalation of additional shifts paid via NHSP and overtime in times of increased occupancy and acuity. During this period the occupancy rate in the unit has been lower than previous years over the last 2 quarter and a decrease in acuity in July and august which has impacted positively on the compliance rate. Qualification in Speciality (QIS) qualified staff decreased to 91% due to two new starters in this quarter but remains well above the national standard of 70% of registered nurses with QIS qualification. The neonatal nurse workforce has a nominated lead for preterm birth.

South Tees Hospitals
The neonatal nurse staffing levels for our L3 unit are compliant with the BAPM ask and the same tool as above is being used to calculate this. That is, we have enough staff based on 80% staffing to the activity over one year. Currently we have an agreement to be overstaffed by 5 x WTE (4 of which posts are being held for newly qualified staff who will not register until September 2025 – as per SLT request). Despite this, 100% compliance had not been achieved on some shifts due to acuity of the patients, sickness and the fact that we are staffed to 80%, despite the uplift. In times of shortages, paediatric colleagues are used to fill shifts and NHSP as required to make us compliant for the shift. The neonatal nurse workforce has a nominated lead for preterm birth

6.Neonatal Medical staffing

North Tees and Hartlepool
The neonatal medical staffing continues to be compliant with BAPM guidance in all tiers. The Advanced Neonatal Nurse Practitioner (ANNP) Workforce is at over establishment following agreement to facilitate additional trainee posts to ensure skill and competence is maintained given the age profile of this work group with the two trainees finishing Year 2 and joining the rota in October 2025. This will facilitate ANNPs being able to spend time at James Cook hospital for skills maintenance and development which has commenced in quarter 4 and quarter 1and will resume in Q3 but paused over summer to facilitate leave. The neonatal lead will return from maternity leave in January 2025.

South Tees Hospitals
For Tier 2 the compliance is 95% with 7.6 WTE with recommendation as 8WTE. It is due to LTFT trainees. However, ANNPs and deanery trainees are managing the 0.4 WTE internally with locum cover. For Tier 3, the compliance is 89% as one consultant is on sabbatical for 6 months. Consultant colleagues taking up extra locum shifts are managing this internally. Tier 1 is 100% compliance.

Anaesthetics staffing
In quarter 2 24hour anaesthetic provision was provided for both services evidenced via rotas.

APPENDICES
Appendix 1 Clinical excess activity actions
Appendix 2 NTHFT Staffing Factors and Clinical Actions
Appendix 3 STHFT Staffing Factors and Clinical Actions
Appendix 4 NTHFT 2025/26 Six Months Short-term Middle Grade Locum Report
Appendix 5 STTHFT 2025/26 Six Months Short-term Middle Grade Locum Report

Appendix 1

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

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

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

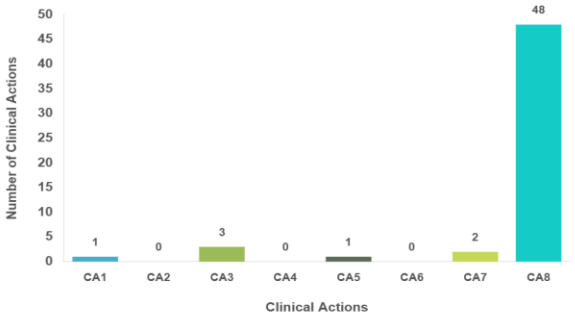
Appendix 2 NTHFT Staffing Factors and Clinical Actions

Number of Staffing Factors
01/07/2025 to 30/09/2025
Download Results

Number of Staffing Factors
01/07/2025 to 30/09/2025
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	84	20%
SF2	Unable to fill vacant shifts	315	76%
SF3	Staff redeployed to another area	11	3%
SF4	MW on transfer duties	2	0%
SF5	MW redeployed to another area	2	0%
SF6	Support staff less than rostered numbers	0	0%
SF7	More than 3 band 5 MWs on duty	0	0%
SF8	No Band 7 Coordinator available	1	0%
SF9	Coordinator taking AN/PN care	1	0%
TOTAL		416	

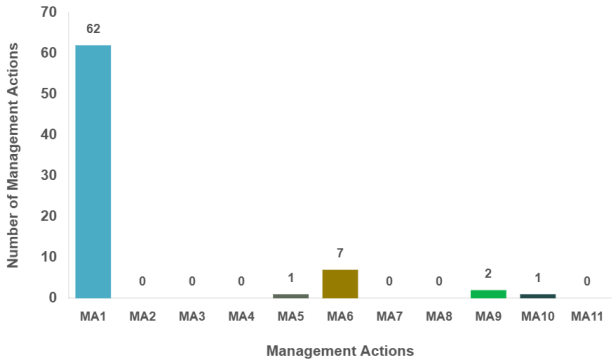
Number of Clinical Actions
01/07/2025 to 30/09/2025
Download Results



Number of Clinical Actions
01/07/2025 to 30/09/2025
Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	1	2%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL (as per Trust guidelines)	3	5%
CA4	Delay/cancel planned procedures e.g. ECV, Ferrinject, cervical suture	0	0%
CA5	Delay in transfer of cases to theatre (perineal repair, MROP)	1	2%
CA6	Delay Elective LSCS > 24hrs	0	0%
CA7	Delay admissions for IOL	2	4%
CA8	Delay in ongoing IOL/ARM	48	87%
TOTAL		55	

Number of Management Actions
01/07/2025 to 30/09/2025
Download Results



Number of Management Actions
01/07/2025 to 30/09/2025
Download Results

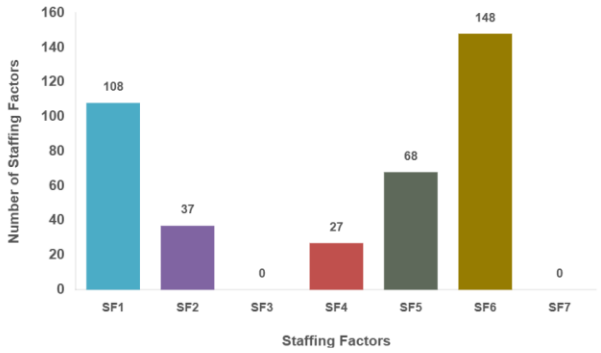
Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	62	85%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	1	1%
MA6	Specialist MW working clinically	7	10%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	2	3%
MA10	Maternity unit on Divert	1	1%
MA11	Home Birth Service suspended	0	0%
TOTAL		73	

Appendix 3 STHFT Staffing Factors and Clinical Actions

Number of Staffing Factors

01/07/2025 to 30/09/2025

Download Results



Number of Staffing Factors

01/07/2025 to 30/09/2025

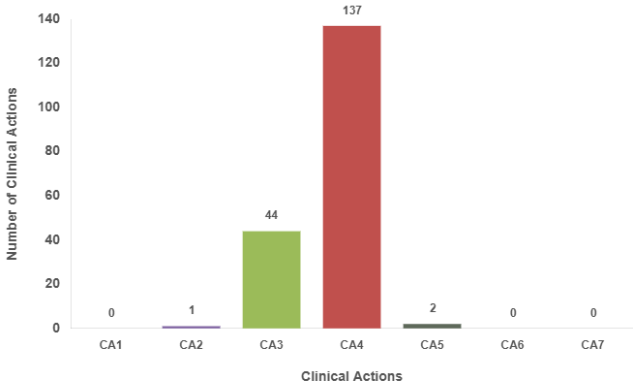
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	108	28%
SF2	Unable to fill vacant shifts	37	10%
SF3	MW on transfer duties	0	0%
SF4	MW redeployed to another area	27	7%
SF5	No MCA on duty	68	18%
SF6	No ward clerk on duty	148	38%
SF7	Skill mix issue (identify)	0	0%

Number of Clinical Actions

01/07/2025 to 30/09/2025

Download Results



Number of Clinical Actions

01/07/2025 to 30/09/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	0	0%
CA2	Delay in accepting transfers	1	1%
CA3	Delay in commencing IOL from admission (>2hrs)	44	24%
CA4	Delay in continuing IOL (>4hrs)	137	74%
CA5	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	2	1%
CA6	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	0	0%
CA7	Delay/cancel planned procedures, e.g. Ferrinject,cervical suture	0	0%
TOTAL		184	

Number of Management Actions

01/07/2025 to 30/09/2025

Download Results

Number of Management Actions

01/07/2025 to 30/09/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	99	92%
MA2	Staff unable to take allocated breaks	2	2%
MA3	Staff stayed beyond rostered hours	0	0%
MA4	Specialist MW working clinically	3	3%
MA5	Manager/Matron working clinically	2	2%
MA6	Midwifery manager called in out of hours	1	1%
MA7	Close Marton Suite	1	1%
MA8	Low dependency women re-directed to FMC	0	0%
MA9	US dept. to undertake EPAU/MAU scans to free MW sonographers	0	0%
MA10	Contact community midwifery team to explore if any visits or clinics could be cancelled and midwives utilised	0	0%
MA11	Maternity Unit on Divert	0	0%
TOTAL		108	

Appendix 4: North Tees and Hartlepool: 2025/26 Six Months Short-term Middle Grade Locum Report

All locums should be

- **Currently work in their unit on the tier 2 or 3 rota**

OR

- **Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**

OR

- **Hold a certificate of eligibility (CEL) to undertake short-term locums.**

Doctors in O&G Training programmes (holding a national training number)

O&G trainees will require a certificate when they undertake short-term locum placements in the following locations:

- Outside of their deanery/HEE Local Office
- In a trust (within their deanery/HEE Local Office) where they have not previously worked as a ST3-7

In gathering evidence to obtain a certificate of eligibility, trainees may include relevant evidence from their existing RCOG Training ePortfolio profile. Note: Trainees are not routinely required to gather proof of ongoing competence for certain practical procedures, in this case, sign off at the corresponding level, outcome 1 or 2 at ARCP may be used to support certificate of eligibility sign off.

RCOG 2022 Guidance on the engagement of short-term locums in maternity care

Month	A	B	C	Compliant	Non-compliant
February 2025	8	0	0	8	0
March 20205	1	0	0	1	0
April 2025	8	2	0	10	0
May 2025	14	0	0	14	0
June 2025	9	0	0	9	0
July 2025	10	0	0	10	0
TOTAL	**50**	**2**	**0**	**52**	**0**
Compliance Rate = 100%					

Appendix 5. STHFT Locum Audit

Audit of Employment of Short term (2 weeks or less) Obstetric Medical Staffing against Royal College of Obstetricians and Gynaecologists (RCOG) Standards

Date:10 Sept 2025

Trust Staff Lead: Mr Sanjay Rao- Consultant Obstetrician and Gynaecologist
Dr Rebecca Fletcher- Consultant Obstetrician, Rota Lead

1. Background and Aims

To ensure that South Tees Maternity Unit meets the RCOG for employment of short-term locum doctors.

2. Objective of Audit

To ensure that 100% RCOG standards are met.

3. Method

Sample size: Review of medical ROTA s
Time Period: February-August 2025

4. Results

Month		Eligibility criteria			% Compliance
	Locum shifts Tier 1 and Tier 2	Currently working in unit	Worked in unit within the last 5 years	Hold RCOG certificate of eligibility	
Feb 2025	8	YES	YES	YES	100%
March 2025	18	YES	YES	YES	100%
April 2025	20	YES	YES	YES	100%
May 2025	8	YES	YES	YES	100%
June 2025	10	YES	YES	YES	100%
July 2025	25	YES	YES	YES	100%
August 2025	21	YES	YES	YES	100%

5. Discussion

- All rota gaps have been covered internally by time shifting where possible or locum cover internally.
- No agency or external locums have been allocated to the rota.
- MTI doctors and LED trust doctors have supported rota gaps.
- Specialty resident doctors have supported rota gaps internally
- There is full compliance to training and use of IT systems including Badger net, Miya, Fluency Flex, Intouch and access to all local guidelines on the Trust intranet.
- All supporting staff have had a period of clinical attachment, induction and observation prior to commencing any locum shift.

6. Action Plan

Action	Person responsible	Timescale
Ensure compliance to RCOG standards for short term obstetric staffing on medirota	Mr Sanjay Rao Dr Rebecca Fletcher	Ongoing

University Hospitals Tees

Critical Care Service Delivery Model – NTHFT

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 2.4

Report author: Lindsey Wallace Care Group Director, Tom Bingham Critical Care Clinical Matron, Fiona McEvoy Associate Director of Nursing

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Approval

Delegation status Jointly delegated item to Group Board

Previously presented to: Care Group Senior Management Team, Site Leadership Team, Resources Committee, Quality Committee, Non-Executive Director briefing session

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:

Risk 35 (Fire)

Risk 271 (Workforce and skillmix)

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.

- **Non-compliance with GPICS standards -**Following two peer reviews in 2021 and 2023 from the North of England Critical Care Network (NoECCN), the visit identified non-compliance with Guidelines for the provision of Intensive Care services (GPICS v2.1) standards. GPICS 3.0 has been released for consultation which highlights further gaps in compliance against key standards and supports implementation of the phased approach, especially in relation to the workforce delivery model. In addition, the Nursing Alliance Critical Care Workforce Optimisation Plan and Staffing Standards 2024 – 2027 and Adult Critical Care National Census highlighted shortfalls in the required workforce model at North Tees and Hartlepool Trust. This is referenced within Risk 271.

- Please note the significance of **CQC regulation 18** which asks providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all regulatory requirements described as part of the Health and Social Act (2008). By way of an example, the CQC report from South Tees in 2019 deemed Critical Care inadequate in safe, effective, responsive and well-led due to lack of assurance regarding nurse staffing levels and non-compliance with GPICS recommendations. As part of the report it outlines the number of staff with post registration award in critical care which was 33% and was below the recommended 50% as is the case now at North Tees. It also highlights the need for improved clinical educator provision, to review the supernumerary coordinator, physio and pharmacy infrastructure in support of GPICS compliance. This resulted in a number of MUST Dos in line with regulation 18 and the risk of reputational damage.

- **Fire Risk & Estate risk.** The aging estate within North Tees has resulted in the critical care unit only having one means of escape which poses a fire risk, in particular from within unit B (of which there are 9 physical beds spaces). In addition to this, the environment has been identified as fragmented, failing to meet the HBN 04-02 standards and lacking appropriate isolation facilities. This was identified within both peer reviews in 2021 & 2023. This is referenced within Risk 35. To note **CQC regulation 15** also sets out the requirements for premises and equipment. The premises need to meet the requirements of all relevant legislation, much of which relates to health and safety.

  An estates task and finish group, led by Director of Estates, has been established which addresses the risks associated to this area. It must be noted that there are plans already drafted to address various options of either renovating existing estate or a new build.

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.

Investment is required to meet all GPIC's standards and the Care Group would like to propose a phased approach in alignment with the Trusts Business Planning cycle and evaluation of

the overall delivery model at each stage. It is recommended that Option 3 is taken forward (reduce one level 3 bed) with Phase 1 commencing in 2025/26 and an investment of £607k. The associated funding has been planned within the operating plan agreed for 2025/26. This will support the uplift and correct workforce skill mix required to comply with GPICs standards. Whilst the approach requires a progressive increase of 1% per year to align to local and national tariffs, it is recognised that a broader evaluation of headroom is to be considered going forwards.

The key issue to highlight within this paper is the need to standardise the workforce in line with national recommendations.

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

- Critical Care are within all predicted values for their key performance indicators offered by the Intensive Care National Audit and Research centre (ICNARC).

- It is acknowledged that Critical Care delivers high patient outcomes in line with national metrics, which is testament to the team and their passion and mitigations in place to manage risk; however, compliance against standards cannot go unrecognised.

- Whilst South Tees has a Post Anaesthesia Care Unit (PACU) that provides a higher level of care, North Tees does not. That said, this will be explored as part of the Group integrated model. North Tees does however provide Level 1 facilities for both surgery (15 beds on Ward 31) and respiratory medicine (14 beds on ward 24/25). The Surgical Level 1 area provides enhanced care for patients following complex surgery and the Respiratory unit has recently introduced a ring-fenced approach for 2 beds in support of acute admissions requiring NIV. Both these facilities provide support for patients who might be at risk of deterioration or have been recently moved from a higher level of care (step down from Critical Care). The Care Group is looking to propose a surgical ring fenced step down bed on ward 31 to help support timely discharge from critical care.

Recommendations:

The Board are asked to approve the recommendation from Quality Committee and Resources Committee which has previously been discussed with Board, which is option 3 (year 1/ phase 1). Option 3 requires a reduction in one level 3 bed. This will support the removal of the unfunded bed and the transfer of funds to enhance the staffing model. Historically the workforce budgeted establishment for this bed was not available as the staffing model was reflective of 85% occupancy.

Current bed occupancy supports the reduction of the level 3 bed and the unit has escalation processes in place for those occasions when demand may be over funded capacity.

To note the paper outlines the investment over a 3 year period to be GPICS compliant with the staffing model in line with national standards. Funding for phase 1 has been built into the operating plan for 2025 /26 (£250,840 PYE or £501680 FYE).

Please note that Phase 1 includes a medical model that provides Consultant cover during the afternoon/ early evening shift. However we now propose to move this to Phase 2 to allow time to recruit and consideration of the collaborative work. To offer assurance, the team will escalate accordingly in times of surge to ensure safe medical cover over the winter period.

The CSU will also continue the work with Estates to address and mitigate as far as possible the associate risks to health and safety (Fire regulations) with the estate strategic outline business case in line with the Group Clinical Services Strategy.

The proposed bed configuration and phased workforce plan offers a safe, affordable and pragmatic route to GPICS compliance. Once agreed, the operational team will begin the phased implementation of GPICs standards commencing Q3 2025/26. These changes will improve quality, patient and staff experience and support the work of the critical care network and group clinical strategy.

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Operational Delivery Group

March 2025

Critical Care Services Delivery Model

1.0 Background

The nature and delivery of intensive care services are evolving with great speed. This is seen both in the increased complexity of treatments being delivered and in the types of facilities to accommodate changes in service delivery

The critical care unit is funded for 16 beds with the physical capacity for 17 patients and comprises of three areas: unit A (four beds), unit B (nine beds) and unit C (four beds). Within this footprint of units, B and C there are three double and three single side rooms. Although the critical care unit at North Tees highlights a funded bed base of 16 (10 level 3 and 6 level 2 or 13 level 3 equivalent), historically from a nursing workforce perspective it is only funded for 8 level 3 and 6 level 2 or 11 level 3 equivalent when compared to GPICS v2.1 and the critical care nursing workforce standards optimisation plan, Appendix 2 & 3)

On 26th April 2023, an NHS Operation Delivery Network (ODN) peer review of Critical Care at University Hospital North Tees was conducted and the service was benchmarked against 'Guidelines for the Provision of Intensive Care services v2 (2022) (GPICs v2.1, Appendix 2).

The review provides impartial advice to both providers and commissioners regarding service provision and compliance with national standards, identifying gaps where appropriate. This paper presents a gap analysis of the Trusts compliance with GPICs with four key areas highlighted as non-compliant. These were nursing workforce, medical workforce, supporting services, estate and environment.

2.0 Nursing workforce

Registered nurse staffing standards published within GPICS standards v2.1 (Appendix 2) and in the *Critical Care Nursing Workforce Optimisation Plan and Staffing Standards 2024 – 2027* (Appendix 3) aim to produce a positive impact on both quality of care and safety for critically ill patients and are as follows:

- Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.
- Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.
- Each Critical care unit must have an identified supernumerary critical care Matron, dedicated solely to managing critical care who has overall responsibility for the nursing element of the critical care service.
- There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) clinical shift leader (band 7), who provides the supervisory clinical coordinator role on duty 24/7 in critical care units.
- Units with greater than ten beds and/or with a large number of single room and/or challenging geographical footprint must have an additional supernumerary Enhanced

Critical Care nurse (band 6 with critical care course and Step 3 competency) over and above the clinical shift leader to enable the delivery of safe care.

- A minimum of 50% of registered critical care nurse must be in possession of a post-registration critical care award. These nurses should be regarded as enhanced critical care nurses who hold Step 2 & 3 post graduate national competencies.
- Each critical care unit must have a dedicated supernumerary Clinical Nurse Educator responsible for coordinating the education, training and CPD (Continuing Professional Development) framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0wte educator per 50 nursing and non-registered healthcare staff.
- Assistive or supportive staff must not be used to replace RN roles.
- All novice critical care nursing staff (staff new to critical care, including overseas nurse) must be allocated a period of 12 weeks supernumerary practice to enable achievement of basic specialist competence.

There are six areas of non-compliance within the nursing workforce to achieve these standards, which are:

- Enough Registered Nurse budget for the actual funded beds
- A supernumerary clinical shift leader (band 7)
- An additional supernumerary Enhanced critical care nurse (band 6)
- Minimum of 50% registered nursing staff in possession of a post registration academic programme in critical care nursing. This should include consideration of training time and designated departmental uplift requirement to achieve standards.
- 1.0 wte clinical educator, at a ratio of 1:50 per nursing and non-registered staff
- An increase in uplift in line with other critical care units to support a training allowance.

Currently, there are 13 registered nurses on shift which includes one supernumerary co-ordinator (Band 6) on duty per shift for 16 funded critical care beds. To mirror GPICS v2.1 we should have 15 registered nurses on, x1 supernumerary clinical shift leader (Band 7), x1 supernumerary Enhanced critical care nurse (Band 6) and 13 registered nurses to achieve national staffing ratios for critical care. Each shift should have 50% of the nursing workforce at Enhanced critical care nurse level band 6 or above).

The average funded occupancy per year over last 3 years is 72%. The ODN (Operating Delivery Network) peer review report highlighted the impact of the current estate on visibility within the unit and the continual dynamic risk assessment required to ensure safe staffing, patient care and leadership are maintained. The estate is not fit for purpose and as a result has a huge impact on the resources required to safely manage the environment.

Critical care currently has a workforce of around 90 Registered nurses and 7 health care assistants (excluding critical care outreach team). The team has 1wte band 7 (substantive) clinical educator and 0.8wte band 6 (fixed term) clinical educator in post. The temporary post has been funded through adult critical registered nurse upskilling funding and is in place until July 2025. This is an attempt to support the team to the minimum of 50% registered nursing staff in possession of a post registration academic programme in critical care nursing in line with GPICs standards.

Recommended workforce

To achieve full compliance with GPICs (Option 1) and have a ratio of one supernumerary clinical shift leader (band 7) and a second supernumerary enhanced critical care nurse (band 6), providing a ratio of 1:8 beds an uplift of 5.5wte band 6 nurses to band 7 and an additional increase of 10.84wte band 6 Enhanced critical care nurses is required. This includes the requirement for the current deficit in workforce to actual funded beds and supports an improvement to the ACC award compliance.

In addition to this, an uplift of 22wte band 5 nurses to enhanced critical care nurse status (band 6), who are possession of adult critical care post graduate award. This would achieve the standard of 50% of nurses with an adult critical care award. This would also improve turnover, succession planning and opportunity. Currently there are 17.52wte band 5 nurses with the desired qualification with a further 7.92wte on the training courses pending completion.

Within this paper we have provided costings for some alternative options that although will not provide full GPICS compliance, will significantly improve the overall workforce service delivery model, with a more realistic financial impact.

To achieve compliance with GPICs and have 1wte clinical educator per 50 members of staff an additional 1wte band 6 registered nurse is required. Critical care currently has 32% of the registered nursing workforce with a post registration academic programme in critical care nursing against a compliance standard of 50%. Non-compliance with this standard has been recognised and risk 5669 was placed on the risk register.

The investment in an additional clinical educator recurrently will support all aspects of training within the service in line with the GPICs requirements and recognised national framework.

The national framework consist of four steps for competencies:

- Step 1 is the starting point and specific competencies are required for the registered nurse to be deemed capable of caring for a critical care. General progression takes up to 18 months to complete
- STEP 2 and 3, involves two post graduate qualifications and can take up to 4 years
- STEP 4 is required for all senior and coordination roles within critical care (Appendix 3).

To achieve the required training, sufficient resource should be included in establishment to allow attendance at the taught components of the mandated courses. A recent point prevalence survey suggested on average, 7% of the RN establishment is on the mandated training courses in a 12 month period. In view of this, it is recommended that a starting point for headroom should be at a minimum of 24%. North Tees critical care is at 21%, which is the lowest in the region. By way of comparison as a group, South Tees is at 25% and it is suggested in the recommendations a requirement as high as 28% may be required depending on turnover, training requirement and skill mix. *(Critical Care Nursing Workforce optimisation plan and staffing standards 2024 – 2027)* (GPICS standards v2.1)

As part of the phased approach we have highlighted a progressive increase of 1% per year to achieve the 24% headroom. As part of the group restructure, it is recognised that a broader evaluation of headroom is being considered.

In addition to registered medical, nursing and allied health professionals, critical care units are reliant upon a range of support staff whose role are vital to the provision of high-quality care and form an essential part of the multidisciplinary team. Although there is no formal recommendation through GPICS relating to support staff, the clinical environment at North Tees, as discussed, can be very challenging due to it fragmented footprint. In view of this a recommendation of an increase of 4.99wte band 3 should be supported to improve quality and safety delivery of critical care patients'

In addition to the above considerations it's important to consider other factors such as Maternity, sickness and turnover. The age profile and maternity percentage over the last 3 years, demonstrates the importance of appropriate forecasting to minimise the impact on both headcount and skill mix. Over 50% of staff are aged within the maternity age threshold and an average of 3-5.5% off on maternity leave each year. Staff generally take 9-12 months off and when you factor in annual leave it can be anywhere from 12-14 months off.

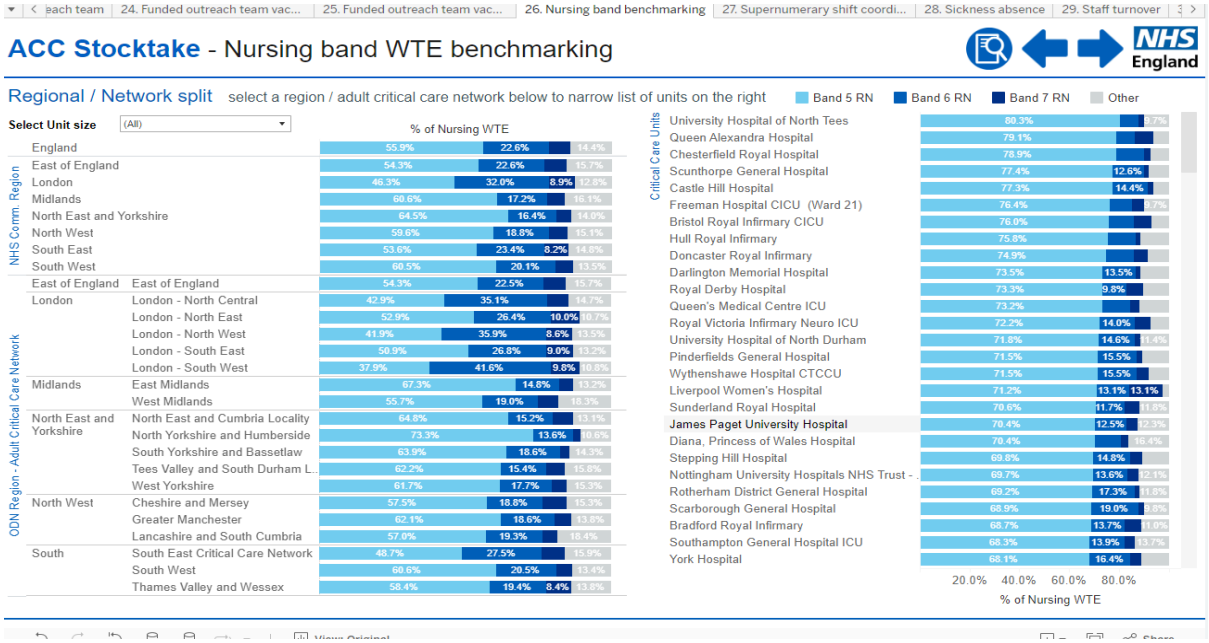
Due to the recruitment process and training programme associated within critical care, in general, it can take 6 months from recruitment to independently managing a critical care patient. It's important therefore to factor this into our workforce service delivery and recruit into permanent posts rather than fixed term.

Turnover within critical care can be variable and can have a huge impact if not forecasted proactively. The turnover post covid peaked at 16% and we lost many experienced staff. The cost to recruit and train, for the first year, a critical care nurse is in the region of 12-15k therefore it's extremely important we build a sustainable workforce and reduce the turnover threshold. Currently, turnover at North Tees critical care is one of the highest in the region which also correlates with our workforce service delivery model compared to other trusts.

Sickness within critical care has been over trust target for over a year and demonstrates an upward trajectory, 7-10% this financial year. The management of sickness within critical care is in line with policy, with support and scrutiny discussed at monthly attendance management clinics. The predominant reason for sickness being cited as stress/anxiety/depression.

2.1 NHS England national adult critical care – needs analysis stocktake (nursing)

In 2022 and 2023 national benchmarking stocktakes were undertaken which identified North Tees critical care nursing workforce skill mix as a national and regional outlier with the highest band 5 workforce nationally as demonstrated in the graph below.



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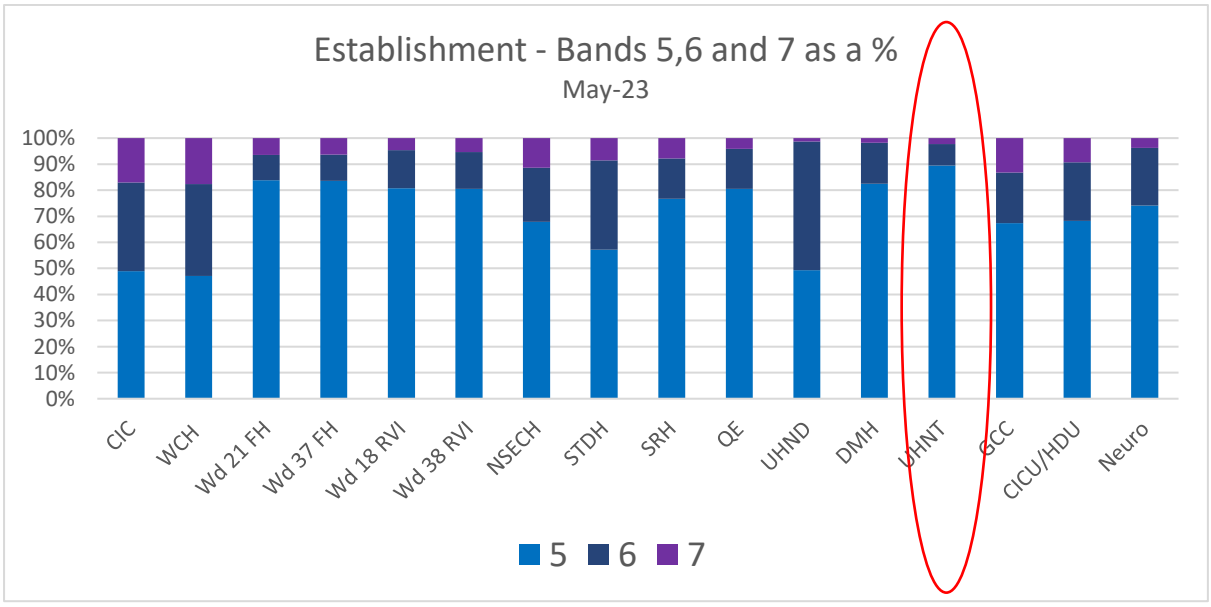
Further to GPICs, gap analysis and the adult critical care (ACC) stocktake, the service requests investment in the band 6 and band 7 nursing workforce to support compliance with the national standards and bring the service in line with its regional peers. It is evident from the graphs below that North Tees nursing workforce has the lowest number of these bands in the region. As this data was conducted in early 2023, it is recognised that the gap may have widened further. A repeat stocktake has been completed in August 2025 and is likely to suggest very little change in the data and compliance with national standards.



With the most recent critical care workforce optimisation plan 2024-2027 developed by the UK Critical Care nursing Alliance (Appendix 3) it outlines the career pathways that should be available, including banding structure, within all critical care units. GPICS v3.0 aims to support this methodology and is planned to be released March 2025.

Furthermore, investment in this nursing workforce model will recognise the expertise, skills and competence of experienced critical care nurses. In turn, this will reduce attrition within the service thereby creating a sustainable workforce for the future.

The themes relating to staff turnover are cited as progression, banding and opportunity. As previously mentioned within this paper, progression to achieve step 1, 2 and 3 competencies takes a minimum of 3 to 4 years.

2.2 Critical Care Outreach

The Critical Care Outreach (CCOR) service is currently funded with 5.64wte and consists of 3.64wte band 7 critical care nurses and 2.0wte band 6 trainee critical care nurses. There is a recently developed defined development pathway for critical care outreach nurses for progression from band 6 to 7. It is a 24 hour, 7 days a week service with one staff member per shift. All CCOR nurses have completed their national competencies with postgraduate accreditation (Step 2&3), Physical assessment skills and Non-medical prescribing qualifications.

3.0 Medical Workforce

GPICs states that patients should be able to receive the same standard of intensive care wherever they are admitted in the UK.

As such, the standards for the medical workforce requirements are as follows:

- Patients' care must be led by a consultant in Intensive Care Medicine
- Consultant work patterns must deliver continuity of care
- The daytime consultant to patient ratio must not normally exceed a range between 1:8 and 1:12. This ratio is complex and needs to be cognisant of the seniority and competency of junior staff, the reason for admission and the number and complexity of emergency admissions. The night-time ratio cannot be defined
- Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout
- There must be a designated Clinical Director and/ or a Lead Consultant for Intensive Care medicine
- A consultant in intensive care medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours must be able to attend within 30 minutes
- The ward round must have daily input form nursing, microbiology, pharmacy and physiotherapy and regular input from dietetics, speech and language therapy and clinical psychology to assist decision making.

There are two areas of non-compliance with the standards: The consultant to patient ratio during day time hours and the multidisciplinary ward round as per the above specification which will be addressed in turn within this report.

Currently, on weekdays there are 2 consultants covering critical care between 8am and 1pm. The rest of the day the unit is covered by 1 consultant. At weekends, there is 1 resident consultant between 8am and 2pm following which the consultant is non-resident on call.

There is an escalation process in place for times of high activity with associated skill mix considerations in place, however this is on an ad hoc basis. The funded occupancy within the unit sits at an average of 72% over the last 3 years.

Recommended workforce

To achieve compliance with GPICs and have a consultant to patient ratio of 1:8 equates to an investment of 1.25 Consultant PAs per weekday and 4PA per weekend daytime cover to provide a second consultant until 6pm during weekdays and weekend days.

3.1 Consultant recruitment

A recent capacity and demand exercise post Covid-19 identified that because of additional theatre lists and service creep over a number of years there was the need for 5.46wte consultants. Agreement to appoint into the vacancy position was granted in 2023 through the delivery model. However, to date the department has been unsuccessful in appointing to any of the 5.46wte posts.

Recognising the challenges to recruit which are a national issue as well as local the department are exploring opportunities to upskill the SAS workforce to support with mitigating the gap. As detailed above it is important to recognise that whilst the department recognises the need to achieve GPICs standards that achievement of the required additional PA's would need to be undertaken through additional sessions generally paid at a premium for the short to medium term until recruitment improves.

4.0 Allied Health Professionals

4.1 Physiotherapy

Physiotherapy is an integral component in the multidisciplinary management of critically ill patients admitted to intensive care, considering both respiratory management and early rehabilitation. The service provision should be based upon the overall patient case-mix taking into account acuity, dependency and complexity of the clinical case-mix. Staff resources and capability should be appropriately matched both in knowledge, skills, and number to deliver comprehensive respiratory care and holistic rehabilitation. The suggested ratio from GPICs would be 1wte physiotherapist to 4 ICU Level 3 beds.

Standards for the physiotherapy workforce are as follows:

- Physiotherapists must participate in opportunities for integrated decision making and dissemination of clinical information. This includes handovers, consultant led multidisciplinary ward rounds, MDT meetings, team briefings or operational and patient safety briefings.
- The intensive care MDT must have an identifiable lead physiotherapist who will be accountable for clinical service delivery, provide training and mentorship to junior staff and oversee the clinical governance and quality assurance. Regionally and nationally this is provided by an 8A Clinical Specialist. This allows relevant research, pathway development and training and education.
- All physiotherapy staff must receive appropriate capability- based training to ensure delivery of high quality physiotherapy intervention within critical care. Training must extend to non-intensive care staff involved in out of hours / on-call cover

- Physiotherapy staffing must be adequate to provide both respiratory management and rehabilitation components of care, ensuring compliance with both clinical and professional guidelines and standards.
- Physiotherapists as part of the multidisciplinary team, must ensure the completion of a comprehensive clinical assessment of those at risk of or with identified physical and non-physical morbidity within 4 days of admission to intensive care and before discharge from intensive care.
- Patients receiving rehabilitation must be offered therapy by the multidisciplinary team across a seven- day week and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient. Rehabilitation plans should be updated accordingly. Physiotherapy services should provide assessment and intervention for physical rehabilitation seven days per week.
- Physiotherapists must ensure a formal handover of care to the relevant ongoing physiotherapy team following discharge from intensive care. This should include the holistic individualised structured rehabilitation plan.

There are three areas of current non-compliance with the standards:

- Completion of the comprehensive clinical assessment within four days of admission to intensive care and before discharge from intensive care / multidisciplinary rehabilitation be available seven days a week and formal handover of care inclusive of a holistic individualised structured rehabilitation plan.

- In addition the physiotherapy team do not regularly participate in multidisciplinary MDT's / ward rounds

- Non-compliance is largely attributed to current workforce levels. At present the physiotherapy workforce assigned to critical care is only sufficient to provide service weekdays between 08.30- 17:00 and daily staffing numbers fall below GPICs recommendations. Outside of these hours (overnight on calls / weekends / bank holidays) the service is covered for respiratory physiotherapy only by the oncall service.

Recommended workforce

To achieve GPICs recommendations of 1 WTE physiotherapist to 4 ICU level 3 beds and provide a physiotherapy service that provides both rehabilitation and respiratory specialist care equitably 7 days a week a total investment of:

- 1.21 WTE Band 8A Physiotherapist
- 3.63 WTE Band 6 Physiotherapist

This investment in conjunction with the investment in occupational therapy and therapy support staff would enable a comprehensive MDT therapy rehabilitation service to be delivered. Specialist physiotherapy service would be provided 7 days a week between the hours of 08:00 – 20:00. This would play an integral part in the patients' recovery and clinical outcomes, ensuring that critically ill patients receive an equitable service 7 days a week.

Rehabilitation after Critical illness (RaCI)

Investment in the physiotherapy service can support meeting the Rehabilitation after critical illness in adults Quality Standards (QS158):

Quality Statement 1: Adults in critical care at risk of mortality have their rehabilitation goals agreed within four days of admission to critical care or before discharge from critical care, whichever is sooner. The physiotherapy team will take a lead role in the completion of the comprehensive clinical assessment and set individual rehabilitation goals within 4 days of admission of critical care for those patients identified as being at risk of morbidity.

Quality Statement 2: Adults at risk of morbidity have a formal handover of care, including their agreed individualised structured rehabilitation programme, when they transfer from critical care to a general ward. The therapy team will provide a structured formal handover of care inclusive of an individualised rehabilitation programme to the general ward physiotherapy team for those patients identified as at risk of morbidity. The team will review the patient for 48 hours post discharge from critical care to support the ward team and encourage continuity of care.

Quality Statement 3: Adults who were in critical care and at risk of morbidity are given information based on their rehabilitation goals before they are discharged from hospital.

Quality Statement 4: Adults who stayed in critical care for more than four days and were at risk of morbidity have a review 2-3 months after discharge from critical care. The therapy team will review each patient identified as at risk of morbidity post critical care stay prior to discharge home from the ward. They will aim to triage the patient and identify suitable follow up for 2-3 months after discharge. Follow up can include a MDT clinic appointment with the Consultant, Nurse, Physiotherapist and Occupational Therapist or potentially the addition of a telephone appointment where appropriate.

Currently the RaCiI clinic has very limited spaces (approx. 1 clinic per month / 4 patients). With investment the therapy team have the capacity to increase commitment to clinic but this would also require the additional support from the MDT.

With the investment in AHP services as outlined in phases 1 - 3 RaCi provision would be delivered in a stage approach. All AHP requirements would be met at completion of phase 3 funding.

Phased approach

Phase 1 25/26	Phase 2 26/27	Phase 3 27/28
7 day dedicated physiotherapy cover 8.30 – 5pm Would also require to keep NBH on-call shift for ITU Senior Specialist physiotherapy cover (band 6 and above) 7 days a week	7 day dedicated physiotherapy cover: Weekday OT cover 08.00 – 20.00 Mon –fri 08:30-17:00 Weekends and Bank holidays Would also require to keep NBH on-call shift for ITU	7 day dedicated physiotherapy cover: 08.00 – 20.00 seven days a week Senior Specialist Physiotherapy Cover (band 6 and above) 7 days a week

	Senior Specialist physiotherapy cover (band 6 and above) 7 days a week Increased capacity for Raci	RaCi delivered as per standards above.

4.2 Occupational Therapy

The National Institute for Health and Care Excellence (NICE) guidance recommends early intervention from a multi-professional therapy team to deliver patient-centred care, goal-directed rehabilitation programmes. Occupational Therapists deliver meaningful, functional interventions that address patients' complex physical, cognitive, psychological and social needs.

The national standards are:

- Critical Care units must have access to occupational therapy 5 days a week during working hours
- Patients receiving rehabilitation must be offered therapy by the multidisciplinary team, across a seven-day week, and of a quantity and frequency appropriate to each therapy in order to meet the clinical need and rehabilitation plan for an individual patient.

Recommendations:

- There should be an identifiable lead occupational therapist with appropriate experience, who will be responsible for service provision and development
- The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation programme that address the complex functional, cognitive and psychosocial needs of the patient cohort.
- Occupational therapy staff on the critical care unit should be able to assess and provide non pharmalogical treatment for those patients who present with delirium
- The occupational therapy service should aspire to delivery of a seven- day service for critical care patients.

Recommended Workforce

There is currently no funded Occupational Therapist staffing on critical care. The unit has access to an occupational therapist approximately 2 mornings per week. A staffing ratio of 0.23 WTE Occupational therapists per bed has been suggested. To meet national standards and achieve dedicated occupational therapy in the critical care unit and investment of 1.21 x WTE band 7 & 1.19 WTE band 6 Occupational Therapist is required.

In order to provide a seven – day service 0.60 WTE B3 generic therapy support worker would be required.

4.3 Nutrition & Dietetics

Patients in the critical care setting are at high risk of malnutrition. Critically ill patients are likely to require enteral, parenteral, or oral nutrition support (or a combination of these) to meet their nutritional needs. Recent evidence suggests that provision of nutrition to critically ill patients is complex, and that not all patients will gain the same benefit. The dietitian is best placed to provide nutritional advice to the multi-professional team on the optimal way to manage the nutritional needs of all critically ill patients.

The national standards state:

- Critical care units must have access to dietitian five days a week during working hours
- There must be a dietitian as part of the critical care multidisciplinary team.

GPICs recommends a staffing level of 0.05 - 0.1wte per critical care bed. This equates to 1.2wte Band 7 input. Although this standard is not met in full in terms of a specific dietician for critical care in entirety, the patients do receive input from dietetic services, especially in relation to parenteral and enteral feeding regimes ensuring that critically ill patients receive appropriate support for their nutritional needs.

Recommended workforce

To achieve compliance with this standard in full and have a specific dietician for critical care services an investment of 0.7wte dietician is required.

4.4 Speech and language therapy (SALT)

The role of speech and language therapy services in critical care is to assess and manage the range of speech, swallowing and cognitive impairments that patients experience following critical illness, trauma, major surgery or long-term decline.

GPICs recommend a minimum staffing level of 0.1wte SALT per bed.

Currently there is no designated SALT provision for critical care and the service is therefore considered as non-compliant with GPICs. However, it is important to note that patients requiring SALT input are currently seen through individual referrals to the service when required. The investment in a specific SALT role within critical care would enhance patient experience and outcomes through for example, reduced length of stay.

Recommended workforce

To achieve full compliance with this standard the investment of 0.5wte SALT Band 7 is required for a designated critical care service.

4.5 Pharmacist

Clinical pharmacy is an integral part of the multidisciplinary critical care team, delivering direct pharmaceutical care to patients, optimising pharmacotherapy in individual patients as well as on a unit-wide basis and providing a key role in medicines optimisation.
GPICs standards for pharmacy within critical care are:

- There must be a designated intensive care pharmacist for every critical care unit.
- There should be 0.1wte pharmacist for every Level 3 bed and for every 2 x Level 2 beds for a 5 days a week service.
- The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy.
- As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays).

Recommended workforce

There is currently 1.0wte Band 8a pharmacist specifically for critical care and therefore to achieve compliance with this standard further investment of 0.3wte Band 8a is required.

4.6 Psychologists

The psychological impact of an intensive care admission may be severe, with approximately 50% of patients suffering acute stress and long-term psychological morbidity. Families and staff are also affected by intensive care stress, and often require psychological support.

GPIC standards include;

- All patients must be screened daily for delirium using a validated instrument
- Non pharmacological strategies must be in place to prevent and reduce delirium

Currently, critical care does not have any designated psychologist input, however the team are able to refer patients for psychology support on an individual basis. This however, means that not all patients or families receive the specialist support in a proactive manner. Any patients identified through a rehabilitation clinic as needing psychological support are referred at this point. It must be noted that not all patients attend a clinic and therefore the demand may not be quantified in full.

Recommended workforce

To achieve compliance with this standard the investment of 0.7wte 8B Psychologist is required.

4.7 Rehabilitation after critical illness (RaCI)

Adults in critical care who are at risk of developing physical and non-physical morbidity need a comprehensive assessment to establish their rehabilitation needs and put a rehabilitation plan in place. Starting rehabilitation early can improve physical and non-physical functioning and prevent future problems. The needs of the person in critical care can change very quickly; therefore, goals should be continually reviewed and updated within the rehabilitation programme.

In 2009, NICE (Appendix 4) published guidelines entitled Rehabilitation after Critical Illness (CG83) that emphasised improved identification of need, access, and quality of rehabilitation during the critical care admission, within the wider hospital, and upon hospital discharge into the community. In 2017, NICE refined CG83 with the publication of four standards (QS158, Appendix 5), reflecting high-priority areas for quality improvement in relation to rehabilitation pathways for critically ill adults. Enhancing survivorship, or the quality of survival, is now central to our management of critically ill patients. As such, rehabilitation should be multi-professional, interdisciplinary and coordinated across the recovery continuum to optimise patient outcome.

Recommended workforce

To achieve compliance with national guidance the following workforce is also required to deliver a full RaCI service for the future: 1.0wte band 6 RaCI lead (nurse or physiotherapist), 3.0wte band 3 support staff.

It is acknowledged that investment in other areas throughout this paper such as medical workforce and band 6 registered nurse/physiotherapist and support staff may off set this recommendation and these elements are not duplicated in the recommendation and financial summary sections.

5.0 Estates and Environment

The peer review recognised that the unit fails to meet the relevant standards and the majority of recommendations within GPICs/ HBN standards and as such was deemed unfit for purpose. It therefore presents significant challenges to ensure patient care and safety is optimal.

It is to be noted that the Trust is currently working on an estates strategic outline business case whereby a new critical care unit has been agreed as the priority. In the meantime an improvement to the existing estate is recommended and plans are being put in place to support this. The first phase of this to occur is to provide suitable decant facilities for the improvement work to occur which is being factored into the 2026/27 Estate backlog maintenance plan.

6.0 Bed Occupancy & Reconfiguration

Due to the significant investment required a second proposal has been suggested to offset some of the financial requirement. As the critical care unit at UHNT has an average occupancy of 72%, an option to close x1 level 3 bed has been interrogated and review of the activity for both level 2 & 3 has taken place to understand how we could adapt the bed configuration. This is outlined below;

7.0 Critical Care Bed Review (December 2024)

To note the data in this report dates back to 2023 which is when the paper was first drafted.

Critical Care supports all specialties within the Trust, taking patients from Accident & Emergency, base wards and directly from theatre. Current bed base in the unit is 16 beds with the ability to flex to 17 beds dependant on the acuity of patients, with a breakdown of, 10 level 3 beds and 6level 2 beds.

Occupancy for 2023-24 averaged 70% with Level 2 occupancy being consistently higher than Level 3 over this time-period however, the winter period brings increased pressures, consistently raising occupancy to 89%.

7.1 Length of Stay

Average length of stay for higher acuity patients range from 5.4 days to 5.53 days during 2023-24 Length of stay for patients in level 2 beds remains consistent at an average of 2.85 days.

Cancelled elective operations as a result of no critical care bed available is kept to a minimum with only two cancelled during this time period (April 2023 and January 2024) and zero cases April 2024 to date.

7.2 Delayed Discharges

During 2023-24 there were 527 patients delayed over four hours and of those 45 patients were delayed over 24 hours indicating 75.83% of patients had a delayed discharge from the unit, this is currently reporting at 72.06% (April to November 2024). GIRFT Clinical Operational

Standards for Emergency pathways identify the winter priorities for both North Tees and South Tees in terms of timely patient transfers out of Critical Care for an in-patient bed. This will support the improvements required in relation to delayed discharges as part of ICNARC.

Whilst South Tees has a Post Anaesthesia Care Unit (PACU) that provides a higher level of care, North Tees does not. That said, this will be explored as part of the Group integrated model. North Tees does however provide Level 1 facilities for both surgery (15 beds on Ward 31) and respiratory medicine (14 beds on ward 24/25). The Surgical Level 1 area provides enhanced care for patients following complex surgery and the Respiratory unit has recently introduced a ring-fenced approach for 2 beds in support of acute admissions requiring NIV. Both these facilities provide support for patients who might be at risk of deterioration or have been recently moved from a higher level of care (step down from Critical Care). The Care Group is looking to propose a surgical ring fenced step down bed on ward 31 to help support timely discharge from critical care.

8.0 Considerations

Consideration 1 – Remodel beds based on acuity - Preferred model

The table below considers the impact of utilising beds differently by closing one level 3 bed and converting one level 3 bed to two level 2 beds. This will allow for a different staffing model within the unit.

Table 1: Suggested bed base

	Level 3 (ITU)	Level 2 (HDU)	Total beds
Current bed base	10 beds	6 beds	16 beds (able to flex to 17 beds)
Suggested bed base	8 Beds	8 beds	16 beds

This would affect the occupancy levels within the unit by; level 3 occupancy would increase from an average of 53.6% to 67.0% April to October 2023, with a higher occupancy emerging during the winter period and would have exceeded 8 beds on 20/151 occasions.

During the winter months of 2023-24, occupancy increased to an average of 82.98% and would have exceeded bed base on 41 occasions. Overall, maximum occupancy occurred on 13 occasions and exceeded 16 beds on three time during that period.

Table 2: Adjusted occupancy

Time period	Average of Level 3 Occupancy	Average of Proposed occupancy Level 3	Average of Level 2 Occupancy	Average of Proposed occupancy Level 2	Overall Average occupancy
April to October 2023	53.60%	67.00%	89.49%	67.11%	67.03%
November 2023 to March 2024	66.38%	82.98%	87.28%	65.46%	74.18%
April – October 2024	56.87%	71.09%	89.64%	67.23%	69.04%

Level 2 occupancy would reduce due to an increase in bed base, however would have still been over occupied on 14 occasions during 2023-24, ranging from 9 to 12 beds.

Consideration 2 – Remodel bed profile

Consideration 2 considers remodelling the overall bed base to 15 beds by reducing one ITU bed to 9 beds from 10 beds and leaving the level 2 beds at 6 beds, as shown in the table below:

Table 3: Suggested bed base

	Level 3 (ITU)	Level 2 (HDU)	Total beds
Current bed base	10 beds	6 beds	16 beds (able to flex to 17 beds)
Suggested bed base	9 Beds	6 beds	15 beds

Reducing the bed base would increase the overall occupancy to an average of 79.17% from 74.18% in the winter months of 2023-24, with the beds being over utilised on nine occasions during this time-period and on 2 occasions April to October 2024. Occupancy for level 2 beds would remain as it currently is.

Table 4: Occupancy based on remodelled bed base

Time period	Overall Average occupancy (16 beds)	Overall Average occupancy (15 beds)	Average of Level 3 Occupancy	Average of Level 3 Occupancy based on 9 beds	Times utilised over beds base (15 beds)
April to October 2023	67.03%	71.56%	53.60%	59.55%	4
November 2023 to March 2024	74.18%	79.17%	66.38%	73.76%	9
April to October 2024	69.04%	73.77%	56.87%	63.19%	2

Consideration 3 – Remodel bed profile

Consideration 3 looks at remodelling the overall bed base to 14 beds; ITU bed to 10 beds and reducing level 2 to 4 beds, as shown in the table below:

Table 5: Suggested bed base

	Level 3 (ITU)	Level 2 (HDU)	Total beds
Current bed base	10 beds	6 beds	16 beds (able to flex to 17 beds)
Suggested bed base	10 Beds	4 beds	14 beds

Reducing the bed base would increase the overall occupancy to an average of 84.82% from 74.18% in the winter months of 2023-24, with the beds being over utilised on 46 occasions during this time-period and on 32 occasions April to October 2024.

Table 6: Occupancy based on remodelled bed base

Time period	Overall Average occupancy (16 beds)	Overall Average occupancy (14 beds)	Average of Level 3 Occupancy	Average of Level 2 Occupancy based on 4 beds	Times utilised over beds base (14 beds)
April to October 2023	67.03%	76.67%	53.60%	134.23%	27
November 2023 to March 2024	74.18%	84.82%	66.38%	130.92%	46
April to October 2024	69.40%	79.04%	56.87%	134.46%	32

9.0 Summary

The above analysis is based on a snapshot bed position and does not take into account the fluctuation in acuity and movement of patients throughout the day.

The reports demonstrates there are pressures at times within the unit, as expected peaking within the November to March period with occupancy increasing within level 3 beds, however, if the bed base was to be reduced to 15 beds the number of times beds were utilised over the bed base was minimal, however this increases significantly when the bed base is reduced to 14 beds.

10.0 Risks/ BAF

There are two risks on the trust risk register which relate to the issues described in this paper; Risk #35 and ~1003 (legacy risk 5669) (see appendix 1). These risks relate to the failure to meet GPICs standards and the critical care estate and relate to the following BAFs: 1A Patient Safety and Outcomes, 1B Patient and Carers Experience, 1C Healthcare Standards in Single Oversight Framework, 2A Workforce and 3A Transforming Our Services.

11.0 Conclusion/ Next steps

The Trusts compliance with the Trusts critical care services delivery model has been highlighted throughout this paper with a focus on the workforce recommendations to support compliance against all standards. It must be noted however that the department will never be fully complaint within the existing estate.

That said, the peer review team observed that there are excellent enabling relationships between unit staff with high levels of confidence and mutual respect apparent. It was clear that there is excellent teamwork between the doctors, nurses, physiotherapists and AHPs who clearly respect and value each other's views and work cohesively together.

The service recognises the significant investment required to support a move towards full compliance and is presented in the financial summary below.

It is acknowledged that Critical Care delivers high patient outcomes in line with national metrics, which is testament to the team and their passion; however, compliance against standards cannot go unrecognised.

The department would like to acknowledge that significant investment is required to meet all standards and would like to consider a phased approach in alignment with the annual business planning cycle and evaluation of the overall delivery model.

12.0 Recommendation

The Collaborative Care Group recommend the investment in the workforce outlined in this delivery model. This would ensure the Trust is fully compliant with the workforce element in line with GPICs national standards and supports a workforce model fit for the future.

It is however, recognised that the investment required is significant. It is proposed that a phased approach could be considered as outlined below with the associated funding requirements presented. Consider option 3 is the preferred bed model with a reduction of one level 3 bed. This is considered the most appropriate way to deliver against the recommended GPICs workforce model without impacting negatively on patient safety and experience and the critical care network should occupancy sit consistently above 80%.

13.0 Financial Summary

Option 1 - 13 x Level 3

Category	Role	WTE	£GBP	Phase 1 25/26	Phase 2 26/27	Phase 3 27/28
Nursing Workforce	Band 7 Clinical Shift Lead	5.50 WTE (uplift)	£83,096	£83,096		
	Band 6 Enhanced Critical Care Nurse (2nd Co-ordinator)	5.64 WTE	£362,876	£362,876		
	Band 6 Enhanced Critical Care Nurse (13th bed)	5.64 WTE	£362,876	£362,876		
	Band 6 Enhanced Critical Care Nurse	22.00 WTE (uplift)	£106,468		£106,468	
	Band 3 Healthcare Assistants	4.99 WTE	£210,866		£126,773	£84,093
Educator	Band 6 Clinical Educator	1.00 WTE	£52,067	£52,067		
Medical	Band 8A Advanced Critical Care Practitioners	3.00 WTE	£277,741		£277,741	
Headroom	3% Headroom Increase (Nursing)	21% to 24%	£97,234		£97,234	
Rehabilitation	Band 8B Psychologist	0.70 WTE	£61,631		£61,631	
Medical	Substantive Consultant	1.25 PA Weekday 4 PA Weekend	£240,517	£105,490	£135,027	
Physio	Band 8A Physiotherapist	1.21 WTE	£90,654		£90,654	
	Band 6 Physiotherapist	3.63 WTE	£200,343	£200,343		
OT	Band 7 Occupational Therapist	1.21 WTE	£77,795		£77,795	
	Band 6 Occupational Therapist	1.19 WTE	£99,306			£99,306
	Band 3 Specialised Therapy Assistant	0.60 WTE	£20,029			£20,029
Dietitian	Band 7 Dietitician	0.70 WTE	£45,005			£45,005
SALT	Band 7 SALT	0.50 WTE	£32,147			£32,147
Pharmacist	Band 8a	0.30 WTE	£22,476			£22,476
			£2,443,127	**£1,166,747**	**£973,324**	**£303,056**

Option 2 - Reduce 1 bed (12 x Level 3)

Category	Role	WTE	£GBP	Phase 1 25/26	Phase 2 26/27	Phase 3 27/28
Nursing Workforce	Band 7 Clinical Shift Lead	5.50 WTE (uplift)	£83,096	£83,096		
	Band 6 Enhanced Critical Care Nurse (2nd Co-ordinator)	5.64 WTE	£362,876	£362,876		
	Band 6 Enhanced Critical Care Nurse	22.00 WTE (uplift)	£106,468		£106,468	
	Band 3 Healthcare Assistants	4.99 WTE	£210,866		£126,773	£84,093
Educator	Band 6 Clinical Educator	1.00 WTE	£52,067	£52,067		
Medical	Band 8A Advanced Critical Care Practitioners	3.00 WTE	£277,741		£277,741	
Headroom	3% Headroom Increase (Nursing)	21% to 24%	£97,234		£97,234	
Rehabilitation	Band 8B Psychologist	0.70 WTE	£61,631		£61,631	
Medical	Substantive Consultant	1.25 PA Weekday 4 PA Weekend	£240,517	£105,490	£135,027	
Physio	Band 8A Physiotherapist	1.21 WTE	£90,654		£90,654	
	Band 6 Physiotherapist	3.63 WTE	£200,343	£200,343		
OT	Band 7 Occupational Therapist	1.21 WTE	£77,795		£77,795	
	Band 6 Occupational Therapist	1.19 WTE	£99,306			£99,306
	Band 3 Specialised Therapy Assistant	0.60 WTE	£20,029			£20,029
Dietitian	Band 7 Dietitician	0.70 WTE	£45,005			£45,005
SALT	Band 7 SALT	0.50 WTE	£32,147			£32,147
Pharmacist	Band 8a	0.30 WTE	£22,476			£22,476
			£2,080,251	**£803,872**	**£973,324**	**£303,056**

Option 3 - Reduce 1 bed (12 x Level 3) - Phasing changes

Category	Role	WTE	£GBP	Phase 1 25/26	Phase 2 26/27	Phase 3 27/28
Nursing Workforce	Band 7 Clinical Shift Lead	5.50 WTE (uplift)	£83,096	£83,096		
	Band 6 Enhanced Critical Care Nurse	27.64 WTE (uplift)	£133,763	£133,763		
	Band 5 Critical Care Nurse	5.64 WTE	£335,581		£335,581	
	Band 3 Healthcare Assistants	4.99 WTE	£210,866		£126,773	£84,093
Educator	Band 6 Clinical Educator	1.00 WTE	£52,067	£52,067		
Medical	Band 8A Advanced Critical Care Practitioners	3.00 WTE	£277,741		£277,741	
Headroom	3% Headroom Increase (Nursing)	21% to 24%	£97,234	£32,411	£32,411	£32,411
Rehabilitation	Band 8B Psychologist	0.70 WTE	£61,631		£61,631	
Medical	Substantive Consultant	1.25 PA Weekday 4 PA Weekend	£240,517		£105,490	£135,027
Physio	Band 8A Physiotherapist	1.21 WTE	£90,654		£90,654	
	Band 6 Physiotherapist	3.63 WTE	£200,343	£200,343		
OT	Band 7 Occupational Therapist	1.21 WTE	£77,795		£77,795	
	Band 6 Occupational Therapist	1.19 WTE	£99,306			£99,306
	Band 3 Specialised Therapy Assistant	0.60 WTE	£20,029			£20,029
Dietitian	Band 7 Dietitician	0.70 WTE	£45,005			£45,005
SALT	Band 7 SALT	0.50 WTE	£32,147			£32,147
Pharmacist	Band 8a	0.30 WTE	£22,476			£22,476
			£2,080,251	£501,680	£1,108,077	£470,495
			PYE	£250,840		

Appendix 1

Risk	Description	Controls in Place	Gaps in Controls	Assurances	Current Risk Level
1003	Critical care at UHNT do not meet specific GPICS standards related to Nursing, medical, AHP's and support staff - which include; 1. Band 7 clinical shift leader 24/7 2. Additional supernumerary Enhanced Critical Care nurse (band 6 with critical care course and Step 3 competency) over and above the clinical shift leader due to geographical footprint and number of beds within the unit. 3. Only 32% of critical care nurse hold a post graduate critical care award (national standards is 50%). 4. 1wte Educator in post - (currently 1:100 compared to national standards 1:50) 5. Pharmacist provision 1.0wte, compared to national standard 1.3wte due to number of beds within the unit. 6. Physiotherapist cover currently 5 days per week	Optimise skill mix available and careful consideration of allocation to support team dynamics within each shift. Support from ward matrons, clinical educator, data manager and senior clinical matron if demand is high and/or safety concerns can't otherwise be mitigated. 2. Increase staffing levels as required, if available, to meet patient acuity demand. 3. Effective forecasting of recruitment and retention to minimise turnover gaps 4. Time to be given to staff to complete their post graduate certificates in critical care nursing. Monitor trajectory of compliance to achieve 50% compliance. This however	Consultant critical care medical cover does not meet GPICS standards related to a 1:8 ratio. Non- compliant with GPICS to have an additional supernumerary nurse available as required within GPICS standards Non-Compliant with GPICS, <50% of critical care nurses possess a post graduate award Non-compliant with GPICS regarding clinical educator provision, high turnover impacts this further. Non-compliant with GPICS regarding pharmacist provision, weekend, sickness or annual leave cover unavailable	Metrics relating to patient safety and performance reviewed monthly Positive peer review around patient safety and performance Excellent team working, high level of confidence and mutual respect apparent within the team Good patient safety and quality indicators Within predicted values in all KPI's from Intensive Care National Audit and Research Centre Positive 'appreciative support visit'	Moderate

	against standards of 7 days per week. 7. Service provision in line with NICE cg83 and QS158 is not achieved. Unable to deliver short and long term clinical assessments due to resources. 8. Medical consultant ratio of 1:8 available daily between 08:00-13:00 compared to national standards of 08:00-18:00. The unit has seen an increase in medication errors, pressure ulcers and Infection control issues over recent months. The impact of junior and inexperienced workforce in this specialist area correlates to this increase. The service has seen a negative change within the recent staff survey metrics which include: morale, engagement, and burnout, motivation, safe and healthy. All of which have been escalated to the unit leadership team on multiple occasions.	creates a separate risk due to increasing gaps in rota due to 21% uplift - recommended minimum uplift for critical care units is 24% (NoECCN providers-21-25%) South Tees uplift is 25% 5. Robust internal training plan led by clinical educator 6. Pharmacist to work closely with nursing and medical team to forecast any issues relating to gaps in service provision. 6. Physiotherapy on call service available at weekends 7. We promote ICU STEPS to patients. Clinical follow-up on ward setting by CCOR.	Non-compliant with GPICS regarding physiotherapy provision, only on call service at weekend Short and long clinical assessments not achieved in line with cg83/QS158 cg83 rehabilitation clinics not offered for all patients who had a critical care stay >48hours Ongoing low staff morale due to workforce gaps. High turnover of staff, limited experienced critical care staff. Psychological support not available to support CG83 clinics		

	The skill mix has been highlighted during 2 peer reviews and the national stock take for critical care services which has also impacted on Turnover within the unit. The staff turnover has been above Trust average which has now left the unit with a skill mix and experience deficit which impacts directly on patient care.	8. RaCI clinic provision for 4 patients per month			

35	The evacuation strategy progressive horizontal evacuation (PHE) cannot be achieved due to the escape route from Unit B via the South Stairwell not being wide enough to accommodate evacuation on beds / trolleys of very high dependency patients. This route is not large enough to be used as a place of temporary safety and / or provide continuity of care. As a result, means of escape from Unit B for patients is in one direction only, via Unit C and travel distances exceed those prescribed within HTM 05-03. The means of escape for independent persons, staff and visitors is available via the South Stairwell, this route is through the Store Room towards the rear escape staircase. Because the escape route via the South Stairwell is not suitable for highly dependent patients, we do not meet the	Staff have received mandatory fire safety training via ESR and local induction training from their manager on commencing employment as outlined in their TNA. Staff participate in annual Fire Evacuation drills (last one carried out 12/05/23) which comprised of a specific evacuation training table top exercise. Staff have been briefed that in the event of a fire in Section B, they should take as many patients as possible out via the escape route leading towards the lift lobby. This is recorded in the PK1 Local Fire Risk Assessment.	Poor access and egress to bed spaces particularly cubicles Lack of supported isolation facilities, no air locks or lobbies available Single rooms have solid doors hindering line of sight and impacting workforce efficiencies Lack of viable horizontal and vertical evacuation corridors Non-compliance with GPICS standards relating to 2nd supernumerary senior nurse Lack of emergency alarm system in every bed space Non-compliance with GPICS standards relating to clinical educator team	Positive regional peer review around patient safety and performance Excellent team working, high levels of confidence and mutual respect apparent within the team Good patient safety and quality indicators Within predicted values in all KPI's from Intensive Care National Audit and Research Centre Positive 'appreciative support visit'	Moderate

	requirements of Chapter 3 of Health Technical Memorandum 05-02: Guidance in support of functional provisions (Fire Safety in the design of healthcare premises) particularly 3.4 which states that " The design and construction of the building should ensure that at all times, patients, visitors and staff can move away from a fire to: a place of temporary safety inside the building on the same level, from where further escape is possible, ultimately to a place of safety outside the building; or lead directly to the outside." Additionally, we are in contravention of the following sections of the Regulatory Reform (Fire Safety) Order 2005 Part 2 Section 14 (2) (a) emergency routes and exits must lead as directly as possible to a place of safety	There are currently five Fire Wardens trained within ITU Fire Detection and Alarm Systems - The automatic detection of fire and warning system is provided, tested and maintained in accordance with the recommendations of BS 5839 Part 1 – (BS EN 54) – to an L1 standard. The Fire Alarm System has been zoned in accordance with North Tees & Hartlepool NHS Foundation Trust Fire Plan drawings, which show the fire	Non- compliance with GPICS standards relating to a minimum of 50% of the nursing working having a 60 credit post graduate certificate in critical care nursing No multi-parameter patient monitoring system		

	Part 2 Section 14 (2) (b) in the event of danger it must be possible for persons to evacuate the premises as quickly and as safely as possible Part 2 Section 14 (2) (c) the number, distribution and dimensions of emergency routes and exits must be adequate having regard to the use, equipment and dimensions of the premises and the maximum number of persons who may be present there at any one time. The findings quoted from the Authorising Engineer (Fire) relating to ITU is copied below: □ The PHE route towards the lift hall and adjoining compartments is acceptable as there are evacuation lifts and suitable routes to adjoining compartments for continuation of care. □ Should this route not be available due to a fire in the	compartmentation. Each 60 minute compartment is defined as a separate fire detection zone. This enables individual cause and effect reactions to be taken in relation to each zone. Fire Safety Policy RM13 is regularly reviewed and updated Competent Fire Safety Advisor / Officers are employed to offer advice and guidance on matters of fire safety			

	right-hand side of the unit then there is no suitable route for escape from the left-hand sub compartment. The existing sub compartmentation would only allow a limited time for phase 1 escape (PHE) and little in the way of preventing smoke migration from the affected area. □ It would not be possible to access the lobby and doors to the left-hand stairway with ICU beds and escape onto the flat roof is totally not acceptable. □ It is imperative that both sides of the unit have alternative means of escape (access) to a separate fire compartment where continuation of care can be maintained. The current Critical Care Unit within UHNT does not conform to HBN 04:02 standards. ICU has been identified as a high priority for the rectification of compartmentation issues				

	detailed in the recent compartmentation survey, as a compensatory factor.				

Appendix 2

Guidelines for the provision of intensive Care Services version 2.1 June 2022; https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services

Appendix 3

UK Critical Care Nursing Alliance

Critical Care Nursing Workforce Optimisation Plan and staffing Standards 2024 - 2027

ukccna_workforce_optimisation_plan_2024-2027.pdf

Appendix 4

CC3N National Step competencies 2018;

https://www.cc3n.org.uk/step-competency-framework.html

Appendix 4

Rehabilitation after critical illness in adults, clinical guidance (CG83) March 2009; https://www.nice.org.uk/guidance/cg83

Appendix 5

Rehabilitation after critical illness in adults, Quality Statement 158 September 2017; https://www.nice.org.uk/guidance/qs158

Associated documents

QEIA for bed reduction	Copy of QIA - level 3 bed closure.xlsx

NHS
University Hospitals Tees

People Committee

23 September 2025 & 28 October 2025

Connecting to: University Hospitals Tees - Board

Chair of Committee: Mark J Dias

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.

Medical Job Planning. Progress has been noted; however, the originally anticipated target of 95% - expected by end-March 2025 - remains unmet. A subsequent request to extend the deadline to end October 2025 for full completion was approved, yet the revised target was also not achieved. The Board has now requested that this area be prioritised, with a focus on establishing a robust foundation to support the next cycle's delivery.

Autism and Disability Training. Ongoing discussions on contents and financial implications.

Equality, Diversity and Inclusion. In response to the Supreme Court's ruling clarifying the legal definition of 'sex' there is a statutory obligation to provide both single-sex and unisex facilities. The organisation has initiated policy revisions and business case for capital investment. These actions are designed to ensure a respectful and dignified environment for all colleagues, in full compliance with legal requirements and aligned with our values of inclusion and workplace integrity.

Education and Training Compliance Report: Mandatory training compliance was reported at 87.44% across the Group, with NTHFT achieving 90.27% and STHFT at 85.73%. Despite these overall figures, face-to-face training topics continue to present challenges - particularly in areas such as resuscitation. The Board is therefore asked to consider targeted intervention to support improvement in these critical domains.

Caring
Better
Together

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.

Safe Staffing Report. Average percentage of shifts filled against planned nurse staffing increased to 99% [NT] 98% [ST] (July 2025). Registered staff sickness fell to 3.8% (below 4% target)

Improving Resident Doctors Working Lives Programme. NHS(E) launched their IRDWL programme in 2024. UHT baseline assessment submitted (12.09.2025) with nothing significant of concern. Areas for improvement incl. environment in which resident doctors work, taking of annual leave and reducing payroll errors.

Maternity. Verbal updates on actions to address cultural and leadership concerns. External feedback from Simon Mehigan, National Maternity Improvement Advisor, was positive indicating confidence in the progress made to date. Deep dive in November People Committee.

GMC Survey Report. NTHFT held steady over three years, with slight gains in 2025. STHFT showed marked overall improvement.

Staff Welfare. Counselling provision noted significant improvements with a timelier and more consistent offer across UHT; waits of more than 32 weeks have been eradicated.

Annual staff flu vaccination programme. Started 01.10.2025 and a three-month campaign data would be used to target areas of low uptake. Vaccinations were being made available in areas of high foot fall however, if the uptake was not great further clinics and ward walk-rounds would be put in place. Both Trust websites would be regularly updated with vaccine information, clinic dates and flu champion contact details.

Freedom to Speak Up Report: The National Guardians Office (NGO) is to be disbanded by March 2026 and discussions were ongoing regarding future arrangements. Work ongoing to align FTSU policies and IT systems across UHT

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

Equality, Diversity and Inclusion. The Committee approved the publication of the UHT Equality, Diversity and Inclusion (EDI) Annual Report. The report highlights key developments including the growth and impact of Staff Networks, the implementation of Leadership Training for Network Leads, and continued efforts to align organisational values and survey insights with Clinical Service Units (CSUs).

Organisational Restructuring: There had been good engagement with the Executive Team and trade unions had commended the open dialogue.

Medical Revalidation Annual Report. People Committee recommended that the report be accepted as assurance against regulatory requirements and escalated via the Board and report to the NHS England Level 2 Responsible Officer.

New National Statutory Leadership Framework. Currently being socialised. UHT offer based on amalgamating best of models and methodologies across Group.

Guardian of Safe Working Annual Report: Both organisations reported persistent rota challenges and limited workforce resilience during periods of elevated sickness absence and annual leave, resulting in increased reliance on locum staffing. Nonetheless, improvements were noted in the distribution of work schedules and the implementation of enhanced reporting systems. The Committee reviewed and approved the report.

Apprenticeship Levy Utilisation. As at the end of August 2025, NTHFT currently had 159 live apprentices and STHFT currently had 291 live apprentices. A significant proportion of the standards utilised across UHT were Level 7, reporting at 26%. good utilisation of funding was reported although it was acknowledged that further work was required to align this to strategic workforce plans.

Education & Learning Plan: The relationship between the overarching strategy and enabling plans (People and Education) was clarified, with emphasis on delineating Committee roles to avoid duplication between People and Academic Committees.

Recommendations:

Medical Job Planning – further prioritisation to attain 95% target
Mandatory Training – attendance on clinical face to face programmes, e.g. resuscitation
Note improvements in staff counselling provision and apprenticeship levy utilisation
Approved reports: Medical Revalidation Annual Report. Guardian of Safe Working Annual Report and Equality, Diversity and Inclusion (EDI) Annual Report

University Hospitals Tees

Nurse Safer Staffing Monthly Report (Aug 2025 data)

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 3.2

Report author: Lindsay Garcia, Director of Nursing, Emma Roberts, Associate Director of Nursing and Professional Workforce, Debi McKeown, Nurse Workforce Lead

Executive director sponsor: Emma Nunez, Chief Nursing 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 partner's ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Choose an item.

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

This report details nursing staffing levels for August 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 required.

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.

At South Tees, the bi-annual nurse establishment review will be presented to Board in January. This review paper is to determine any requirements to adjust the existing nursing workforce model. The data is a triangulation of the SNCT findings, professional judgement and actual base establishments.

At North Tees and Hartlepool, the next bi-annual nurse establishment update will be presented to Board in January 2026 – this will be a review paper and will continue to highlight the requirement for investment into several nursing workforce models as per the bi-annual review carried out in 2024/25. This update will then support the completion of the annual nurse establishment review that will be presented to Board in February 2026 using three cycles of the current SNCT data across adult, Paediatrics, ED and Community.

The workforce leads are currently working to align the cycles of bi-annual nurse establishment reviews, with a repeat review planned for early 2026 once CSUs are in place.

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 average percentage of shifts filled against the planned nurse staffing across South Tees for August 25 has decreased by 1% to 97%.

In August 2025, sickness absence among registered staff increased by 0.95%, while sickness among unregistered staff decreased by 0.23%. Despite this month-on-month fluctuation, there has been a notable reduction in sickness rates for both staff groups when compared to the same period last year.

Staff turnover increased during August for both registered and unregistered staff. However, overall turnover remains significantly lower than in August 2024, indicating a positive year-on-year trend in workforce retention.

The monthly Workforce Assurance Meetings have established a constructive forum for colleagues to review staffing spend in relation to safe staffing levels and patient quality indicators. This initiative is a key component of the ongoing workforce assurance business

cycle, supporting the calculation of required staffing levels to deliver safe and effective care while minimising reliance on temporary staffing.
To further support cost improvement plans, enhanced scrutiny of current workforce metrics has been introduced. Additionally, there is now broader engagement from specialist nurses and nurse practitioners across each collaborative, ensuring alignment with rostering best practices already established within ward settings.

At North Tees the overall planned nurse fills for August remains 99%, which continues to align with the current enhanced care requirements particular during the night so there remains a continued reliance on temporary staffing to safely staff in patient areas. Review of this service and its ability to deliver the required demand remains in place and is currently being supported by the anticipated data that has been taken during STEP week.

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 a robust tracking model has been devised to check progress of the over recruited newly qualified nurses. The process will be reviewed centrally through workforce assurance and aligned with all agreed posts as per vacancy control panel. This approach will ensure that all posts are tracked and recorded accurately for regional / national updates for the graduate nurse outcome project

The centralisation of care support worker recruitment has been agreed based on the outcome of the pilot and this will continue until a further review in April 2026.

North Tees and Hartlepool turnover for August 2025 has increase within the registered nursing workforce to 5.26% and a decrease in the HCSW line to 7.89%

At North Tees, the NQN's in the Sep25 cohort have been appointed into permanent and fixed term roles throughout Trust most have now commenced into post. RN's and NQN's (January 2026 cohort) continue to be appointed into forecasted vacancies and the 20wte planned over recruitment, as per the SLT agreement. It is anticipated that all NQNs for both the September 2025 and January 2026 cohorts have been fully accounted for when planning employment and preceptorship agreements.

The 60wte trainee healthcare support workers are commencing throughout October 2025 to support vacancies within the band 3 line and mitigate current gaps in safe staffing. This pipeline programme of education will support the new trainee HCSW's to gain the required clinical experience and academic requirements to move into a B3 position within a 12-month fixed term post.

To provide further assurance in relation to safer nurse staffing, North Tees have carried out STEP week (Safer staffing, Timely care, Enhanced Care, Planned discharge) from the 1st to the 5th September 2025. This week enabled senior nurses and AHP's to specifically review patient acuity and dependency data and provide further validation of SNCT data in addition to collecting and collating a number of other data sets/metrics that will support a variety of planned or on-going work streams including the re-design of the Enhanced Care service in line with the NHSE ETOC programme. Over 5500 data sets have now being collated and

correlated and an initial report of key finding/themes and proposed actions and recommendations is being drafted.

Recommendations:

The Board of Directors are asked to:

- Note the content of this report and;
- Note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout August 2025.

Board of Directors

6 November 2025

Nurse Monthly Safer Staffing Report

This exception report provides the Board of Directors the monthly University Hospitals Tees nursing safer staffing position across all in patient areas and provides 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 (UHT), Safer Staffing is maintained through twice daily safer staffing meetings (using Safe Care 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 SOPs. All staffing plans are shared through OPEL meetings and Safe Care 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 workforce assurance meetings at both sites have full participation from all appropriate senior nurses including Heads of Nursing, Clinical Matrons and Service Managers to ensure all decision making is appropriate.

Monthly workforce assurance and check and challenge meetings are now embedded in practice to ensure compliance with rostering and safer staffing key performance indicators. At North Tees, the current check and challenge meetings have recently been reviewed and refreshed to ensure that the required safe staffing and rostering KPIs are reviewed and required actions are agreed on a monthly basis. These meetings will now be known as monthly workforce assurance meetings and will take place on a monthly basis from September 2025, further supporting a future UHT approach.

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.

During August 2025, several areas at South Tees reported fill rates below 80% for Registered Nurses, primarily due to ***patient acuity levels*** and ***staff sickness***:

Day Shifts:

- Ward 33 - Haematology
- Zetland - Stroke Rehabilitation
- Neonatal Unit
- Ward 21 - Paediatrics
- Maternity Centre Friarage

Night Shifts:

- Ward 31 – Acute Assessment Unit
- CICU – Cardio Intensive Care Unit
- CHDU – Cardio High Dependency Unit
- Maternity Centre – Friarage

In addition, the following areas reported fill rates below 80% due to a ***reduced elective programme*** during the reporting period:

Day and Night Shifts:

- Ward 6 – Short Stay Elective
- Ward 22 – Paediatric Surgery

These figures highlight the impact of clinical demand and service changes on staffing fill rates and support ongoing efforts to align workforce planning with patient care needs.

In August 2025, the following areas at North Tees and Hartlepool presented a fill rate of less than 80%

- Low RM and HCSW fill rate on delivery suite and ward 22 due to vacancies - filled by Sep25 NQM cohort, short term sickness and a higher level of maternity leave.
- Critical Care had low RN fill rate due to reduced acuity during this reporting period.
- Low HCSW fill rate on EAU due to increased vacancy and short-term sickness.
- Low HCSW fill rate on SCBU due to long term sickness.
- Low HCSW fill rate on Elective care unit due to reduce activity.
- Low HCSW fill rate on Ward 28 due to increased short term sickness.
- Low HCSW fill rate on Ward 25 due to long term sickness.
- ACU, 24, 25, 26, 27, 32, 40, and 42 had an increase in HCSW fill up to 115-170% due to the demands of enhanced care, particularly at night.

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:

Overall Ward Fill Rate		**August 2025**
	RN/RMs (%) Average fill rate – DAYS	89.9%
	HCA (%) Average fill rate – DAYS	91.8%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	94.0%
	HCA (%) Average fill rate – NIGHTS	100.4%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**97%**

Table 1b Trust Planned versus Actual fill – North Tees and Hartlepool:

Overall Ward Fill Rate		**August 2025**
	RN/RMs (%) Average fill rate – DAYS	87%
	HCSW (%) Average fill rate – DAYS	93%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	94%
	HCSW (%) Average fill rate – NIGHTS	115%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**99%**

- **Nurse Sensitive Indicators**

At South Tees, staffing was not directly referenced in any concluded PSIRF reviews in August 2025.

- **Red Flags Raised through Safe Care Live**

During August 2025, a total of 9 staffing-related red flags were raised at South Tees. These included:

- **5** flagged as *Shortfall in Registered Nurse (RN) time*
- **2** flagged as *Missed intentional rounding*
- **2** flagged as *Less than two RNs on shift*

Documented resolutions are available via the SafeCare log, providing assurance that appropriate action was taken following escalation.

To support timely resolution and oversight, weekly reminders are issued by the Workforce Assurance Team to Clinical Matrons, prompting review and closure of any resolved red flags.

During August 2025, a total of 2 staffing-related red flags were raised at North Tees and Hartlepool;

- **1** flagged by EAU as *Shortfall in Registered Nurse (RN) time*

(Due to short term sickness within the coordinator role, escalated and suitable RN re-deployment carried out).

- **1** flagged by Ward 40 as *Less than two RNs on shift*

(Due to short term sickness, escalated at safe staffing meeting and suitable RN re-deployment carried out).

- **Datix/In-Phase Submissions**

At South Tees during August 25, there were 102 Datix submissions relating to staffing. Staff are encouraged to Datix any staffing related issues which are reviewed and discussed as part of workforce assurance and governance meetings. The majority of Datix submissions, highlight a reduction in staffing on Ward 9, Ward 12, Ward 3 and Redcar Community Nursing PCN. All shortages raised were managed through the Safe Care process throughout August 25.

At North Tees, in August 25 there was an increase in in-phase reports relating to nurse staffing. A total of 14 were submitted by the Care groups, which have been summarised below;

- Delivery Suite – 9 linked to RM staffing levels, short term sickness and increased acuity, internal escalation plans followed to provide safe staffing levels and non-urgent care postponed.

- Ward 22- 1 linked to RM staffing levels due to short-term sickness, again internal escalation plans followed to provide safe staffing levels across maternity services.

- Ward 40- 2 linked to RN cover and skill mix, due to short term sickness, escalated within care group and suitable redeployment made from other areas to provide safe staffing levels.

- Surgical Decision Unit- 1 linked to increased acuity with admissions, escalated to site manager to support department

- Emergency Department- 1 linked to reduced RN cover due to short term sickness, internal escalation followed, matron supported workforce.

All staffing risks 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 was put 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.

- **Vacancy & Turnover**

Across the group, the vacancy position continues to be positive. Both sites submitted a joint paper to the Full Executive Team meeting and agreement was secured to over recruit NQNs from the September cohort. This has now been completed and applicants working through the in the recruitment process

As per the South Tees financial ledger for August 2025, vacancies show as –38.49 WTE (RN and RM combined). The vacancy position as per the financial ledger indicates a vacancy of 147.82 WTE for HCSW's. Centralised recruitment of HCSW's took place in July 25 to mitigate against the vacancy / establishment gap increasing in the future. 44 WTE HCSW's were successfully recruited. Interviews for the second cohort are scheduled for October 25.

At North Tees, the B5 RN vacancy position remains positive across the in-patient wards and departments. In August 2025 the vacancy level has increased -13.2 WTE, with forecasting to the end of October 2025 seeing this reduce to 0 WTE. All current and forecasted vacancies are now being appointed into using the NQN cohorts for Sep25 and Jan26 with some additional recruitment of RNs. The planned over recruitment of 20wte RN is underway and plans to fill unfilled shifts due to long term sickness and maternity leave. Thus, reducing the reliance on bank and agency over the coming months.

At North Tees, the HCSW vacancy position across all services in July 25 is -66.01wte. Following the introduction of the 60wte B2 trainee HCSW posts, the forecasted vacancy for these posts for in-patient services will reduce to approx. 6wte by November 2025 (start dates throughout October 2025).

- **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 August 2025 can be reviewed in Appendix 2.

Table 2 South Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
June 2025	9.20	9.65	+0.45
July 2025	9.22	9.69	+0.47
August 2025	9.14	9.49	+0.35

During August 25, data indicates that 14 inpatient areas exceeded the required average for CHPPD. Areas falling below the required CHPPD levels were primarily impacted by elevated staff sickness rates and increased patient acuity. To mitigate these challenges, twice-daily Safe Care reviews continue to support the planning and redeployment of staff into unfilled shifts.

The greatest variance between required and actual CHPPD was observed in Ward 9, Ward 31, and Ainderby.

- **Ward 9** currently holds 3.3 WTE HCSW vacancies. While staff sickness decreased to 11% (a 3% improvement month-on-month), it remains considerably above the trust average.
- **Ward 31** experienced an increase in staff sickness, rising to 10.5%.
- **Ainderby** also saw a notable increase in staff sickness, up by 4.7% compared to July.

These vacancies have recently been recruited into via the central HCSW recruitment process, with anticipated start dates in September 25. Following completion of supernumerary periods, an improvement in CHPPD is expected.

Staff sickness across these areas is being actively managed, with Health Improvement Plans in place to support recovery and resilience.

In August 2025, the average sickness rate across Registered Nurses (RNs), Registered Midwives (RMs), and Healthcare Support Workers (HCSWs) was **5.50%**, reflecting a reduction in staff sickness over the past 12 months. This positive trend is expected to contribute to a decreased reliance on temporary staffing.

Temporary staffing levels remain variable due to changing service demands. However, a focused effort continues to be made to redeploy existing staff before utilising NHSP.

Weekly prospective reviews and monthly Workforce Assurance meetings with each collaborative enable effective triangulation of key workforce data, including sickness absence and staff turnover rates.

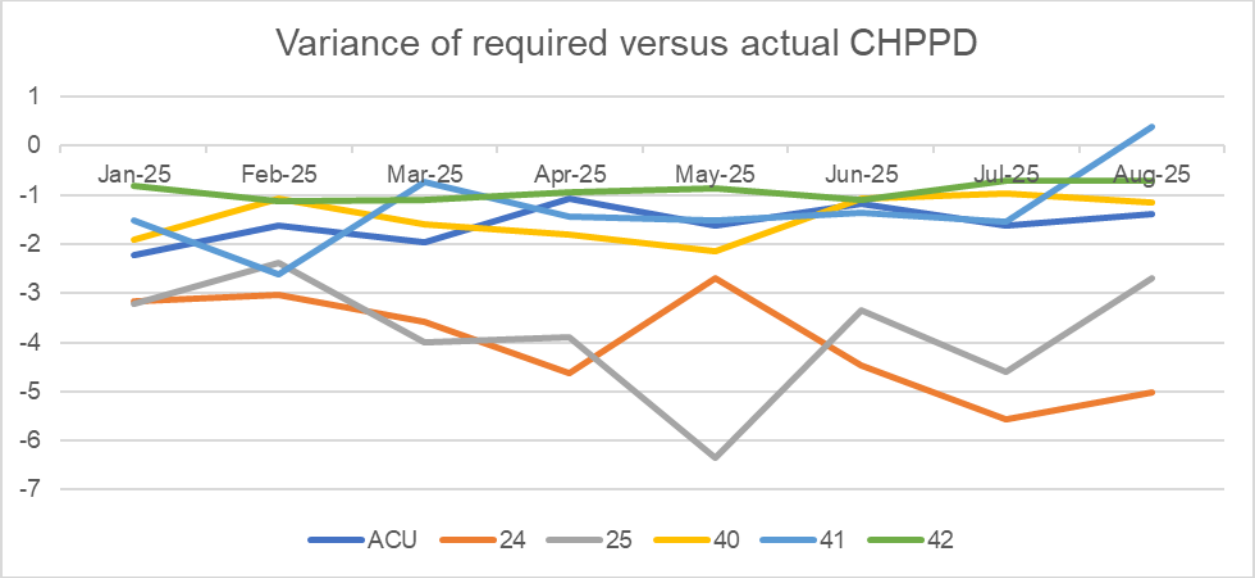
Analysis of NHSP spend indicates that the wards and departments with the highest usage correspond to areas identified in the biannual SNCT establishment reviews as requiring adjustments to staffing levels.

Table 3 North Tees site:

	Required CHPPD (Average)	**Actual CHPPD (Average)**	**Variance**
June 2025	9.25	10.06	+0.81
July 25	9.28	11.48	+2.20
August 2025	9.00	10.19	+1.19

In August 2025 the areas highlighting a higher variance level (>1) at North Tees, and thus, not delivering the required CHPPD were Cardiology, Respiratory, Gastroenterology and Elderly Care. This is reflective of the increased acuity in Respiratory (SNCT level 2 patients) and of increased HCSW vacancy in the other departments. These areas have also been the focus of the most recent bi-annual nurse establishment review where the proposed nurse establishment models in line with the formal review process have been presented, indicating that establishments in these areas require investment.

Chart 1 presents the variance of the required and actual CHPPD for these areas since January 2025.



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 continues to exceed 4% (allocated within headroom) and maternity leave that has previously not been backfilled consistently.

The presentation of monthly workforce rostering KPI's and metrics now allows for more detailed correlation between various metrics and planned and actual CHPPD. These monthly reports are used in the monthly workforce assurance meetings (WAMs) to provide a clear identification of areas with low or no compliance and associated planned actions to improve positions.

Nurse Recruitment and Retention

- South Tees has introduced a streamlined tracking system for newly qualified nurses recruited above establishment:
- Progress Monitoring: Tracks the development of over-recruited newly qualified nurses and cross referenced with temporary staffing requests
- Central Oversight: Reviewed through workforce assurance to maintain consistency.
- Post Alignment: Linked to all approved roles via the vacancy panel.
- Accurate Reporting: Ensures all posts are recorded correctly for regional and national Graduate Nurse Outcome updates.
- Legacy mentors continue to play a vital role in supporting staff throughout their career journeys. They proactively source relevant information, act as a liaison between staff and management, and foster a culture of development and support. By working closely with HR colleagues, they help deliver tailored one-to-one outcomes that recognise individual needs. This approach enhances workforce flexibility, enabling staff to work in ways that suit both their personal circumstances and the needs of patients. Additionally, legacy

mentors contribute to the ongoing improvement of organisational culture and leadership across NHS settings.

Similar processes in place at North Tees and Hartlepool in relation to the monitoring of all nurses appointed into 'over recruited' positions. Monthly plans to move them from over recruited 12m fixed term posts into permanent established posts by way of natural turnover. Monthly check in sessions have been planned to ensure that they are feeling supported in their new roles in addition to standard preceptorship programme. Unfortunately, North Tees and Hartlepool no longer benefit from the role of the legacy mentor as the roles were disestablished following the removal of funding from NHSE.

Across the Group, 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.

- **Temporary Staffing**

At South Tees, demand for nursing and midwifery bank and agency staffing in August 2025 decreased by **13%** compared to August 2024. Additionally, bank filled hours declined by **15%** over the same period. These reductions reflect improved workforce stability and may indicate a positive impact from ongoing efforts to reduce sickness absence and optimise staff deployment.

Nursing agency use continues to be minimal at South Tees. In August 2025, a total of **164** nursing agency hours were booked; this is a reduction of 190 hours month on month. All nursing agency hours in August were utilised within Friarage Theatres.

ODP agency usage remains present within the Trust. In August 2025, a total of 387 hours were utilised across the following areas:

- **Friarage Theatres:** 236 hours
- **Cardio Theatres:** 139 hours
- **Orthopaedic Theatres:** 12 hours

While this represents a marginal month on month increase, it is a reduction of 927 hours compared to the same period last year.

The continued use of agency staffing reflects a strategic approach to meeting service demands in the areas of greatest need whilst maintaining efforts to limit reliance on external staffing solutions.

In August 2025, bank staffing spend decreased by £75,793.71 (-6%) compared to August 2024. Similarly, agency staffing spend saw a significant reduction of £29,682.77 (-56%) year on year. These reductions reflect improved workforce planning and reduced reliance on temporary staffing solutions.

The overall fill rate for bank and agency staffing in August 2025 was 82.2%, consistent with the same period last year. While the fill rate remains static year on year, the reduction in

demand provides a more accurate reflection of ward requirements, resulting in a more reliable and representative fill rate.

At North Tees and Hartlepool, all temporary staffing spend (NMAHP, Medical and Dental, Health Care Scientist and Admin and Clerical) is discussed monthly via the Temporary Staffing Focus Group (TSFG) with escalations and updates to Joint QUAD on a monthly basis.

- Agency spend YTD is £1,127k lower than previous year
- Agency spend is still lower than in any month last year and is consistent with prior months
- Bank spend YTD is £238k higher than previous year
- Bank increase still lower than agency reduction overall
- Enhanced care in M5 £16k higher than the average of 24/25 and £35k lower than Jul-25. Drivers of in month increase are vacancy and sickness (by NHSP coding)
- Locum spend YTD is £102k lower than previous year
- M5 spend is £30k lower than YTD average, partly linked to Theatres shut down in August
- Overtime spend YTD is £179k lower than previous year
- M5 spend has increased c. £8k from Jul-25

Key Priorities

At North Tees the current key priorities are as follows:

- Continued monitoring of temporary staffing, over time use, sickness/absence & turnover
- Bi-annual nurse establishment review paper (update).
- Adult in-patient SNCT, ED SNCT, Paeds SNCT and Community CNSST data collection planned for Oct/Nov 2025
- Supporting the introduction of Trainee HCSW (60wte B2) from Oct 25 – initial education and KIT days planned
- Presentation of STEP data and overall recommendations to Group CNO
- Recruitment centre planned for the recruitment of the remaining Jan26 NQN cohort
- Focus on nursing workforce development with multiple new career pathways including aspirant leader
- Impact of Legacy Mentorship – conclusion and presentation of research

At South Tees the current key priorities are as follows:

- Continue to explore staff feedback regarding Work-Life Balance approaching winter, this includes a review of the redeployment SOP with staff input and the plan for utilisation of non-ward-based nurses to support at times of critical need

- Finalisation of the temporary staffing equitable rates of pay proposal across both sites. This will continue to link with all CIP initiatives

- Continuous development of clear career pathways for new to care staff with a focus on the pathway to be a registered nurse

- Maintain safe staffing ratios by embedding the actual, stretch and extremis model within wards and departments with a clear escalation process.

- **RECOMMENDATIONS**

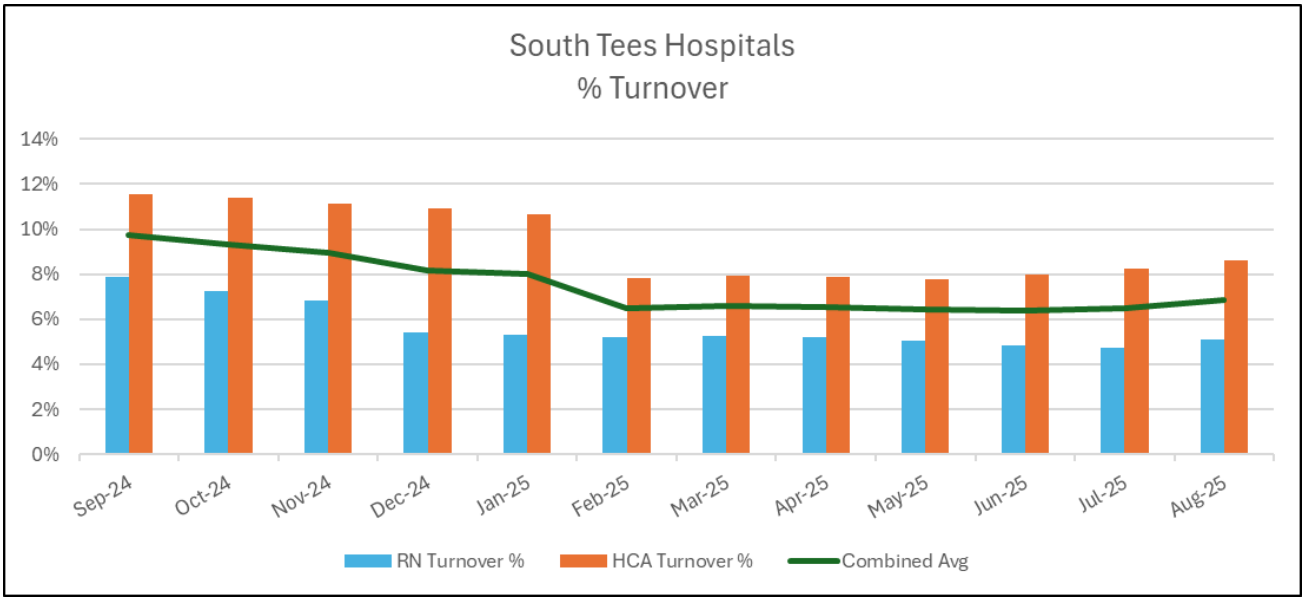
The Board is asked to read the content of this report and to note the progress made across both sites in relation to developing and retaining the nursing workforce.

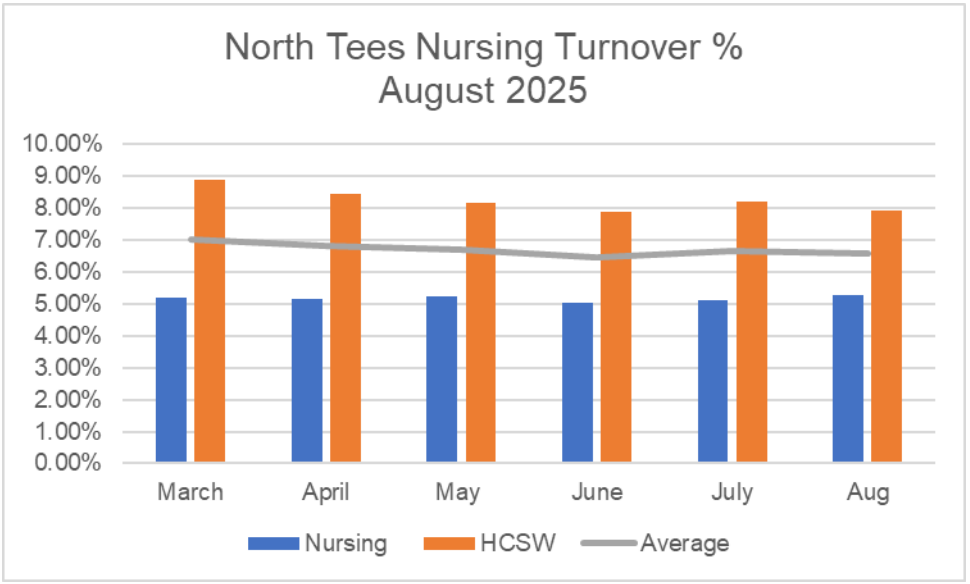
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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 August 2025





Caring Better Together

Appendix 2

South Tees Average CHPPD Breakdown by Ward (August 2025):

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ward 1	8.55	7.78	-0.77
Ward 31	9.69	6.48	-3.21
Ward 2	6.43	4.90	-1.53
Ward 3	7.82	5.25	-2.57
Ward 4	8.65	6.66	-1.98
Ward 5	5.54	4.75	-0.79
Ward 6	4.83	4.49	-0.34
Ward 7	5.33	4.68	-0.65
Ward 8	5.55	4.98	-0.57
Ward 9	8.70	4.26	-4.44
Ward 11	8.21	6.81	-1.40
Ward 12	9.04	6.58	-2.46
Ward 14	6.60	5.76	-0.84
Ward 24	9.40	10.21	0.80
Ward 25	9.94	7.05	-2.89
Ward 26	8.57	6.93	-1.64
Ward 27	7.81	11.97	4.16
Ward 28	8.48	7.08	-1.41
Ward 29	4.87	5.11	0.24
Cardio MB	5.94	7.98	2.04
Ward 32	7.14	6.49	-0.65
Ward 33	7.92	6.50	-1.42
Ward 34	7.48	5.78	-1.70
Ward 35	7.60	7.27	-0.34
Ward 36	6.58	5.32	-1.26
Ward 37 - AMU	10.62	8.29	-2.33
Spinal Injuries	9.83	7.08	-2.75

CCU	15.55	14.31	-1.24
Critical Care	16.89	23.47	6.58
CICU JCUH	22.39	26.73	4.35
Cardio HDU	10.34	14.24	3.91
Ward 24 HDU	11.21	22.29	11.09
CDU FHN	7.97	7.22	-0.75
Ainderby FHN	11.69	7.37	-4.32
Romanby FHN	7.39	6.96	-0.43
Gara FHN	6.46	11.60	5.13
Rutson FHN	7.98	7.53	-0.45
Friary	8.24	8.51	0.27
Zetland Ward	8.82	6.67	-2.16
Tocketts Ward	7.87	5.73	-2.14
Ward 21	9.25	14.99	5.74
Ward 22	13.69	17.52	3.82
Neonatal Unit (NNU)	12.48	13.37	0.89
Paediatric Critical Care (PCCU)	16.86	32.58	15.71
Grand Total (Average)	**9.14**	**9.49**	**0.35**

North Tees Site - CHPPD by ward for August 2025

Row Labels	Average of Required CHPPD	Average of Actual CHPPD	Variance
Acute Cardiology Unit	7.43	6.04	-1.39
Critical Care North Tees	20.24	29.19	8.95
Elective Care Unit	6.79	18.65	11.86
Emergency AMB	7.17	10.26	3.09
Neonatal Unit	10.89	18.94	8.05
Paediatrics	9.96	20.22	10.26
SDU	10.30	11.27	0.96
Ward 24 (Respiratory)	8.55	6.94	-1.61
Ward 24 RSU	13.10	9.69	-3.41
Ward 25 (Respiratory)	8.80	6.60	-2.21
Ward 25 RSU	11.34	10.86	-0.48
Ward 26	6.89	5.43	-1.46

Ward 27 (Gastroenterology)	7.96	6.71	-1.25
Ward 28 (Surgery)	6.23	6.01	-0.22
Ward 31 (Surgical Observation Unit)	8.06	8.28	0.22
Ward 32 (Fragility Fracture)	8.46	8.08	-0.38
Ward 33 (Orthopaedic & Spinal)	6.33	5.88	-0.46
Ward 36	8.10	5.85	-2.25
Ward 38	6.24	5.66	-0.58
Ward 40 (Acutev Elderly)	8.09	6.94	-1.14
Ward 41 (Stroke Unit)	7.89	8.23	0.34
Ward 42 (Elderly Rehabilitation)	9.13	8.41	-0.71
Grand Total	**9.00**	**10.19**	1.19

University Hospitals Tees

Freedom to Speak Up Report Q1 & 2: 2025/26

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 3.3

Report author: *Philippa Imrie, Jules Huggan, Samantha Sinclair, Jim Woods, Freedom to Speak Up Guardians*

Executive director sponsor: *Emma Nunez, Chief Nursing 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:

All risks associated with this presentation are recorded on the risk register. BAF alignment: 5.1, 5.2

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.

The Guardians ask that the 'FTSU A Reflection and Planning Tool' is reviewed, given the significant and ongoing organisational change. This will be completed at a future board development session and will support the FTSU implementation plan with the new Clinical Service Units moving forward.

At the end of June 2025, we were advised the National Guardians Office (NGO) is to be formally disbanded. This decision has implications for Freedom to Speak Up (FTSU), governance, support and national oversight within NHS and associated bodies. The board should note this change and consider the strategic and operational implications for speaking up culture, staff engagement and assurance framework. The North Tees Freedom to Speak Up Guardian (FTSUG), has been selected as part of a small group of regional FTSUG Chairs, to have a conversation with the Department of Health and Social Care, NHS England and the National Guardian Office, to discuss the future vision: what a safe, open culture looks like post-NGO, including how key functions might be delivered differently, locally, regionally, or nationally, in line with the dash review's recommendations. The FTSU Executive Sponsor has also been invited and will attend the meeting. The FTSUG will update the board, when further information is received.

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

FTSU policies for South Tees and North Tees are being reviewed and aligned, with the Detriment Guidance being included.

Anonymous concerns raised at South Tees sites have reduced from 39.5% in Q1 2025/26 to 27.08% in Q2 2025/26.

Anonymous concerns raised at North Tees continue to follow Q1 2025/26 trend of 0% in Q2 2025/26

The issue with the FTSU System at South Tees recording everyone concern as 'yes' for disability status has been resolved.

A concern raiser, based at North Tees, contacted a FTSUG at South Tees evidencing the alignment of a University Hospital Tees FTSU Team.

The FTSU team have secured a new office at Friarage Hospital enabling the FTSU team to have a presence on both of the main South Tees sites.

FTSU team triangulate data and themes and bring to the attention of the appropriate responsible person.

Recommendations:

The alignment of the FTSU Policy which will include the new FTSU contacts and add the detriment guidance.

To complete the Freedom to Speak Up: A Reflection and Planning Tool as we move forward into University Hospitals Tees

To consider the strategic and operational implications for speaking up culture, staff engagement and assurance framework following the announced disbanding of the NGO

To consider the wellbeing of staff during the ongoing organisational changes/restructure.

Board of Directors
6 November 2025

Freedom to Speak Up Report Q1 & 2, 2025/26

1. PURPOSE OF REPORT

The purpose of the report is to provide the Q1 & Q2, 2025/2026 position of the work carried out and the themes which are arising from the Freedom to Speak Up Guardians (FTSUG). The report provides an overview of the themes and issues raised between 1 April 2025 – 30 September 2025 training data, current actions linked to the group improvement plan and proactive work underway.

2. BACKGROUND

Following recommendations from the Francis Report, Freedom to Speak Up (FTSU) Guardians were created with the aim of helping to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. At University Hospitals Tees we work to achieve this by supporting colleagues to speak up about concerns, tackling barriers to speaking up and by ensuring issues raised are used as opportunities for feedback, learning and improvement. Guardians act as independent and impartial sources of advice to staff, supporting staff to speak up when they feel unable to do so via other routes and ensuring that an appropriate person investigates the issues raised and provides feedback on the action taken.

3. DETAILS

Philosophy

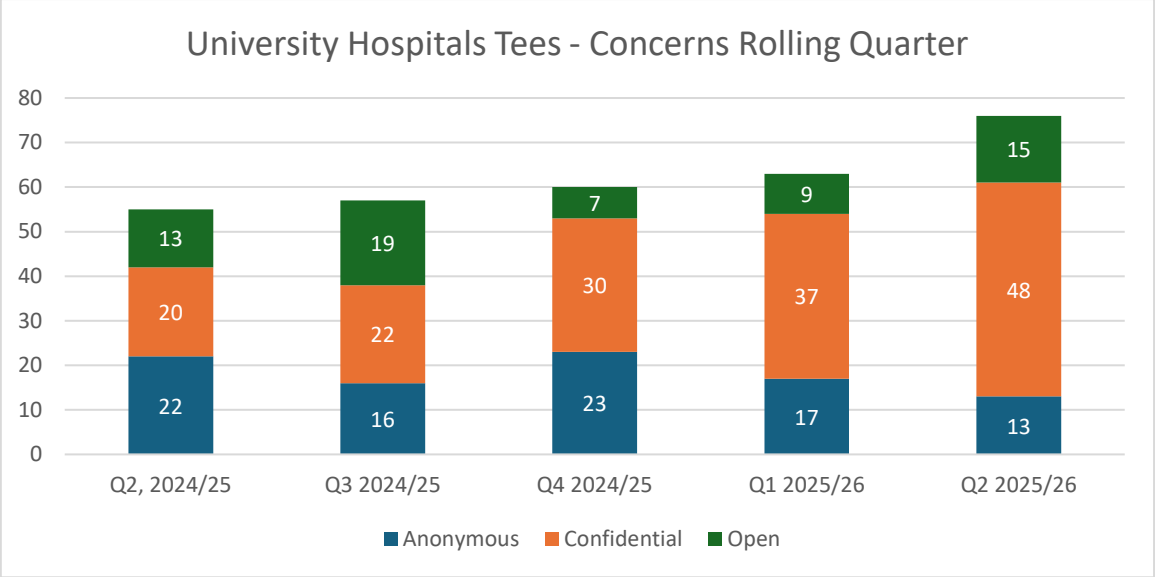
The FTSU ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients and workers. Speaking up not only protects patient safety but can also improve the lives of workers. FTSU is about encouraging a positive culture where people feel they can speak up, their voices will be heard and their concerns or suggestions acted upon. In the eight years since Sir Robert Francis recommendations, the FTSUG role continues to evolve and move away from a whistleblowing culture to one of permission, encouragement, openness and transparency.

Dr Jayne Chidgey-Clark, National Guardian stated, “If we can get the culture right, benefits will follow, including improving patient safety, innovation for improvement, retaining workers and making the National Health Service (NHS) a great place to work”.

Assessment of Concerns

University Hospitals Tees

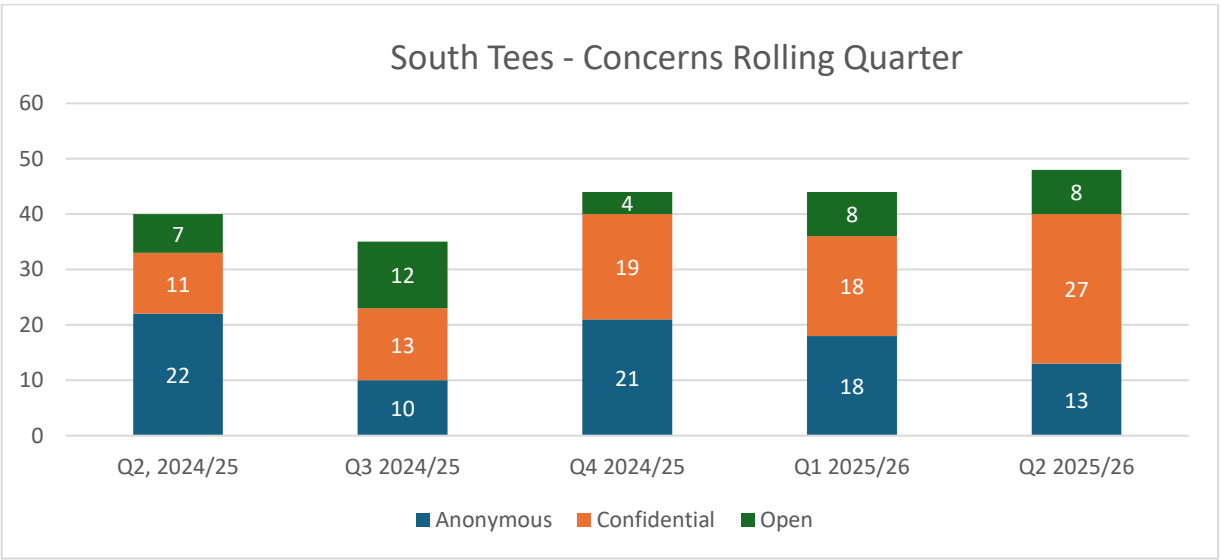
Graph 1



During Q1, 2025/26 UHT received a total of 63 concerns with anonymous reporting for UHT at 27.86%. There was an increase in concern raising in Q2, 2025/26 with a total of 76 concerns. Anonymous reporting for UHT decreased to 17.10% in Q2, 2025/26.

South Tees:

Graph 2



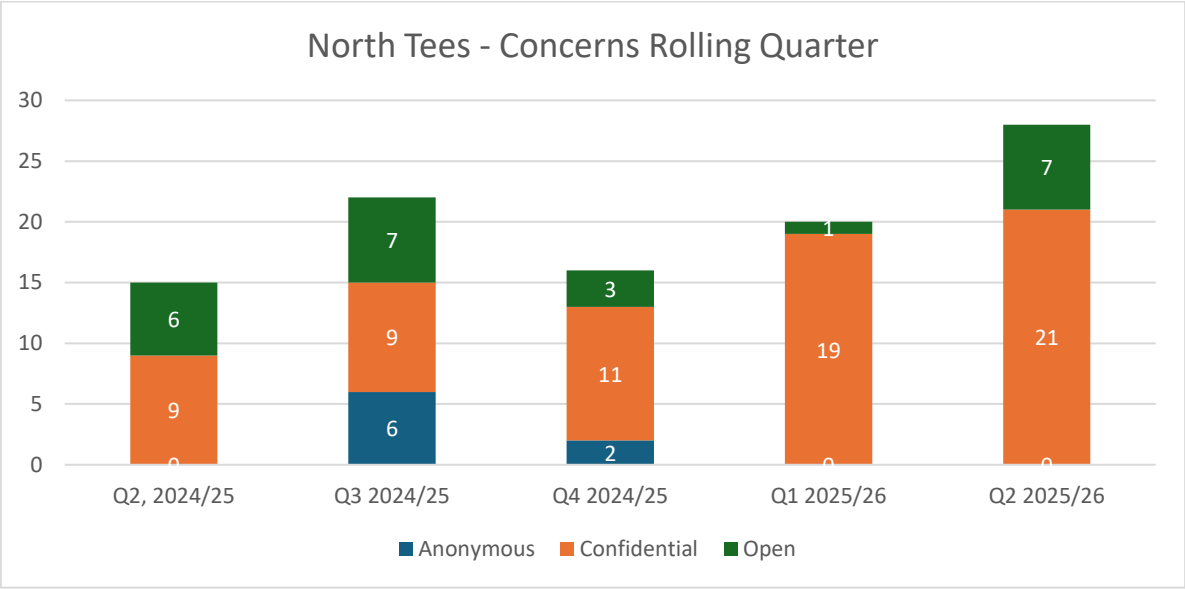
In Q1, 2025/26 the FTSUGs at South Tees received 43 concerns. The number of concerns raised anonymously decreased from 21 (47.7%%) in Q4, 2024/25 to 17 (39.5%). In Q2, 2025/26 the FTSUGs at South Tees received 48 concerns. The number of concerns raised anonymously decreased further in Q2 2025/26 to 13 (27.08%).

Anonymous reporting at South Tees is still higher than the national average (2024/25 – 11.6%). Work is ongoing with IT around changes to the current FTSU system at South Tees to hopefully reduce anonymous cases going forward, pending the introduction of InPhase for FTSU across University Hospitals Tees.

Please refer to appendix 1, which is an analysis of anonymous concerns received at South Tees.

North Tees:

Graph 3



Open reporting at North Tees had decreased to 5% in Q1, 2025/26, compared to 18.75**%** in Q4, 2024/25 but increased to 7(11%) in Q2, 2025/26. The FTSUG continues to promote the speak up, listen up and follow up workshops to create a more open organisational culture, one which is willing to learn and grow, from the concerns that are being raised.

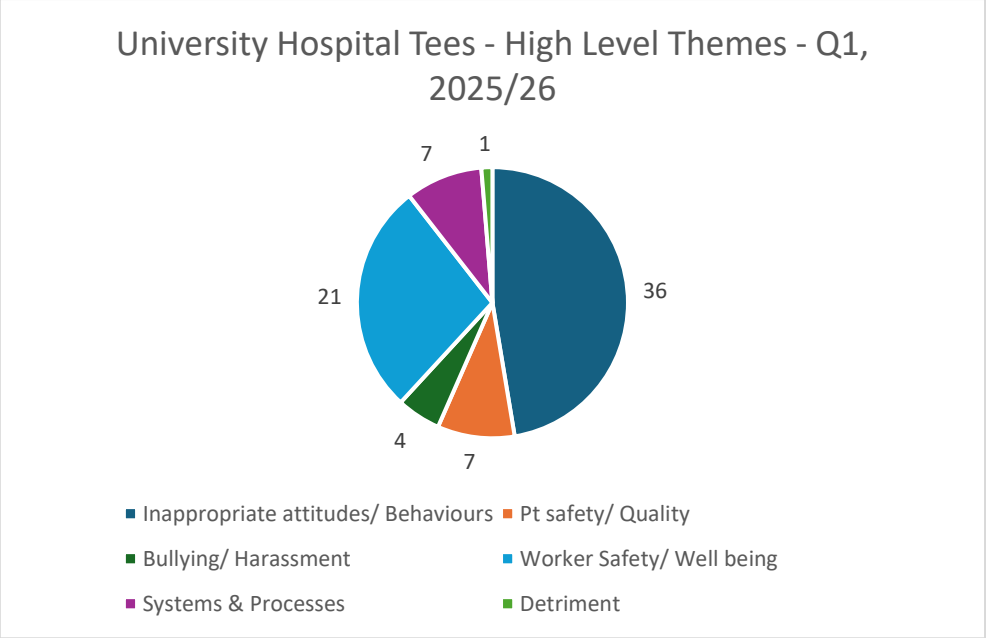
Most workers are speaking up confidentially. In Q1, 2025/26 95% of workers spoke up confidentially compared to 68.75% in Q4, 2024/25. This could be due to the organisational restructure that is currently underway, where staff may not feel as safe to speak up openly. In Q2, 2025/26 confidential reporting decreased to 21 (60.7%). This is a positive decrease of 34.3% as more staff are speaking up openly.

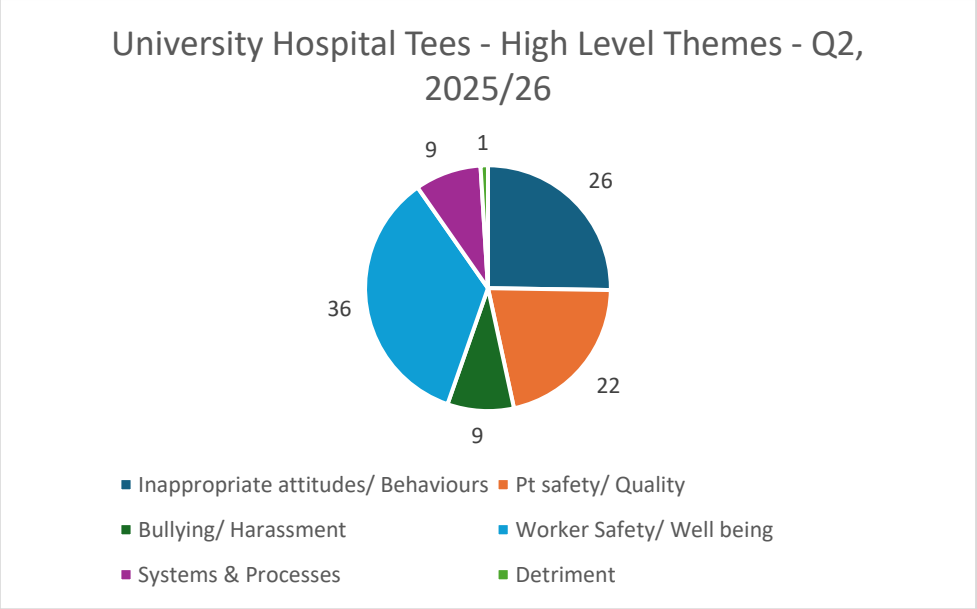
Anonymous reporting at North Tees continues to be low at 0% in both Q1 & Q2, 2025/26. This gives assurance that workers are happy to speak up openly or confidentially, as we aim to make speaking up “business as usual” in an open and transparent way.

Themes

University Hospitals Tees

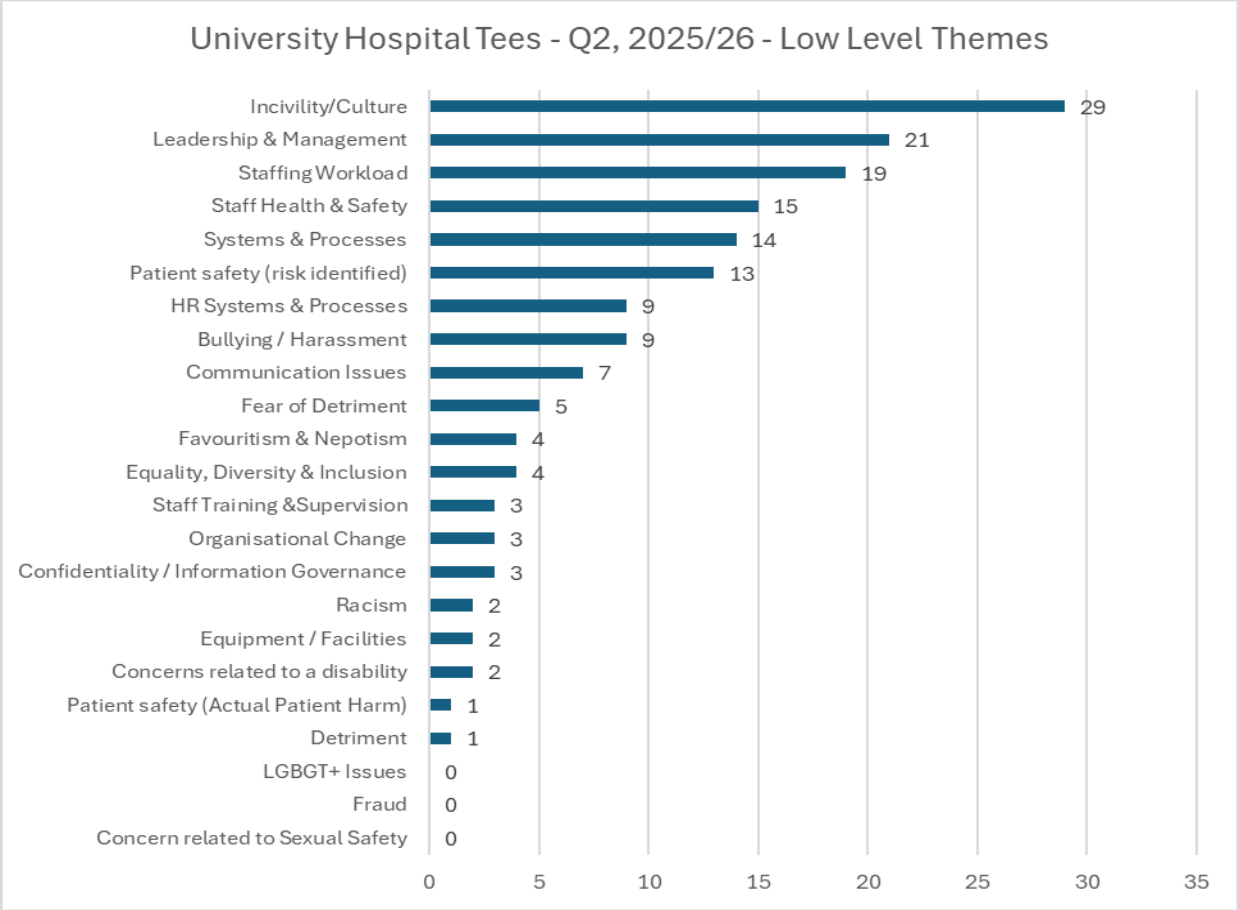
Chart 1 & 2





It is a national requirement to report high-level themes to the NGO on a quarterly basis. For University Hospitals Tees, the highest reported high-level theme for Q1, 2025/26 was Inappropriate attitudes and behaviours. In Q2, 2025/26 Worker Safety/Well Being was the highest report high-level theme. We consider this may be reflective of the ongoing organisational change. To highlight, this was the second highest reported high-level theme nationally at 38.9% of all cases recorded by the NGO in 2024/25.

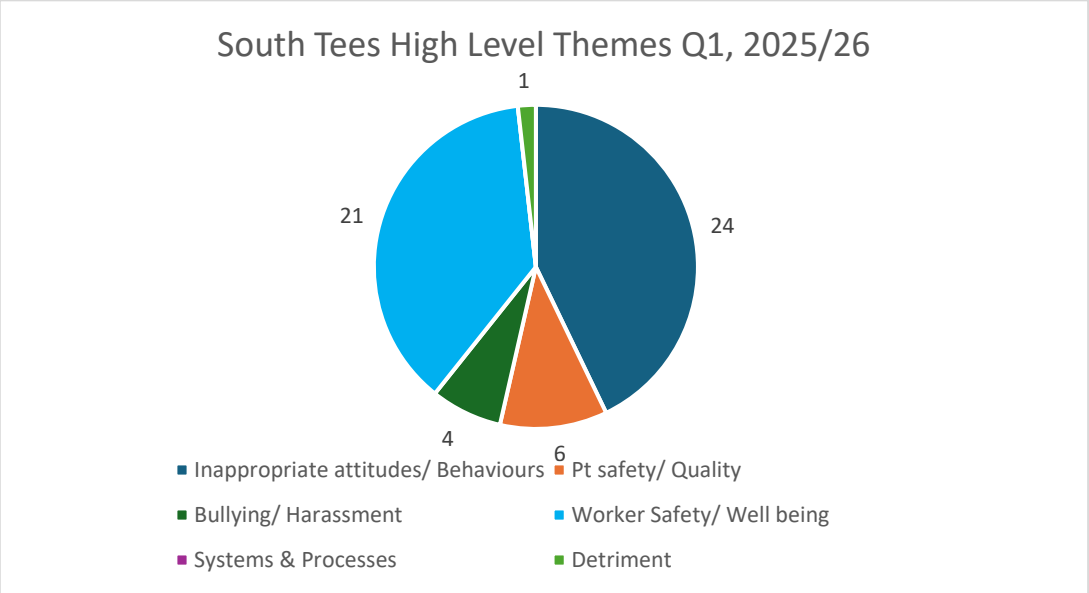
Chart 3

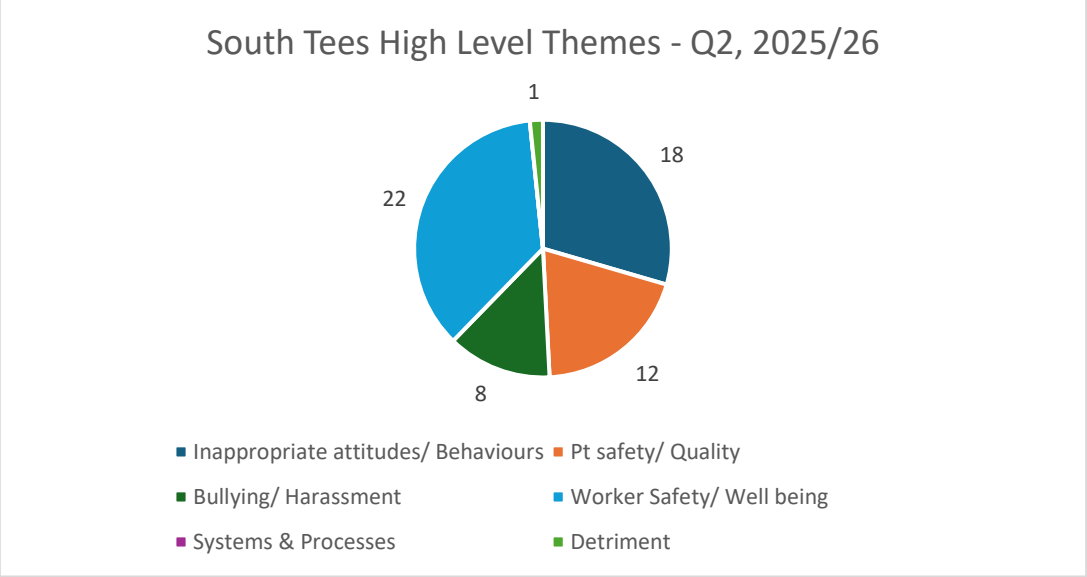


For further organisational learning and triangulation we have broken down the low-level themes. Q2, 2025/26 is the first quarter where North Tees recorded low level themes, therefore this data was not available for Q1, 2025/26. Incivility/culture is the highest reported low-level theme. This again mirrors the national picture as Inappropriate Attitudes/Behaviours accounted for 39.7% of concerns raised nationally. It is important to note that one concern can have a number of themes. From Q2, 2025/26 FTSUG have been reporting organisational change as a low-level theme. There have been three concerns in Q2, 2025/26 where this has been an element of the concern.

South Tees

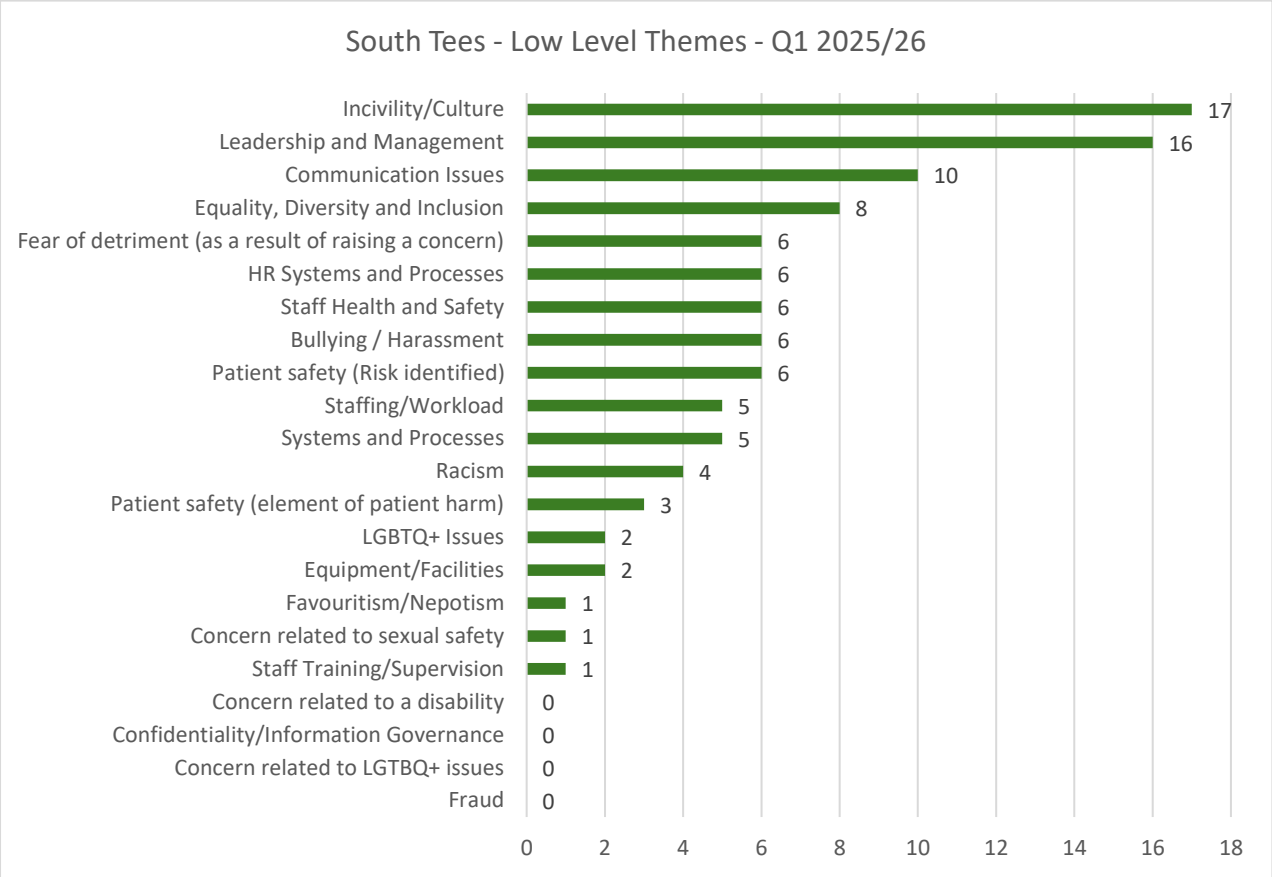
Chart 4 & 5

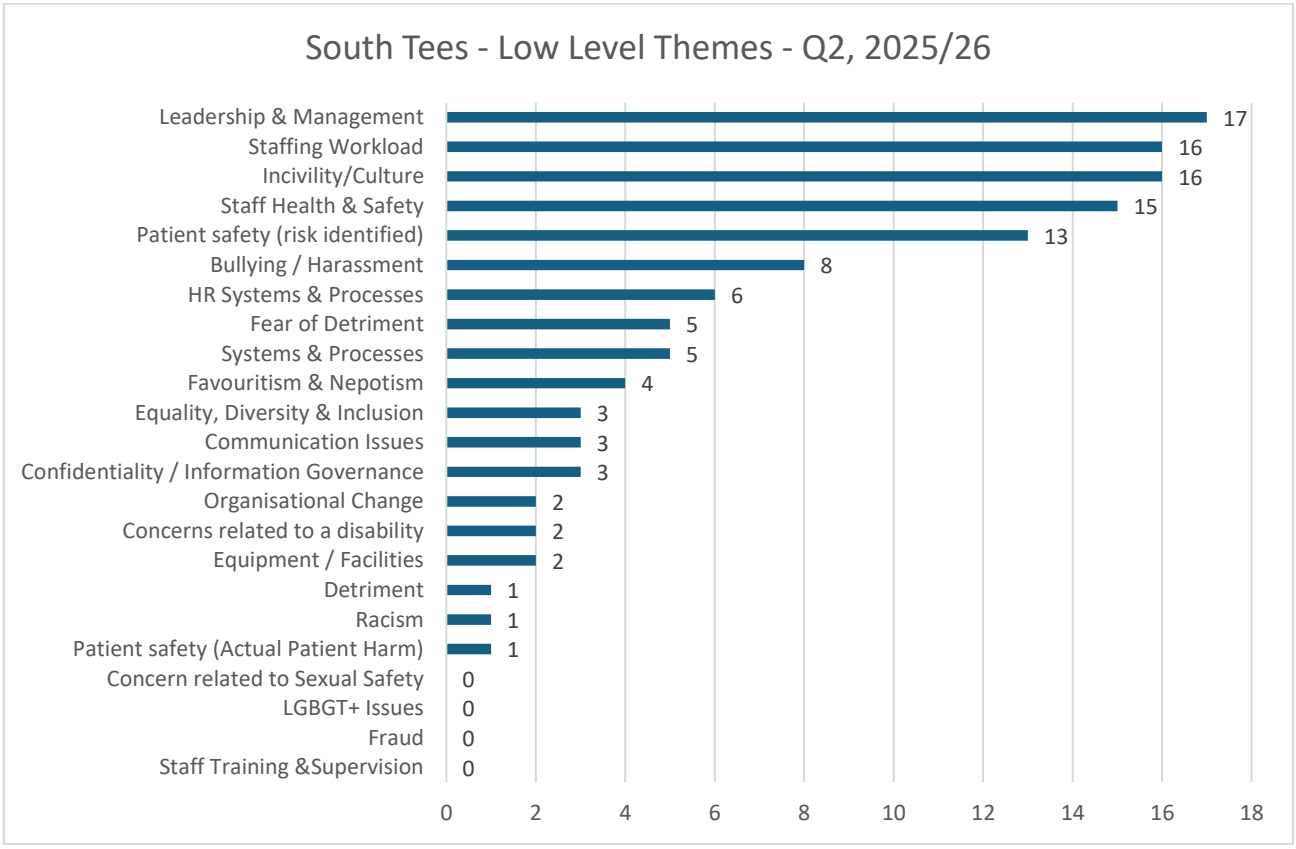




Worker Safety/Well-Being (22) was the most reported high-level theme for South Tees during Q2, 2025/26 and 2nd highest for Q1, 2025/26. As above, we consider this may be reflective of the ongoing organisational change.

Chart 6 & 7





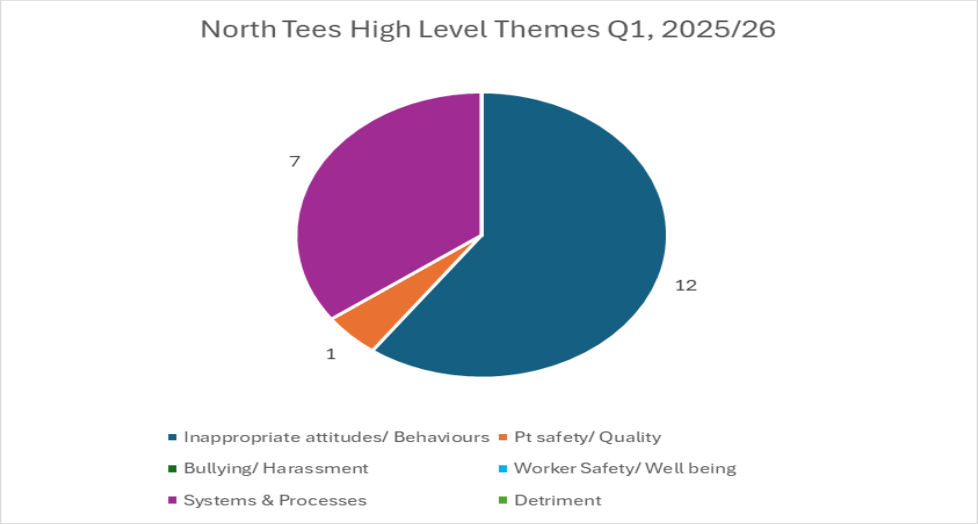
Caring Better Together

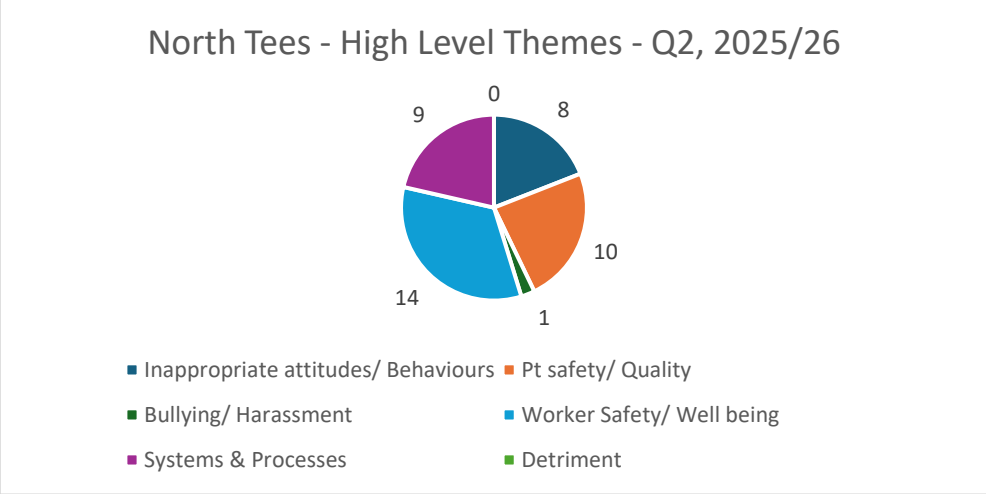
For Q1, 2025/26 the top three low level themes at South Tees were Incivility/Culture, Leadership and Management and Communication. It is worth highlighting that there were 8 concerns with an element of Equality, Diversity and Inclusion. (5 linked to racism, 2 linked to LGBTQ+ and 1 to disability). The FTSUGs continue to meet regularly with the EDI lead.

Staffing/Workload and Staff Health and Safety are in the top three low-level themes at South Tees for Q2, 2025/26. This is reflective of the high-level theme of Worker Safety/Wellbeing.

North Tees

Chart 9 & 10



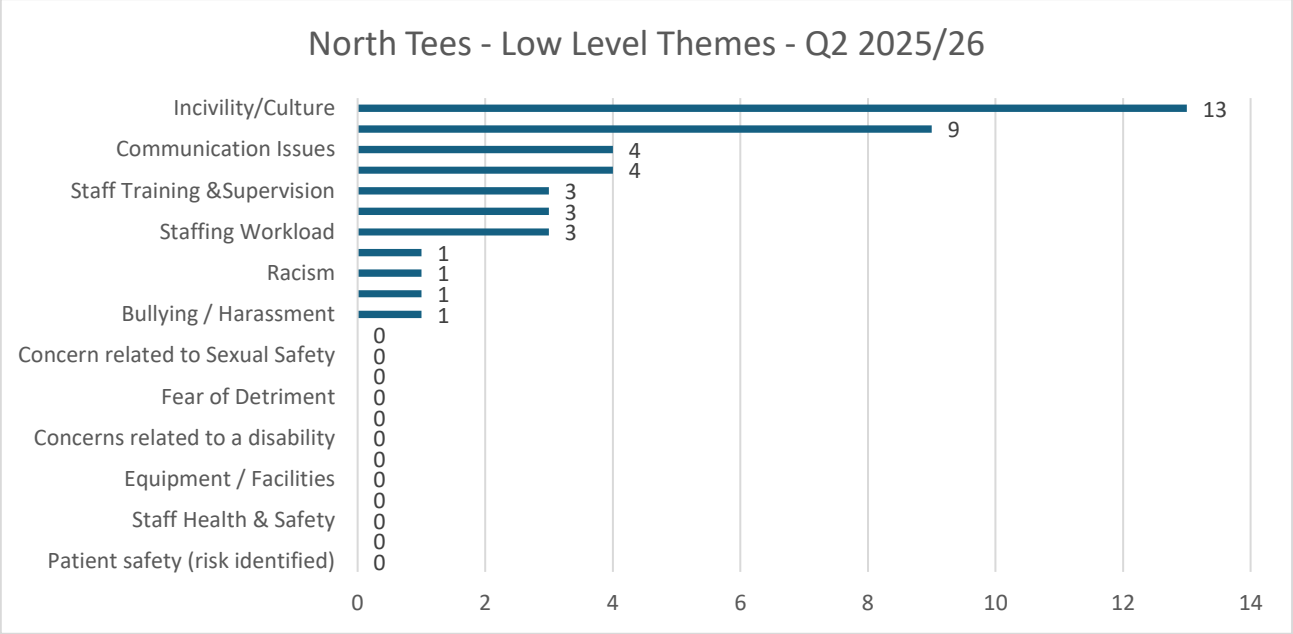


Relationships and behaviours was the highest reported high-level theme at 60**%** for Q1, 2025/26. This aligns with the high reporting on a national level at 40%. Patient safety concerns were low for Q1 2025/26 at 5**%**. From a national picture patient safety concerns are reducing and are currently 17% of concerns raised to FTSUGs. This is due to the robust systems in place like Patient Safety Incident Response Framework. Worker wellbeing although not the primary concern, is impacted because if the concerns they are experiencing.

However, patient safety and quality is the highest reported high-level theme at North Tees for Q2, 2025/26 at 10 (35.7%). Although there are 10 concerns, this includes a group concern

from eight concern raisers, so there are three separate patient safety and quality concerns. Any staff member who raises a patient safety concern is requested to complete an Inphase and the concerns are reported to the Group Associate Director of Patient Safety and are reviewed. Systems and Processes is the second highest reported high-level theme at (9) 32.1% in Q2, 2025/26 compared to 7 (35%) in Q1, 2025/26. Relationships and behaviours is the third highest reported high-level theme in Q2, 2025/26 8 (28.5%) compared to 12 (60%) in Q1, 2025/26. Worker wellbeing although not the primary concern, in Q2 2025/26, was 14 (50%) as concern raisers state their wellbeing has been impacted, secondary to the concern that they have raised.

Chart 11

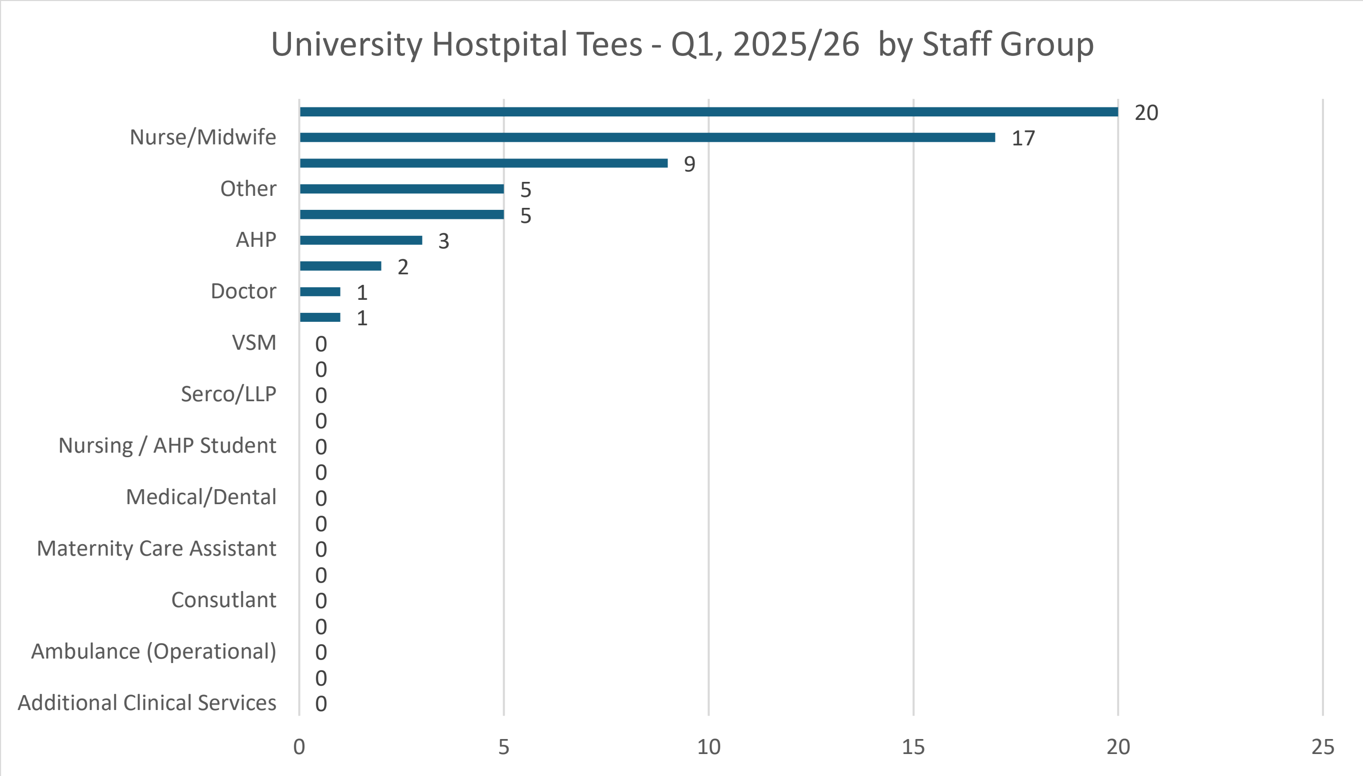


Additionally in the lower-level themes at North Tees the main themes reported are regarding problems with leadership and management, poor communication and lack of training, there was also one concern related to the organisational change. All open concerns and themes are being progressed or investigated and actioned accordingly. Where applicable, staff have received feedback on follow up recommendations.

Staff Groups

Chart 12 & 13 below show the staff groups who have raised concerns at University Hospitals Tees, Table 1 gives the breakdown of staff groups for both Trusts. These are the job titles used by the NGO.

Chart 12 & 13


University Hostpital Tees - Q1, 2025/26 by Staff Group
Nurse/Midwife
Other
AHP
Doctor
VSM
Serco/LLP
Nursing / AHP Student
Medical/Dental
Maternity Care Assistant
Consultant
Ambulance (Operational)
Additional Clinical Services
20
17
9
5
5
3
2
1
1
0
0
5
10
15
20
25

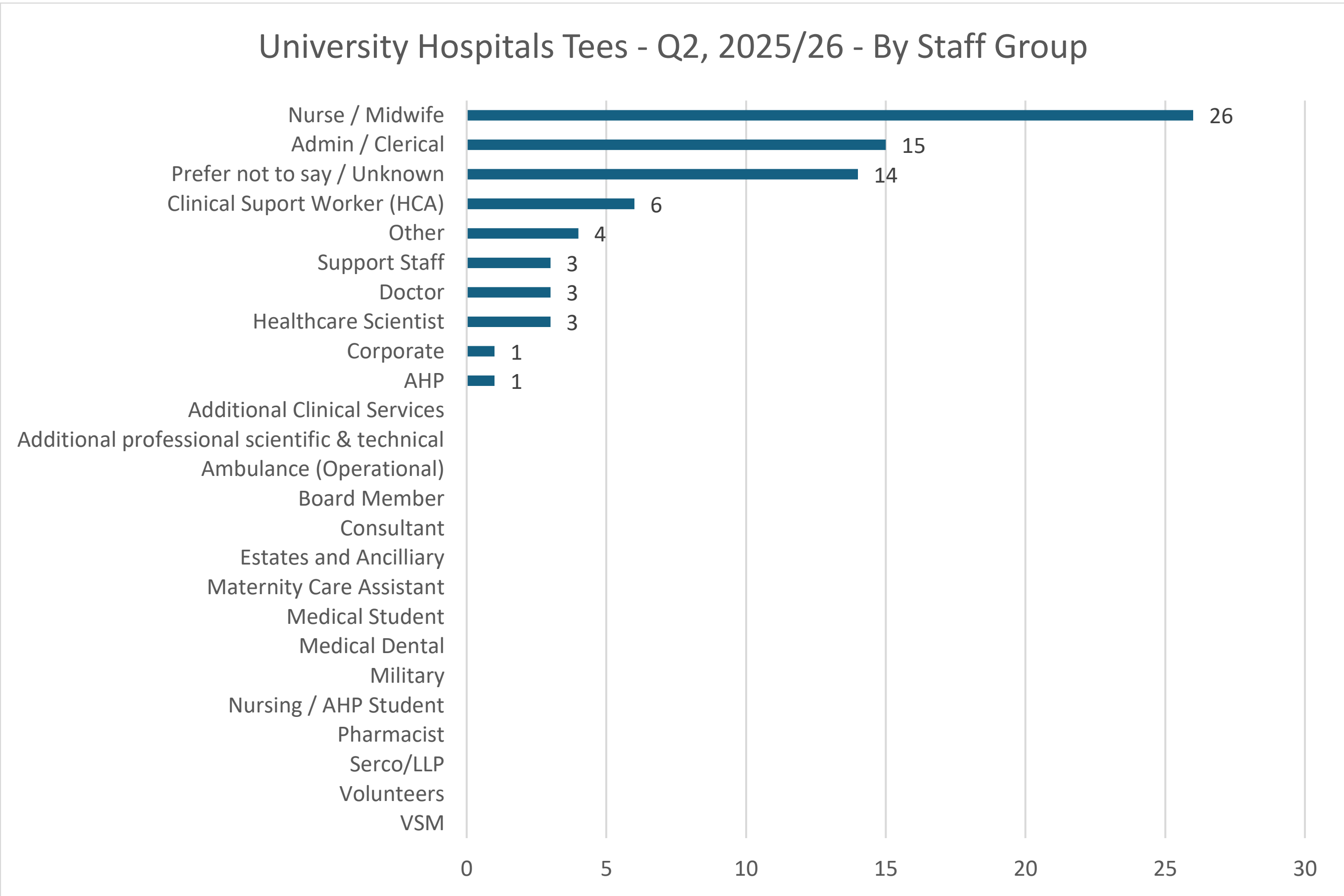

University Hospitals Tees - Q2, 2025/26 - By Staff Group
Nurse / Midwife 26
Admin / Clerical 15
Prefer not to say / Unknown 14
Clinical Suport Worker (HCA) 6
Other 4
Support Staff 3
Doctor 3
Healthcare Scientist 3
Corporate 1
AHP 1
Additional Clinical Services
Additional professional scientific & technical
Ambulance (Operational)
Board Member
Consultant
Estates and Ancilliary
Maternity Care Assistant
Medical Student
Medical Dental
Military
Nursing / AHP Student
Pharmacist
Serco/LLP
Volunteers
VSM
0
5
10
15
20
25
30

Table 1

Role in Trust	STEES	NTEES	UHT
Prefer not to say / Unknown	14	0	14
Nurse / Midwife	11	15	26
Admin / Clerical	9	6	15
Other	4	0	4
Clinical Suport Worker (HCA)	6	0	6
AHP	1	0	1
Healthcare Scientist	0	3	3
Doctor	2	1	3
Corporate	1	0	1
VSM	0	0	0
Volunteers	0	0	0
Serco/LLP	0	0	0
Pharmacist	0	0	0
Nursing / AHP Student	0	0	0
Military	0	0	0
Medical Dental	0	0	0
Medical Student	0	0	0
Maternity Care Assistant	0	0	0
Estates and Ancilliary	0	0	0
Consultant	0	0	0
Board Member	0	0	0
Ambulance (Operational)	0	0	0
Additional professional scientific & technical	0	0	0
Additional Clinical Services	0	0	0
Support Staff	0	3	3
Totals	**48**	**28**	**76**

Not Known/Prefer not to say is the highest staff group at South Tees for Q2, 2025/26 at 14 (29.16%). This decreased from 46.5% in Q1, 2025/26.

At North Tees, Nursing and Midwifery, are the highest reporting staff group in Q2, 2025/26 at 15 (53.5%) followed by admin and clerical at 6 (21.4%). Staff who are speaking up are from a variety of professional backgrounds.

As part of the proactive work during Q2, 2025/26 the FTSUG's at University Hospitals Tees continue to promote the role via attending team meetings, floor walking, community forums, workshops, various training sessions and having a high presence across the organisation. In Q2, 2025/26 FTSUG's have presented to over 300 1st year students at Teesside University who will be placed in various Trust's across the North East.

Equality, Diversity and Inclusion (EDI)

Table 2 below shows the breakdown of concerns raised by sex, ethnicity, sexuality and disability at University Hospitals Tees for Q2, 2025/26. North Tees has only started to record this data from Q1 2025/26. It is worth highlighting that at South Tees staff can self-disclose EDI information via the current FTSU reporting system. This information has to be collected manually at North Tees.

Table 2

EDI Information	STEES	NTEES
Gender:		
Male	8	1
Female	24	9
Prefer not to say	6	0
Unknown	10	0
Ethnicity:		
White	14	10
Asian	0	0
Black	1	0
Other	1	0
Mixed	1	0
Prefer not to say	11	0
Unknown	20	0
Disability:		
Yes	21	1
No	16	9
Prefer not to say	11	0
Unknown	0	0
Sexuality:		
Heterosexual/Straight	14	10
Gay Man	1	0
Gay Woman	0	0
Bisexual	0	0
Prefer not to say	12	0
Unknown	21	0

The FTSUGs are continuing work alongside the various EDI staff groups and meet regularly with the EDI lead to triangulate any issues and themes.

Table 3 & 4

Concerns linked to reported protected characteristics – Q1 2025/26- South Tees			
No. of concern raisers who self-reported being from a BAME background	5	No. of concerns raised related to ethnicity or racism	5
No. of Concern Raisers who self-reported having a disability	Unknown	No. of staff who raised concerns related directly to disability	1
No. of Concern Raisers who self-reported being from the LGBTQ+ community	1	No. of staff who raised concerns related directly to sexuality or gender identity	2

Concerns linked to reported protected characteristics – Q2 2025/26- South Tees			
No. of concern raisers who self-reported being from a BAME background	3	No. of concerns raised related to ethnicity or racism	1
No. of Concern Raisers who self-reported having a disability	21	No. of concerns related to disability	2
No. of Concern Raisers who self-reported being from the LGBTQ+ community	1	No. of staff who raised concerns related directly to sexuality or gender identity	0

Table 5 & 6

Concerns linked to reported protected characteristics – Q1 2025/26 – NorthTees			
No. of concern raisers who self-reported being from a BAME background	1	No. of concerns raised related to ethnicity or racism	1
No. of Concern Raisers who self-reported having a disability	0	No. of staff who raised concerns related directly to disability	0
No. of Concern Raisers who self-reported being from the LGBTQ+ community	1	No. of staff who raised concerns related directly to sexuality or gender identity	0

Concerns linked to reported protected characteristics – Q2 2025/26 – North Tees			
No. of concern raisers who self-reported being from a BAME background	0	No. of concerns raised related to ethnicity or racism	0
No. of Concern Raisers who self-reported having a disability	1	No. of staff who raised concerns related directly to disability	1

No. of Concern Raisers who self-reported being from the LGBTQ+ community	0	No. of staff who raised concerns related directly to sexuality or gender identity	0

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback during the FTSU process. It was recently clarified by the NGO that this can be given through a feedback form, a card, email or verbal feedback and can be given at any point in the FTSU process. Some examples of staff feedback in Q1 & Q2, 2025/26 are included below:

South Tees:

"Thank you so much for your help and support and your colleague Jim who kindly sent me some paperwork which I was really struggling to find"

"Thank you for sticking with me through this and for checking up on me over these last few weeks"

"Thank you for all your help and getting straight back to me." (Q1 – Ongoing case)

"I would have no hesitation in getting in touch with yourself."

"Thank you for being so nice and reassuring on the phone this morning"

"Thanks again for your time and for hearing what we're going through" & "Sorry I'm not feeling at all hopeful with things, but thanks for being there to listen"

"Thanks for listening to me, I just needed to speak with someone who was safe"

"Thankyou for your help and especially your perseverance"

North Tees:

"Thank you for your support today, I will never forget how kind you were to me today."

"Thank you for going above and beyond, to support the escalation of my concern."

"Thank you for your support today, at a very stressful time."

"Just having someone to listen, makes me feel better"

"That when someone raises a concern through the freedom to speak up guardian, those giving the assurance should fully understand the topic at hand and educate themselves on it, instead of listening to assurance from colleagues and repeating this."

"Thank you so much for your support, I feel so much lighter having spoken to you."

"Thank you so much for following up with me and for guiding me into the right direction."

Thank you for listening, it is hard to know who to talk to, when you need to speak to someone impartial.

"It is good to know I have someone to speak to when I am upset, then puts me at ease and gives me good guidance."

"I am concerned that as the FTSUG you cannot attend meetings with me, even if your role is impartial."

Learning Identified from Cases:-

Q1, 2025/26

- From reviewing concerns closed in Q1, 2025/26 for several there is an element that management were aware of staff concerns and were acting on them, but there had not clearly communicated this to the relevant teams. (STEES)
- As an organisation we need to be more curious and invite curiosity to seek the assurance that we are doing the right thing, including speaking to the experts in the organisation, when we are not sure or need an objective perspective (NTEES)
- The highest number of concerns continue to be around relationships and behaviours, a more robust holistic approach, to improve the culture in the organisation, needs to be considered, looking at the culture more curiously and working toward an open, transparent and psychologically safe working environment. (NTEES)
- In the current climate of a fast pace changing environment more consideration needs be given in terms of putting people before process, by achieving outputs with clear communication, thought and consideration. (NTEES)
- As an organisation we need to be receptive and resilient to receiving constructive and fair feedback, when there are suggestions of improvement, rather than come for a place of retaliation. (NTEES)

Q2, 2025/26

- Conversations between FTSUG and concern raiser often empower staff to approach line managers/supervisors directly (UHT)
- When staff have spoken up to the Senior Management Team about a concern or an improvement, they should be followed up and assured that their concern has been listened and responded to within the scope of possibility (UHT)
- A high proportion of concerns continue to be around relationships and behaviours, a more robust holistic approach, to improve the culture in the organisation, needs to be considered, looking at the culture more curiously and working toward an open, transparent and psychologically safe working environment. (UHT)
- In the current climate of a fast paced, changing environment more consideration needs be given in terms of putting people before process, by achieving outputs with clear communication, thought and consideration (UHT)
- The importance of leaders having the opportunity to hear staff and to feedback (STEES)
- When new systems are put in place, workers should receive advanced adequate training, so staff feel prepared and supported, to mitigate unnecessary stress and anxiety. (NTEES)
- When staff are on sick leave a term of reference should be formulated with the worker regarding check in calls, so staff are not off for long periods of time without this support offering, which can further impact wellbeing. (NTEES)

University Hospital Tees Awareness Raising and Training

Table 7

All staff inductions
Preceptorship Training
Undergraduate Medical Students
Postgraduate Doctors
T-Level Students
Teesside University
Care Group 1-3
NTH Solutions Induction
Quarterly Community Forum
Joint Forum
Schwartz Round Steering Group
Quarterly Community Forum
Quarterly Patient Safety Steering Group
Quarterly Senior Practitioner Manager Operational Meeting
Quarterly Matrons Meeting
Quarterly Care Group Senior Management Team Meetings
Quarterly Group People Committee
Quarterly Board
Monthly meetings with Care Group Directors
Ward/Directorate Meetings
Care Certificate
People Hub
Digital/Health Records Team Meetings
North East Yorkshire Regional Conference
Freedom to Speak Up Champion Network
North Tees People Group

South Tees Training Figures Q1 & Q2 2025/26

As per end of August 2025/26 training at South Tees via ESR was as below. There have been no workshops requested at South Tees. We feel this is due to the high number of staff who have completed training via ESR. We are awaiting updated figures from Workforce.

Element	In Date	Overdue	Total	% Compliance
Freedom to Speak Up - Level 1	8088	1935	10,023	80.69%
Freedom to Listen Up - Level 2	2423	614	3037	79.78%
Freedom to Follow Up - Level 3	19	23	42	45.24%
Trust	**10,530**	**2,572**	**12,639**	68.57%

The Guardians at South Tees site also attend Teesside University on an annual basis to work with third year student nurses and Allied Health professionals raising awareness of FTSU, the guardians attended a recent induction for Allied Health Professionals with approximately 200 students present.

North Tees Training Figures Q1 2025/26

At North Tees training via ESR is Speak Up - 373, Listen Up - 95, Follow Up - 13

With 124 staff attending FTSU Workshops

North Tees Training Figures Q2 2025/26

At North Tees training via ESR is Speak Up - 421 Listen Up - 95, Follow Up – 13 with 172 staff attending FTSU Workshops

FtSU at North Tees and South Tees have created a new University Hospital Tees induction which will be rolled out at the beginning of October as part of the new induction programme.

Speak Up Week - 13 October 2025

As directed by the NGO, this year will be 'Speak up Week' rather than 'Speak up Month' during w/c 13 October 2025. There are events planned across University Hospitals Tees sites, Teesside University, a Town Hall event at the LLP. FTSU have successfully requested funding to support with merchandise to promote this as currently FTSU has no allocated budget. The guardians have linked with comms to promote the upcoming planned events and locations. There is a regional virtual FTSU conference on 1 October 2025 that the exec team have been invited to. The Guardian Team at University Hospitals Tees have been involved in the arrangement of this.

University Hospital Tees Key Achievements/ Implementation Plan

The FTSUG's across University Hospital Tees, have developed an implementation plan, which is reviewed regularly by the guardians, updates are provided below on some elements of the plan. As elements of this are core business of the FTSUG's, some of the actions are ongoing, forming part of their everyday work.

Table 6

Action	Lead Trust	Due Date	Progress	Status (open, ongoing, completed, to note)
Champion training Development of Champion role, awareness and training Network	Group	Q1-4 2025/26	Both North and South Tees continue to expand their FTSUC network, through a fair recruiting process, as per National Guidance. FTSUC are trained, can attend quarterly network meetings, have informal bi –annual 1-2-1 and are asked to support staff and signpost and collect high level themed data for triangulation. The first UHT FTSU Champion meeting was held on 26 September 2025.	Ongoing
Detriment Work	Group	Q4, 2025/26	To tackle the barrier of detriment for workers speaking up, an additional resource of awareness sessions and guidance has been developed. This has now been approved and will be included with the new University Hospital Tees FTSU policy.	Complete
Staff survey to be used to develop focussed work in each area.	Group	Q1, 2025/26	The staff survey 2024 has now been published, the FTSUG's have completed a review of the data have broken this down into care groups and collaboratives and are in the process of completing walkabouts across sites focusing on those areas who have scored higher and lower than average.	Complete

Data Peer Review	Group	Q1-4 2025/26	As part of the Group reflection work the FTSUG's at North and South Tees thematically peer review a selection of cases, on a monthly basis.	Ongoing
Triangulation of Data	STEES NTEES	Q1-4 2025/26 Q1-4 2025/26	STEES attend current cases, staff side, patient safety meetings, STACQ monthly meetings attended. Group People Committee and Board. NTEES attend patient safety steering group, Care Group SMT, Group People Committee and Board.	Ongoing
EDI - Guardians to link with EDI Network Meetings	Group	Q1-4 2025/26	All FTSUG's are members of relevant network meetings across the sites. NTees has established a weekly People Hub, run by the network leads. The FTSUG uses this as another platform to connect with staff and promote FTSU and work with the network leads.	Ongoing
Group Recording System	Group	TBC	FTSU System for recording concerns. Currently bespoke at STees, NTees currently has an Excel Spreadsheet. To align as a group in the recording of concerns, the InPhase system has been agreed and waiting for a date for implementation.	Ongoing

Conclusion:

Members of the Group People Committee are asked to support the alignment of the FTSU Policy which will include the new FTSU contacts and add the detriment guidance.

To complete the Freedom to Speak Up: A Reflection and Planning Tool as we move forward with University Hospitals Tees

To consider the strategic and operational implications for speaking up culture, staff engagement and assurance framework following the announced disbanding of the NGO.

To consider the wellbeing of staff during the ongoing organisational changes/restructure.

Enclosed:

Appendix 1 – Anonymous Reporting Review South Tees

Review of Anonymous Reporting at South Tees

1. National Analysis – Benchmarking of Anonymous Reporting Rates

FTSU data from peer trusts shows South Tees consistently ranks in the top decile nationally for anonymous reporting — significantly above the national average, peers, and organisations of other sizes, including North Tees, which records few or no anonymous cases. This makes South Tees a national outlier (Figure 1).

There is a small but statistically significant positive correlation between total concern volumes and anonymous reporting at a national level. At South Tees, high anonymity coexists with lower than median concern volumes compared to peer trusts (151 vs 205.5) however given the large standard deviation in the results, South Tees is not an outlier in terms of numbers of concerns received.

The high rate is unusual and the reasons behind our high rates of anonymous reporting need to be better understood considering our new group working model with NTH who have historically recorded low-to no anonymous reporting and with proposed changes to the FTSU reporting system.

2. Local Analysis – Overview

Five years of data (2020–2025) show a steady rise in concerns raised to the FTSUGs, possibly due to greater Guardian visibility or staff need (Figure 2). The first half of 2025 already shows 44 concerns, indicating sustained high activity.

Anonymous reporting rates fluctuate considerably from quarter to quarter, but our annual rate has remained steadily consistent (Figures 3 and 4). This may indicate that anonymous reporting is somehow “baked in” to either our organisational culture, our current model of FTSU or system design. We also have seen a decline in open reporting with a commensurate rise in confidential reporting suggesting shifting comfort levels or perceptions of safety over time (Figure 5).

3. Correlation Between Stress Periods and Reporting Method

During organisational stress periods, anonymous reporting showed a small negative relationship, while confidential reporting showed a strong positive correlation. This suggests staff are seek added protection without full anonymity during pressure periods, reinforcing the need for multiple, flexible routes.

4. Fear of Detriment and Reporting Method

Since we first started to capture this in 2024, the theme Fear of Detriment has been recorded most often in confidential reports (20.8%), followed by open (18.4%) and anonymous (15.0%). Differences were not statistically significant suggesting that fear does not appear to be a dominant driver of anonymity, though measurement is new, subjective, and harder to capture in anonymous cases.

5. Higher-Level Thematic Analysis

High Level Theme	STH 2020-present	STH 2024/25	NGO 2024/25	NGO Peer trusts 2024/25
Inappropriate attitudes/behaviours	36.3%	52.8%	39.7%	40.5%
Bullying/harassment	32.7%	15.1%	18.4%	22.7%
Worker safety/wellbeing	22.1%	23.9%	38.9%	37.9%
Patient safety/quality	13.8%	20.1%	17.8%	18.2%
Detriment	1.6%	3.1%	2.9%	2.4%

Anonymous reports were more likely to involve inappropriate attitudes/behaviours, while bullying/harassment appeared more in open reports. Both differences were statistically significant.

When we looked at our granular themes, bullying was again often reported openly, while communication issues, fraud, and disability-related concerns were more often reported anonymously. These trends may reflect perceived risk, trust, or sensitivity, supporting the need for flexible pathways.

6. Staff Group and Directorate Reporting Patterns

Due to many unspecified entries, we were unable to carry out meaningful analysis. This highlights the need for better data capture on staff groups, job roles, and work areas in any new system.

7. Analysis of Anonymity in Multi-Themed Concerns

Single-themed concerns were more likely to be anonymous; multi-themed concerns were less likely to be. This difference was statistically significant and may reflect the limits of one-way communication in anonymous cases.

8. Analysis of Anonymity in EDI-Related Concerns

EDI-related concerns were more likely to be raised confidentially and less likely anonymously, though differences were not statistically significant. However, inconsistent data collection and a recent surfacing of an issue within the current reporting system means that this analysis may have been carried out on flawed data. We will be revisiting this to exclude disability data, but this reinforces the need to decide what information to prioritise and whether some details should be mandatory in future systems.

9. Visualised data

Figure 1. National Benchmarking Anonymous Reporting. (Large NHS organisations only)

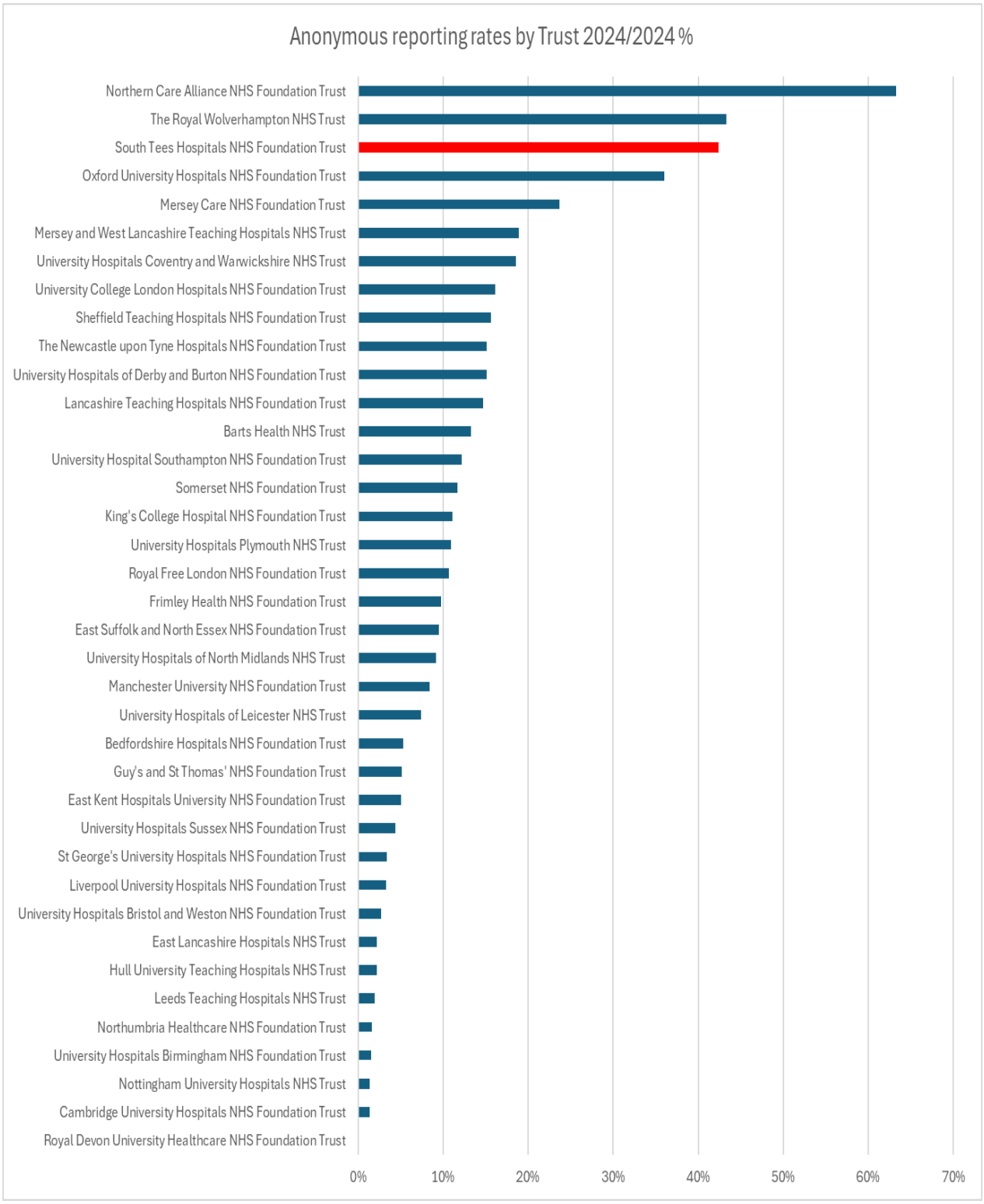


Figure 2. Concerns received by year

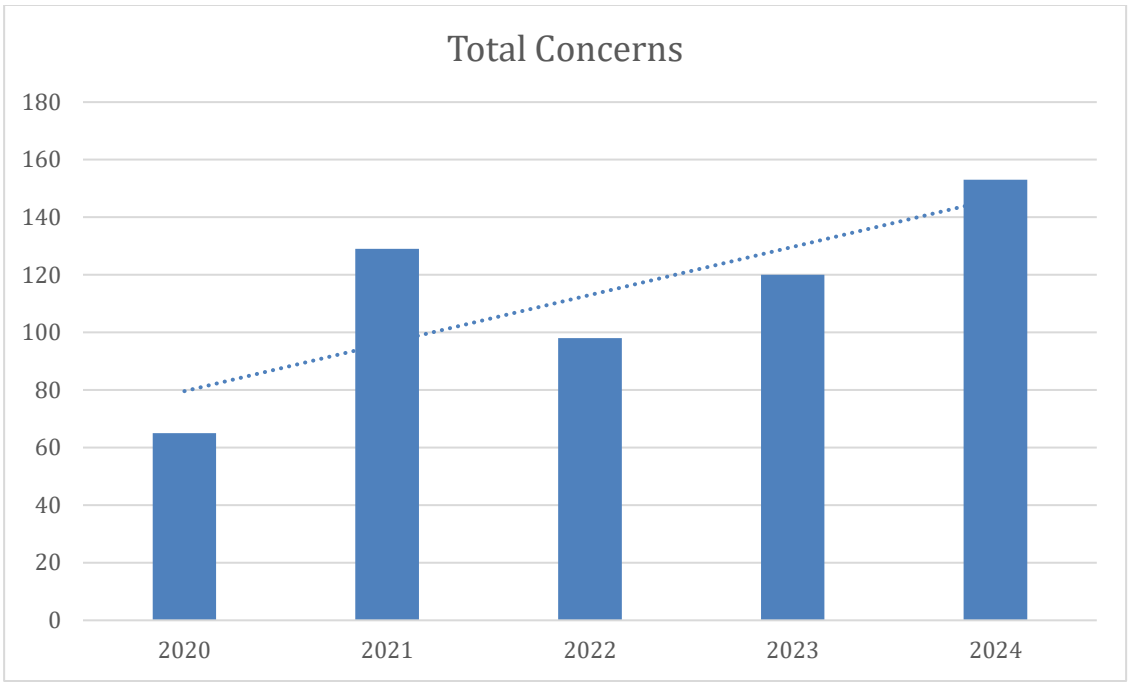


Figure 3. Anonymous Reporting by Quarter and Year

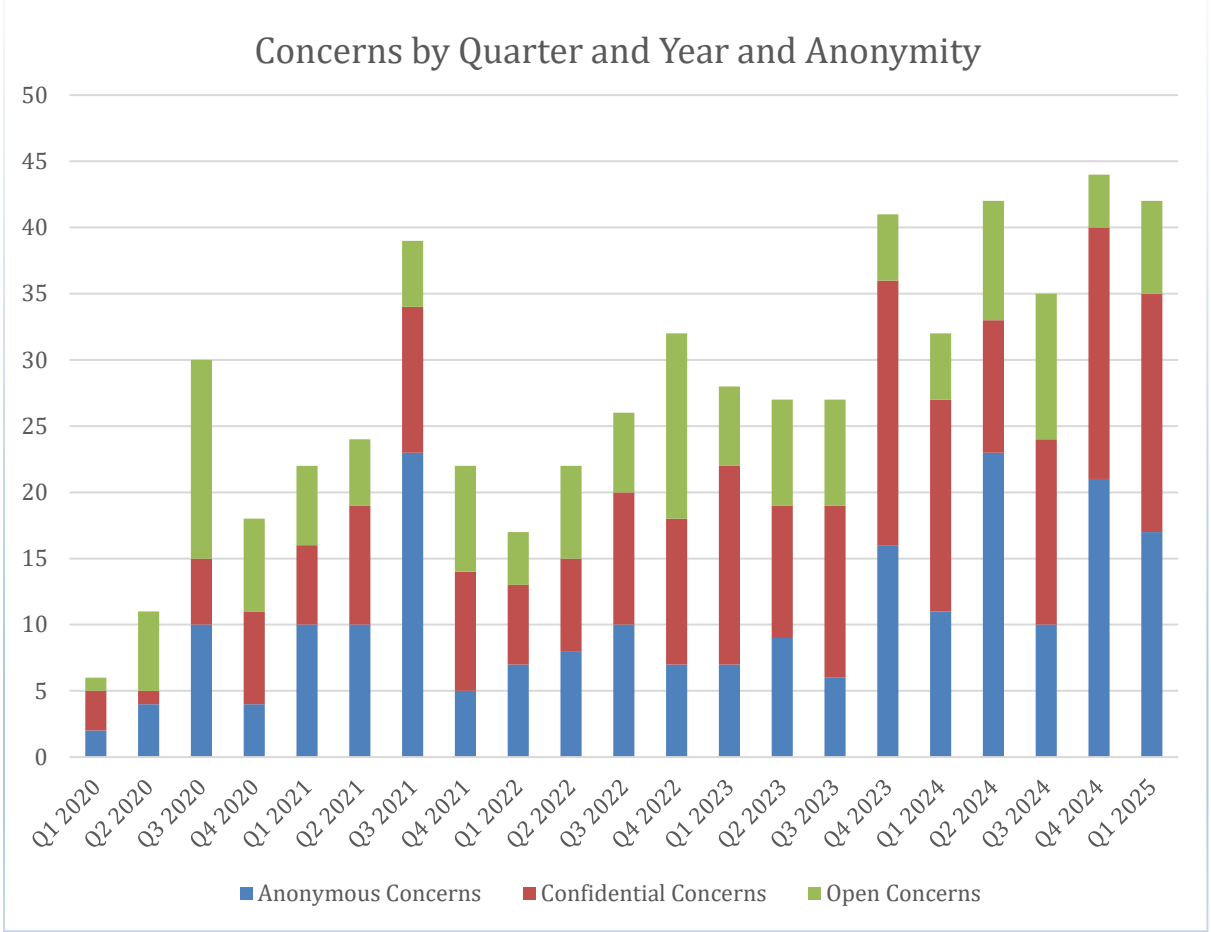

Concerns by Quarter and Year and Anonymity
50
45
40
35
30
25
20
15
10
5
0
Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Q2 2021
Q3 2021
Q4 2021
Q1 2022
Q2 2022
Q3 2022
Q4 2022
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Q1 2024
Q2 2024
Q3 2024
Q4 2024
Q1 2025
Anonymous Concerns
Confidential Concerns
Open Concerns

Figure 4. Anonymous reporting rates over time, trendline showing consistent anonymous reporting

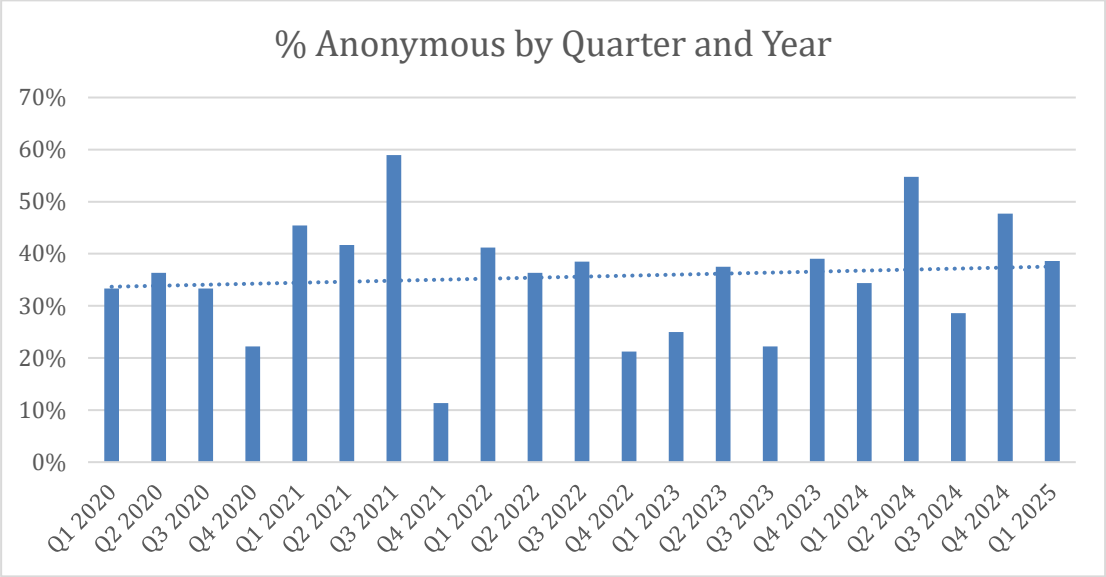
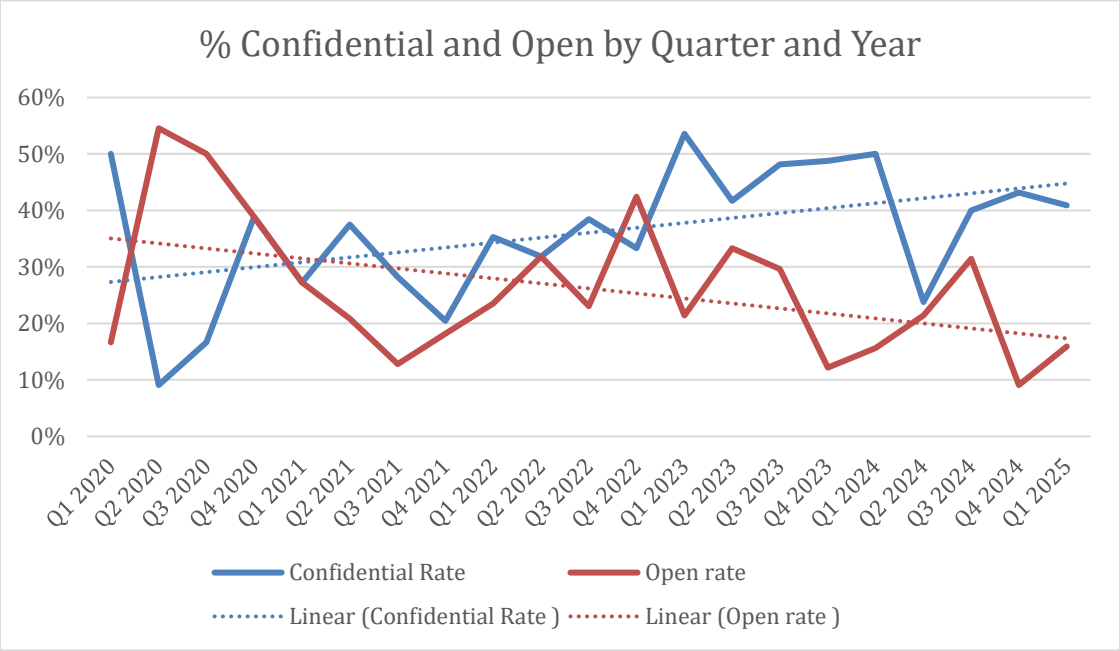


Figure 5. Changes in Open and Confidential reporting trend lines showing gradual shift from Open to Confidential reporting.



University Hospitals Tees

Guardian of Safe Working Annual Reports – August 2024 to July 2025

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 3.4

Report author: Catriona Lane, GOSW STHFT, Rajesh Nanda, GOSW, NTHFT, Laura Hartley, Group Senior General Manager to CMO Office

Executive director sponsor: Mike Stewart, 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, leading to doctors working beyond their contracted hours. Regarding rostering roles across UHT, this may be a complex case for change due to current differing models.

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 with our resident BMA reps to ensure we are addressing issues, some of which feature in the recently relaunched 'Improving working loves of resident doctors' programme.

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

We have had many successes over the last year which are a result of our close collaboratively working culture with resident BMA reps. These include:

a. Standardising our resident doctor forums across UHT ensuring that we have voted in chairs and nominated representatives from directorates.

b. Developed a less than full time worker SOP to reduce pay errors.

c. Developed our ER SOP in line with the new reform.

d. Procured a simpler ER software (STH site only at the moment) which allows for greater access and better data analysis.

e. Procured a new compliance software (STH site only at the moment) which aims to improve the accuracy of resident grade medical workforce pay.

f. Due to pressures on training posts, we ringfenced our locally employed doctor vacancies to those already working for the Group.

g. Hold fortnightly meetings to progress resident grade medical and dental staff workstreams.

h. Weekly guarded time to review work schedule issues and provide solutions.

Recommendations:

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

NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
GUARDIAN OF SAFE WORKING (GOSW) ANNUAL REPORT
1 AUGUST 2024 to 31 JULY 2025

1. PURPOSE OF REPORT

Aggregated annual GOSW report highlighting issues and trends captured through the exception reporting (ER) system raised by resident doctors. 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)	85
Total Resident Doctors	**336**

b. **ERs with Immediate Safety Concerns (ISC).** During this reporting period, 48 doctors submitted 202 exceptions. Four of which were marked as an ISC due to staffing shortages and workload. There are no patient safety incidents reported which link to these exception reports. The review by the supervisor did not highlight any patient safety incidents, but did note the doctors' concerns.

c. **GOSW Fines**. Fifteen fines levied across medicine and surgery due to breaches in the maximum 13-hours shift length and/or 11 hours rest between shifts. Equating in a total of £817 in fines. Increasing the Guardian's reserves to £1,786, after part of the fine was to the doctors in question.

d. **Payment for additional hours**. Payment for additional hours worked continues to be the main outcome. Exception reporting shows approximately 255 additional hours worked, of which 205 hours paid as unplanned overtime.

Data. A summary of ERs is given in appendix one.

4. SUMMARY OF ISSUES, ACTIONS AND RECOMMENDATIONS

a. **Surgery rotas**. Surgery have seen an increase in exception reporting from FY1 trainees who submitted 34 exceptions, in comparison to nine submitted the previous year. The majority relate to the Surgical Observations Unit, the department is aware of the increase.

b. **Orthopaedic rotas.** In August, Orthopaedics implemented a new temporary ten-doctor rota for six months due to supernumerary trainees. As planned, it subsequently reduced

to a nine-doctor rota, which remained an increase to the original eight-doctor rota. Only six exceptions submitted this year in comparison to 21 the previous year. However, it is worth noting that four out of the six submitted in the last quarter.

c. **Medicine rotas**. Resident doctors continue to report concerns relating to workload and staffing shortages; leading to doctors working beyond their contracted hours. Submitting 159 exceptions this year, an increase of 17 in comparison to the 142 submitted the previous year. Issues relate to base wards. The GMC 2025 trainee survey highlighted low satisfaction from trainees in relation to workload in both Cardiology and Gastroenterology. Supervision also scored low within Gastroenterology. The Gastroenterology team have recently undertaken some quality improvement work, which includes review of handovers, huddles, ward rounds etc. To ensure resident doctors are supported and aware of plans for patients from senior decision makers. Clinical Rota Leads within Medicine continue to review rotas based on feedback, engagement with doctors and working with STH colleagues regarding their approach.

d. **Rota gaps/vacancies.** Gaps in rotas can affect wellbeing, workload, and the quality of training. Following the December rotation, O&G had persistent gaps on their tier 1 rota, requiring additional support in the form of agency to provide stability. This is due to training post vacancies and sickness absence. Several doctors also had restricted duties preventing their contribution to out-of-hours cover. The department plan to recruit a locally employed Trust doctor due to persistent gaps/training vacancies. They also scored positively in relation to workload and rota design on the GMC 2025 training survey.

e. **Compliance information.** For the August 2025 rotation, the Trust provided 92% of schedules to the Lead Employer Trust before 8 weeks. This includes any additional trainees allocated after the 12-week deadline.

f. **Exception Reporting Reform.** The GOSW and CMO office continue to work together to ensure the Trust is compliant with the new framework. From 6th August 2025, the Trust has removed all supervisors from the ER process, aligning the change in process with the August rotation.

g. **Out-of-hours hot food provision**. The first vending machine, located in the rainbow room, went live in September 2024. The second became operational in March 2025; however, it only offers cold sandwiches and snacks rather than hot meals.

h. **Clock Changes.** Two of the fines levied relate to the clocks going back in October. The department was unable to put alternative arrangements in place to avoid breaching the max 13-hour shift length. The Trust has previously taken action to remove all shifts 13-hours in length, but most rotas still require 12.5-hour shifts to allow for safe and effective handover between day and night teams. This is a recurring issue every March and October; it is recommended rotas/shifts be adjusted proactively to prevent breaches. Where this does not happen, doctors are encouraged to exception report.

i. **Location/Ward.** Since introducing the option to include the location on exceptions, it has been utilised on 110 reports. Of which, 26 relate to respiratory wards, 24 relate to Gastroenterology wards, 15 relate to the Surgical Observation Unit (ward 31), and another 10 relate to ward 28 and 37 Medical acute unit. Medicine initially requested the ability to record this information to gain further insight into problem areas.

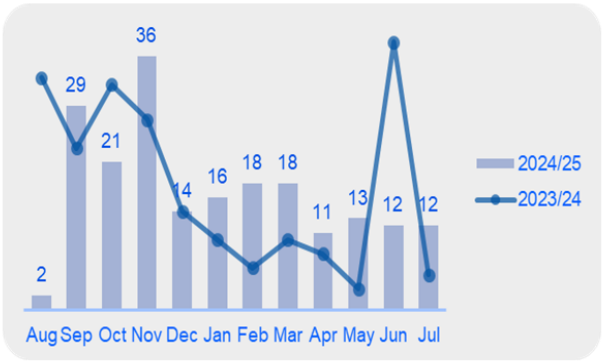
5. CONCLUSION

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 and surgical rotas, this is an area of continued focus.

Exception reporting 1st August 2024 to 31st July 2025

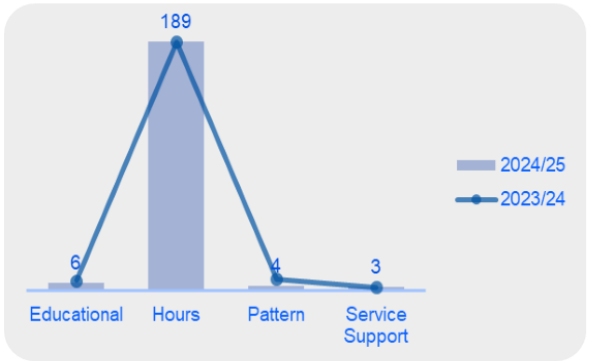
Exception Reporting

1st August 2024 to 31st July 2025



202 exception reports by 48 doctors

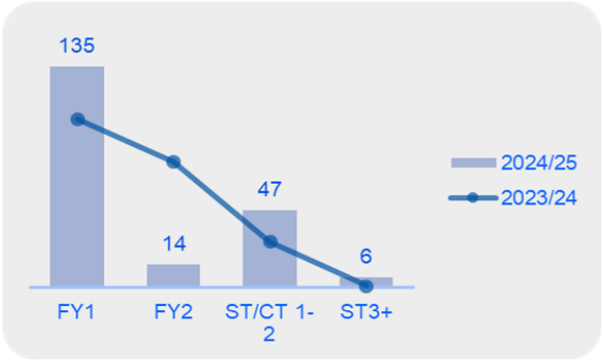
Four marked as immediate safety concerns



Majority (94%) relate to hours worked

74% (150) payment given

16% (32)TOIL given

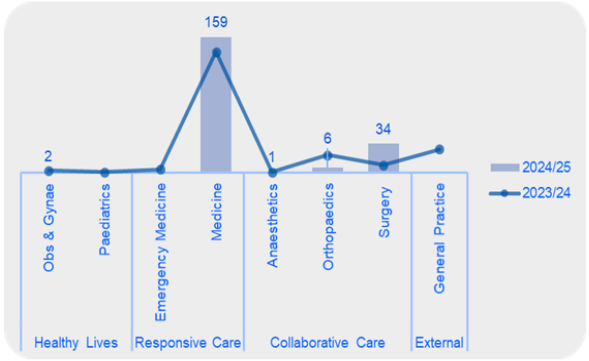


Majority (67%) by FY1 doctors

23% by CT/ST1-2

7% by FY2

3% by CT/ST3 and higher



79% Medicine

17% Surgery

3% Orthopaedics

15 x FINES levied (£817) for working beyond the maximum 13 hours limit. Increasing the Guardians reserves to £1,786

Exception reporting 1st August 2024 to 31st July 2025 – Themes

	Educational	Hours	Pattern	Service Support	Grand Total
Anaesthetics	0	1	0	0	1
ST3+	0	1	0	0	1
Medicine	5	148	4	2	159
FY1	0	94	1	1	96
FY2	2	10	1	1	14
CT/ST1-2	1	41	2	0	44
ST3+	2	3	0	0	5
Obs & Gynae	1	1	0	0	2
CT/ST1-2	1	1	0	0	2
Orthopaedics	0	5	0	1	6
FY1	0	4	0	1	5
CT/ST 1-2	0	1	0	0	1
Surgery	0	34	0	0	34
FY1	0	34	0	0	34
Grand Total	**6**	**189**	**4**	**3**	**202**

SOUTH TEES NHS FOUNDATION TRUST
GUARDIAN OF SAFE WORKING (GOSW) AGGREGATED ANNUAL REPORT
AUGUST 2024 TO JULY 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 August 2024 – 31st July 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)**. 537 ERs were submitted during the annual reporting period. There were 14 ERs that met the criteria for IPSC. The majority related to resident doctors managing unwell patients at the end of their shifts and being unable to leave on time without the patient coming to harm.

c. **GOSW Fines & Finances**. There were 27 fines issued by the GOSW within this annual reporting period. The majority for breaches of the >13-hour shift length. Clock changes at both ends of the winter contributed to a number of these. A significant number of rota patterns with 12.5 hours shifts on the weekend make the risk of this kind of breach ongoing. The fines during this annual reporting period total £3275.09, of which £2046.91 should be added to the GoSW account. This did not exist at the start of the current GoSW tenure and adds to a total of £503.12 allocated to the fund from Feb 24 to July 24. This should make the current GoSW fund at a total of £2550.03, once all movements of funds have taken place.

d. **Payment for additional hours**. A total of 481 hours of overtime has been paid to resident doctors in this annual reporting period. The actual cost of this is becoming clear, with the new ER software easily able to calculate the amount. For the last two months of the year this overtime came to £1190.62 for 52 hours. Extrapolated for average cost per hour, this is approximately £11000 of overtime for the academic year.

e. **Data**. A summary of ERs compared to available data from 23-24, is given in appendix 1.

4. SUMMARY OF ISSUES AND RECOMMENDATIONS

a. **ER themes.** Themes across the year include excess daytime workloads or increased workloads due to staff shortages, and these remain the highest cause of residents staying late,

with most of this overtime directly after the normal working day. Fines related to overtime on long shifts (12.5 hours) are the most common reason for penalty payments.

b. **Clinical areas of concern.** Areas with persistent high levels of ERs are General Surgery, Oncology and Respiratory. The GoSW has reached out to clinical rota leads in General Surgery and Oncology with the annual data, to work with them to explore solutions.

c**. Work Schedules.** At the beginning of the reporting period there was significant concerns around the number of work schedules issued on time to resident doctors. In August 24 this was a low as 50%. However, this has steadily improved through the year, due to hard work and focus from the CMRT and in preparation for August 25, this was near to 95%. LTFT remains an area of challenge, but a new SOP will hopefully improve this for the next academic year.

d. **CMRT.** Throughout the year staffing levels for the CRMT have improved and they are, at the end of the reporting period, at full establishment with all staff members in work. This has helped to ease the burden of a high workload and has contributed to improvement seen with meeting Code of Practice deadlines for work schedules.

e. **ER processes.** The ER process for Aug 24 – May 25 remained via use of a Microsoft Forms application, which was put in place in Feb 24. Whilst this has significantly improved the access to submission of an ER for resident doctors and had the desired effect of greater reporting (doubling at least), the admin burden on the GoSW was considerable. In June 2025 the trust moved across to PayPulse, having initiated an innovation contract with the company. The new software is already easing this burden, providing financial clarity of the cost of overtime and fines and facilitating report production and governance. Work is already ongoing towards the ensuring South Tees is compliant with the new ER framework due to commence in September 2025.

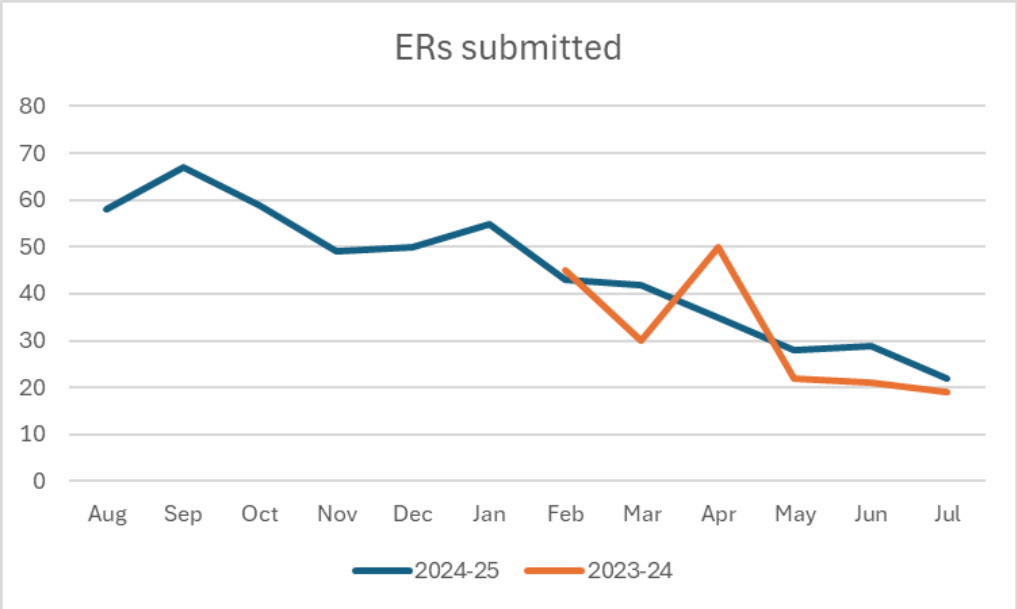
f. Finances. Finance processes remain challenging although progress is being made. The GoSW fines account now exists and there is money available to spend. The process for spending this money and the financial controls required by South Tees are still being negotiated and as of yet none of the fines have been able to be spent.

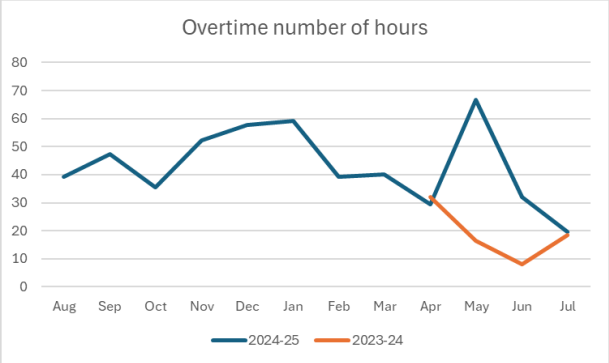
g. **Resident Doctor Forum.** The resident doctor forum has been successfully co-chaired by resident doctors Fergus Dewar and Jack Fletcher this year. Achievements have included updating the Too Tired to Travel policy, showcasing the South Tees Exception Reporting policy as being ahead of the framework reforms as well as being a forum for the resident doctor voice around parking, rota issues, access to rest facilities and fair access to leave.

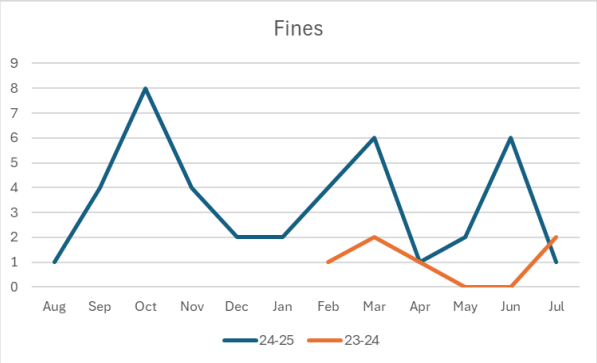
5. CONCLUSION

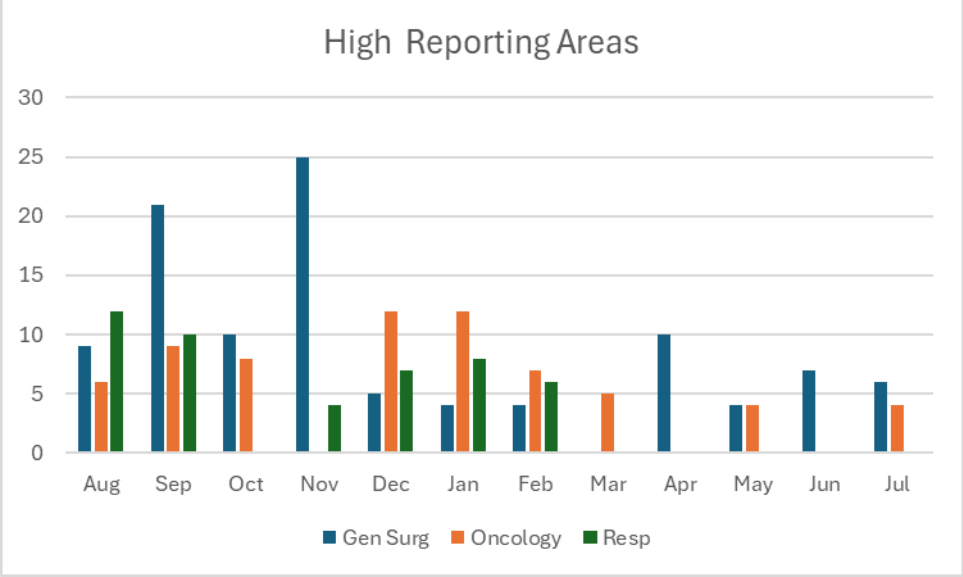
The annual reporting period has shown positive trends in several areas of concern, notably the workload of the CMRT, timeliness of work schedules and the ER process itself. Completing the work on the financial processes around fines for payment to doctors and spending of the guardian funds remains ongoing. ERs for overtime and penalty rate overtime and subsequent fines however remain higher than desired. The accurate ER data available to the GoSW will enable targeted work to improve this for the resident doctor workforce.

Summary of Exception Report Data









CMO OFFICE COVERING PAPER TO SITE BASED GUARDIAN OF SAFE WORKING (GOSW) ANNUAL REPORTS AUGUST 2024 TO JULY 2025

1. PURPOSE OF REPORT

Provide assurance to the Board of Directors regarding issues raised by site based GOSW via their individual annual reports covering the period of Aug 24 to Jul 25. This report also includes highlights from the last year which have resulted from our collaborative working approach with resident grade BMA reps.

2. RECOMMENDATIONS

It is requested that the content of this report is acknowledged for assurance and that teams are thanked for their continued commitment to improve the working lives of our resident grade medical and dental staff.

3. EXCEPTION REPORT (ER) REFORM AND NUMBERS OF ERs RAISED

Over the last year we have worked with closely with our resident grade BMA reps to improve the ER process and more recently worked in conjunction with them to ensure we meet the criteria within the ER reform framework. Specifically, this has included that processes are in place to ensure ER software access from day one of a doctor/dentist arriving, that their confidentiality is maintained, as much as possible, and that educational and clinical supervisors are removed from the ER process. We feel that by fostering a positive ER reporting culture we displaying a transparent and safe environment for our doctors and dentists to raise concerns which ultimately will result in a safe environment for our staff and patients.

4. WORKLOAD ON ROTAS

Both sites continue to report concerns relating to workload and staffing shortages, leading to doctors working beyond their contracted hours. This is evident across a multitude of directorates which poses the question as to whether we are adequately resourced or are using time wisely. We need to monitor this as we move into the CSU structures and explore with teams innovative ways in which to deliver services which are underpinned by resilient rotas. Our deputy associate medical director for resident grade workforce continues to review rotas with clinical teams.

5. 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 HR colleagues to discuss how we approach this case for change. This is likely to be complex and may not fully progress until the clinical service unit (CSUs) leadership structures are in place and they have time to assess what is required.

6. GOSW FINES ACCOUNT

It has taken a while for all stakeholders to understand the contractual obligation we have to our resident grade medical and dental colleagues in regard to the GOSW fines account. We have now been working with the deputy finance directors to agree its use and have a consistent approach across UHT by Oct 25.

IMPROVING THE WORKING LIVES OF RESIDENT DOCTORS PROGRAMME

7. RECENT SUBMISSION AND AREAS OF GOOD PRACTICE

NHS(E) has recently relaunched its commitment to this programme, and we have just submitted our benchmarking assessment. We compiled our assessment with our resident grade BMA reps to ensure their voice was at the forefront of the submission. We have many areas to showcase regarding this programme and other workstreams we have collaboratively worked on throughout the year. These include:

a. Standardising our resident doctor forums across UHT ensuring that we have voted in chairs and nominated representatives from directorates.

b. Developed a less than full time worker SOP to reduce pay errors.

c. Developed our ER SOP in line with the new reform.

d. Procured a simpler ER software (STH site only at the moment) which allows for greater access and better data analysis.

e. Procured a new compliance software (STH site only at the moment) which aims to improve the accuracy of resident grade medical workforce pay.

f. Due to pressures on training posts, we ringfenced our locally employed doctor vacancies to those already working for the Group**.**

g. Hold fortnightly meetings to progress resident grade medical and dental staff workstreams.

h. Weekly guarded time to review workschedule issues and provide solutions.

8. AREAS TO STRENGHTEN

Over the next year we will aim to introduce a resident grade medical and dental annual leave policy which addresses the specific annual leave concerns of this staff group, especially those who are rotational. We will work with our colleagues to improve their rest environments including the provision of hot and cold food. We will listen and act accordingly on other concerns including car parking during on-call and ability to carry out self-directed learning time from home.

9. CONCLUSION

The GOSWs, resident grade BMA reaps and CMO office continue to work together to remedy issues highlighted and be at the forefront of being an employer of choice for our resident grade medical and dental staff.

NHS
University Hospitals Tees

General Medical Council (GMC) Survey Report 2025

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 3.5

Report author: James Ryan

Action required:
Information

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
n/a

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☒

Transforming our services ☐

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☐

Make best use of our resources ☐

CQC domain link:

Effective

Board assurance / risk register this paper relates to:

Caring
Better
Together

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 highlights a small number of areas where there has been adverse feedback for three sequential years or a significant deterioration. Areas such as these are subject to a deeper analysis and the formation of an action plan which is submitted to the Deanery.

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 report describes several areas of concern identified for our resident doctors in training.

The trainers report also shows a deterioration in score and national ranking for both Trusts for the second year in a row, this is likely to reflect ongoing work pressures and the restructure of UHT. For North Tees specifically the survey was undertaken during a period where different consultant groups had differential SPA time, and changes to appraisal and the postgraduate offer have not had chance to affect the score as yet.

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 also highlights some areas of exceptional training in both Trusts. South Tees has significantly improved its national position this year overall and is ranked 4th in the region. North Tees and Hartlepool have ranked in a similar position compared to the previous 2 years.

The 2025 GMC survey that is described in this paper will feed into the following year's quality cycle (25/26).

Recommendations:

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

Board of Directors
6 November 2025
Report on the 2025 General Medical Council (GMC) Survey

PURPOSE OF REPORT

The purpose of the report is to give assurance to the board to the actions the Trusts take in response to the national training survey managed by the GMC. The survey results were published on the 15th July 2025 and this report presents these findings.

BACKGROUND

The GMC survey runs annually and provides a comprehensive picture of the experiences of doctors in training and trainers across the UK. The data from this is used by the Trust and the Lead Employer to assure postgraduate training as part of our ADQM (Annual Deans Quality Visit) on behalf of NHSE.

On the 25th April 2024 the NHS CEO wrote to Trusts about improving the working lives of doctors in training. As part of these recommendations the GMC survey should be reviewed by Trust boards and supported by clear action plans.

DETAILS

Structure of GMC survey

The survey collects data from all acute and non-acute Trusts in the UK. This data is collected by individual trainee speciality (the speciality the trainee is assigned to at that time) and by individual trainee programme (the training programme the trainee is employed into). There is also a trainer's section to the survey.

Trainees are asked questions within 19 individual themes and then rank this statement on a Likert scale. If enough responses are obtained for a question (n>3) the results are compared with the UK national average.

Reports are then delivered in a table format with a colour highlighting themes as significant positive (Dark Green) or negative outlier (Red), non-significant positive (Light Green) and negative outliers (pink) and those falling between these groups (White).

The GMC survey and our quality cycle

Our postgraduate training is assessed on a yearly basis by a formal process led the postgraduate dean and her team. We create and submit a self-assessment document for all specialities against each individual GMC domain and theme. For areas where we have identified short comings, we, in partnership with the specialities in question, create and submit an action plan.

With regards to the GMC survey the quality team at NHSE will highlight areas of concern to the Trusts around 'triple reds' (the same domain ranked within bottom 25% for 3 consecutive years).

Limitations to the GMC Survey

The Dean and the quality team acknowledge that there are limitations with the GMC survey, and it is used as one source of evidence, amongst other intelligence when assessing a training unit. The survey therefore needs to be carefully interpreted.

Limitations include:

- **Engagement of trainees**: The survey is optional and may over represent those who report positively and negatively.
- **Small numbers in some specialities**: This means reports can be heavily influenced by a single trainee. Conversely larger numbers carry more validity.
- **Definition of a speciality**: A trainee from another training programme may report on a speciality that is not their own, for example an internal medical trainee may report on an individual medical speciality such as cardiology.
- **Grade of trainee**: the survey does not easily distinguish by grade, for example an FY1 in surgery could feed into the same report as an ST7 in colorectal surgery when their educational needs and expectations are vastly different.
- **Limitations of methodology**: The questions and scale are subjective and open to interpretation.

Findings from the GMC training survey 2025 for South Tees

The survey produced data for 30 of 37 specialities and for 30 of 53 training programmes at South Tees with a 69% response rate.

- Areas of exceptional training were reported for speciality in Cardiology, Cardiothoracic Surgery, Older persons medicine, Haematology, OMFS, Urology and Vascular surgery.
- Areas of exceptional training by programme were reported in Dermatology, Emergency Medicine, and FY1 EM
- Areas of concern were reported for speciality in Gastroenterology, Neurosurgery, and Respiratory Medicine.
- Areas of concern by programme were reported in General Surgery.

High level findings from the GMC training survey for 2025 for North Tees and Hartlepool

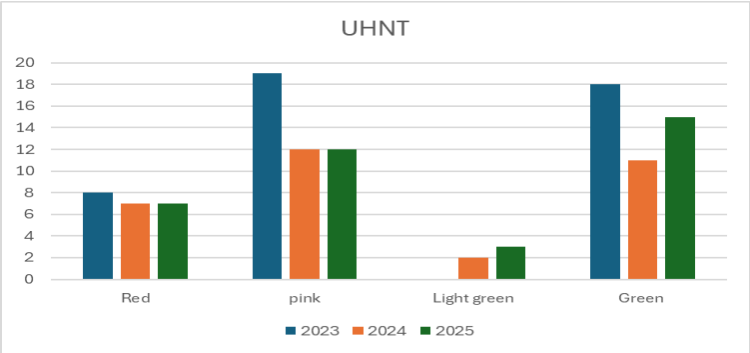
The survey produced data for 14 of 37 specialities and for 18 of 53 training programmes at North Tees with a 67% response rate.

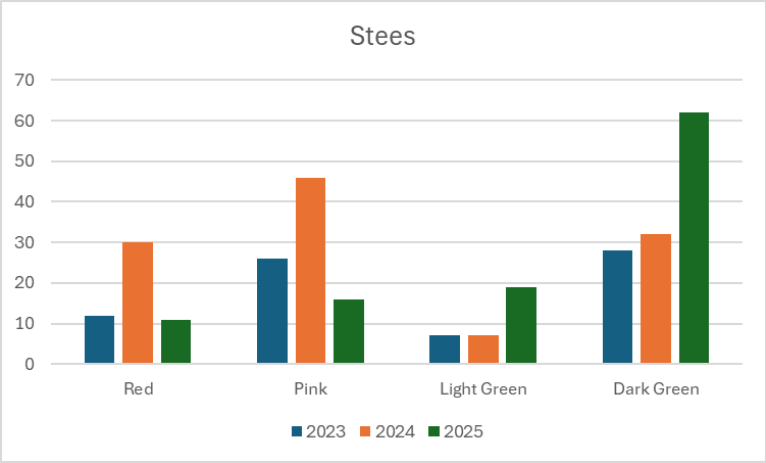
- Areas of exceptional training were reported for speciality in Endocrine and Diabetes, O&G and stroke medicine.
- Areas of exceptional training by programme were reported in GP Medicine, GP O&G, O&G, FY2 paeds and FY1 surgery.
- Areas of concern were reported for speciality in Anaesthetics and Gastroenterology.
- Areas of concern by programme were reported in GP EM.

Overall positions for trainee's survey

The UHNT&H has maintained a consistent overall position over the past 3 years with some improvement in overall dark greens for 2025.

South Tees is reporting a much-improved overall position with a significant increase in dark greens and a reduction in reds.





Regional position

The region continues to receive strong feedback and is consistently rated within the top 2 training areas of the UK. Reports received by the Trusts are compared regionally and nationally.

South Tees has ranked 63 of 225 providers in the UK, and 4th within the region.

North Tees and Hartlepool has ranked 122 of 225 providers in the UK and 8th within the region.

High level findings from the GMC trainers survey for 2025

The response rate tends to be lower for the trainer survey and was 33% for North Tees and Hartlepool and 36% for South Tees.

Both Trusts have reported an overall deterioration in their position, more significantly for North Tees and Hartlepool.

At South Tees concerns relate to rotas, supportive environment and time for training, but are reporting strongly in appraisal, professional development and support for training.

At North Tees and Hartlepool concerns relate to Handover, Appraisal, Support for training, Supportive environment and time for training. They are reporting strongly for rota issues.

Actions from the postgraduate department

The GDME has briefed the CMO, site MDs and GAMDs on the GMC survey. Meetings have occurred or are planned between the postgraduate team and specialities of concern highlighted in the report. Further briefings on the GMC survey will occur within forums such as ST leads, Faculty updates sessions, SMSC, CPG and the CLGs.

Serious issues are managed more proactively by the GDME and his team in conjunction with the speciality schools and the CMOs / site MDs offices.

The actions plans created will feed into this year's SAR / QIP for the 25-26 quality cycle.

RECOMMENDATIONS

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

APPENDICES

(List any appendices)

Appendix A – South Tees national position NHSFT, regional comparison and summary 2025 cycle

Appendix B – North Tees and Hartlepool NHSFT national position, regional comparison and summary for 2025 cycle

Appendix C - Overall regional position for Northern Deanery

Appendix D – Quality and reporting cycles for 25-26

Appendix A

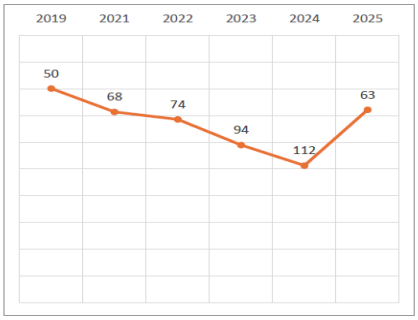
South Tees Hospitals NHS Foundation Trust

GMC National Training Survey — 2025

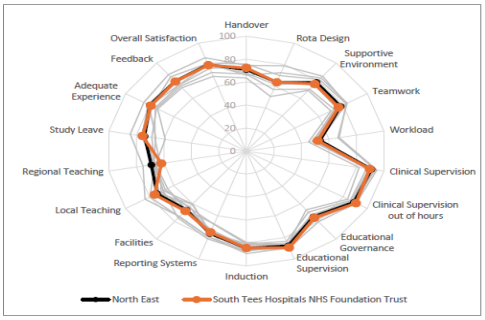
Responses: 281 to 285 (69%)

UK-Wide Rankings by 2025 Trusts are ranked 1-226	63	
Eng Rankings by 2025 Trusts are ranked 1-197	52	
Local Rankings by 2025 Trusts are ranked 1-10	4	

Long-term UK Wide Overall Ranking



Trust Score by Indicator



D	Indicator	Trust	Region
1	Handover	72.37	70.85
	Rota Design	63.74	63.78
	Supportive Environment	76.18	78.07
	Teamwork	76.18	77.95
	Work Load	51.87	53.45
2	Clinical Supervision	89.62	90.97
	Clinical Supervision out of hours	90.66	88.9
	Educational Governance	75.79	74.61
	Educational Supervision	89.42	87.68
	Induction	84.33	84.53
	Reporting Systems	75.17	76.36
3	Facilities	68.06	66.76
	Local Teaching	75.86	73.95
	Regional Teaching	61.80	69.11
	Study Leave	75.61	74.09
5	Adequate Experience	78.98	80.02
	Feedback	79.10	79.42
	Overall Satisfaction	79.54	80.12

Trust rank is based on the overall survey mean score for 2019 to 2025

Included: acute and mental health trusts, community and social care partnerships that also cover acute, mental health and in-patient services

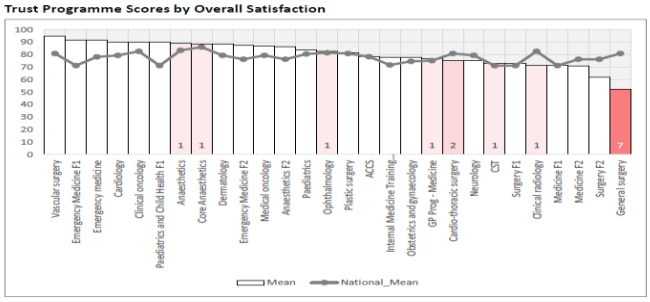
Trust score by NTS indicator

Orange line = South Tees Hospitals NHS Foundation Trust
Black line = North East Local Office
Grey lines = Other North East acute and mental health trusts

South Tees Hospitals NHS Foundation Trust

GMC National Training Survey — 2025

Trust Programme Scores by Overall Satisfaction



Trust Post Specialty Scores by Overall Satisfaction

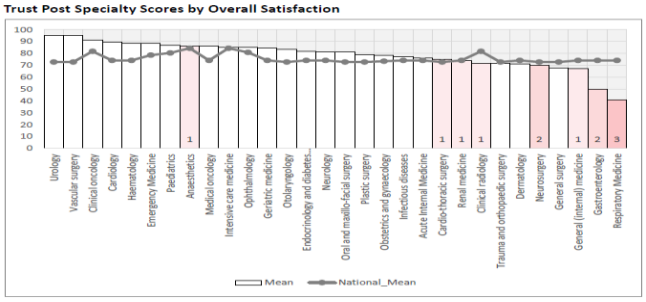


Chart shows:
- Mean score by programme for the 'overall satisfaction' indicator (column chart)
- Number of negative 'red' outliers by programme across all NTS indicators (data label)
- Benchmark mean score for the 'overall satisfaction' indicator (line chart)

Chart shows:
- Mean score by post specialty for the 'overall satisfaction' indicator (column chart)
- Number of negative 'red' outliers by post specialty across all NTS indicators (data label)
- Benchmark mean score for the 'overall satisfaction' indicator (line chart)

Consecutive Reds by Programme and Indicator

Programme Type	Indicator	2021	2022	2023	2024	2025
Anaesthetics	Regional Teaching			41.32	45.83	34.67
Cardio-thoracic surgery	Regional Teaching		0	0.00	0.00	0.00
General surgery	Overall Satisfaction			62.50	68.33	52.50

Consecutive Reds by Post Specialty and Indicator

Post Specialty	Indicator	2021	2022	2023	2024	2025
Cardio-thoracic surgery	Regional Teaching		0	0.00	0.00	0.00

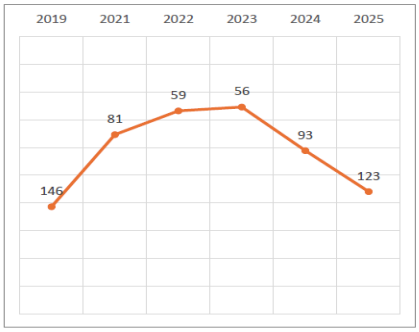
South Tees Hospitals NHS Foundation Trust

GMC National Trainer Survey — 2025

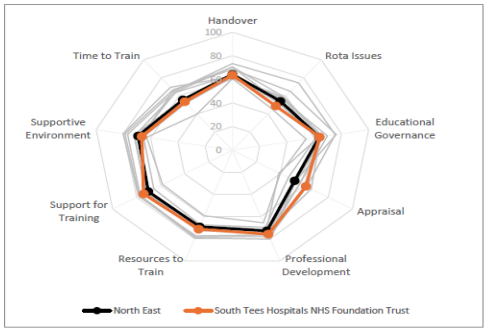
Responses: 151 to 155 (36%)

UK-Wide Rankings by 2025 Trusts are ranked 1-220	123	
Eng Rankings by 2025 Trusts are ranked 1-192	108	
Local Rankings by 2025 Trusts are ranked 1-10	7	

Long-term UK Wide Overall Ranking



Trust Score by Indicator



D	Indicator	Trust	Region
1	Handover	63.59	64.32
	Rota Issues	48.84	54.06
2	Educational Governance	64	63.73
4	Appraisal	61.35	51.93
	Professional Development	75.88	72.8
	Resources to Train	71.38	69.23
	Support for Training	74.15	70.19
	Supportive Environment	66.45	69.26
	Time to Train	53.48	55.73

Trust rank is based on the overall survey mean score for 2019 to 2025

Included: acute and mental health trusts, community and social care partnerships that also cover acute, mental health and in-patient services

Trust score by NTS indicator

Orange line = South Tees Hospitals NHS Foundation Trust
Black line = North East Local Office
Grey lines = Other North East acute and mental health trusts

Caring Better Together

Appendix B

North Tees and Hartlepool NHS Foundation Trust

GMC National Training Survey 2025

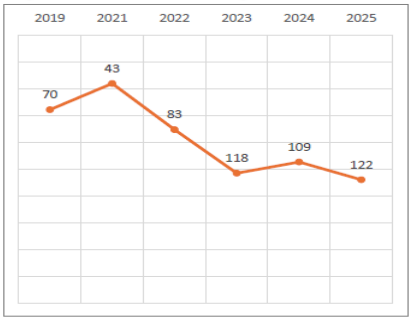
Responses: 141 to 145 (67%)

UK-Wide Rankings by 2025 Trusts are ranked 1-226: 122

Eng Rankings by 2025 Trusts are ranked 1-197: 103

Local Rankings by 2025 Trusts are ranked 1-10: 8

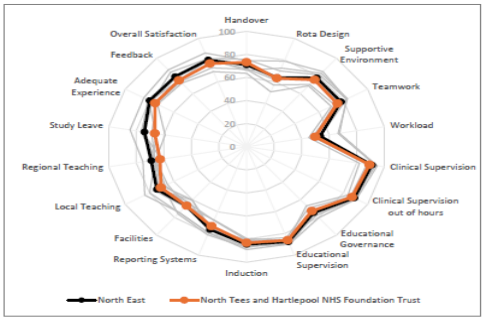
Long-term UK Wide Overall Ranking



Trust rank is based on the overall survey mean score for 2019 to 2025

Included: acute and mental health trusts, community and social care partnerships that also cover acute, mental health and in-patient services

Trust Score by Indicator



D	Indicator	Trust	Region
1	Handover	73.28	70.85
	Rota Design	63.13	63.78
	Supportive Environment	75.56	78.07
	Teamwork	74.85	77.95
	Work Load	49.80	53.45
2	Clinical Supervision	89.12	90.97
	Clinical Supervision out of hours	86.94	88.9
	Educational Governance	72.54	74.61
	Educational Supervision	86.10	87.68
	Induction	83.15	84.53
	Reporting Systems	73.08	76.36
3	Facilities	66.70	66.76
	Local Teaching	70.60	73.95
	Regional Teaching	62.73	69.11
	Study Leave	66.59	74.09
5	Adequate Experience	75.44	80.02
	Feedback	75.00	79.42
	Overall Satisfaction	76.57	80.12

Trust score by NTS indicator

Orange line = North Tees and Hartlepool NHS Foundation Trust
Black line = North East Local Office
Grey lines = Other North East acute and mental health trusts

North Tees and Hartlepool NHS Foundation Trust

GMC National Training Survey 2025

Trust Programme Scores by Overall Satisfaction

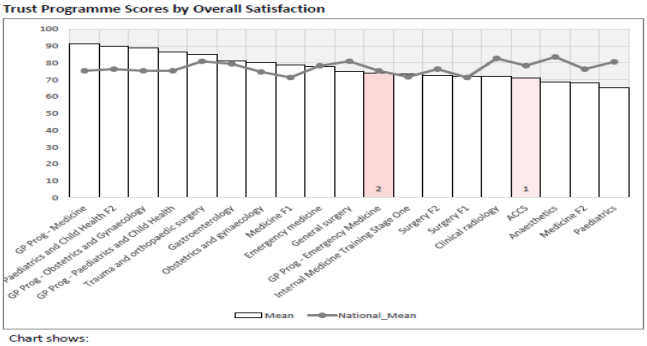


Chart shows:
- Mean score by programme for the 'overall satisfaction' indicator (column chart)
- Number of negative 'red' outliers by programme across all NTS indicators (data label)
- Benchmark mean score for the 'overall satisfaction' indicator (line chart)

Consecutive Reds by Programme and Indicator

Trust Post Specialty Scores by Overall Satisfaction

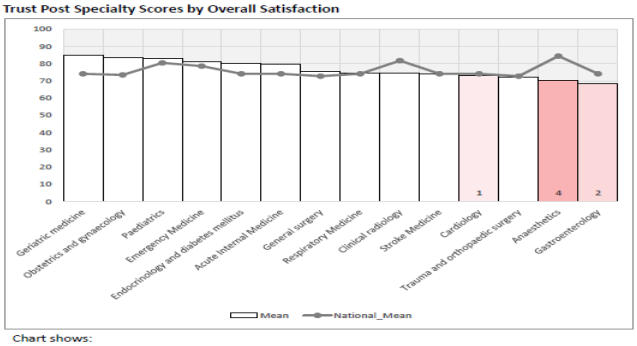


Chart shows:
- Mean score by post specialty for the 'overall satisfaction' indicator (column chart)
- Number of negative 'red' outliers by post specialty across all NTS indicators (data label)
- Benchmark mean score for the 'overall satisfaction' indicator (line chart)

Consecutive Reds by Post Specialty and Indicator

North Tees and Hartlepool NHS Foundation Trust

GMC National Trainer Survey 2025

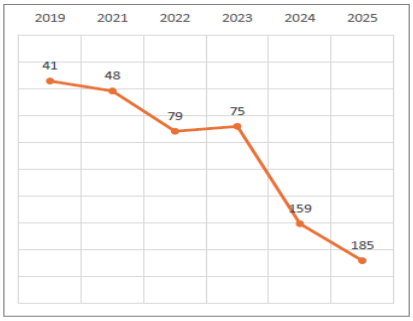
Responses: 61 to 65 (33%)

UK-Wide Rankings by 2025 Trusts are ranked 1-220: 185

Eng Rankings by 2025 Trusts are ranked 1-192: 160

Local Rankings by 2025 Trusts are ranked 1-10: 9

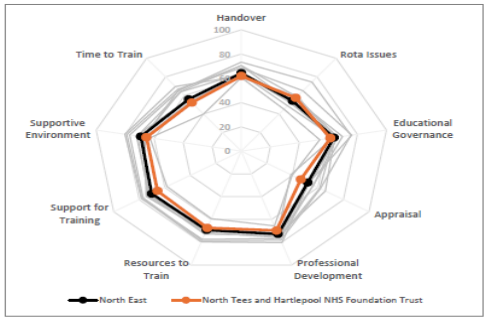
Long-term UK Wide Overall Ranking



Trust rank is based on the overall survey mean score for 2019 to 2025

Included: acute and mental health trusts, community and social care partnerships that also cover acute, mental health and in-patient services

Trust Score by Indicator



D	Indicator	Trust	Region
1	Handover	61.86	64.32
	Rota Issues	57.38	54.06
2	Educational Governance	61.28	63.73
4	Appraisal	46.57	51.93
	Professional Development	69.62	72.8
	Resources to Train	67.34	69.23
	Support for Training	65.66	70.19
	Supportive Environment	65.32	69.26
	Time to Train	52.15	55.73

Trust score by NTS indicator

Orange line = North Tees and Hartlepool NHS Foundation Trust
Black line = North East Local Office
Grey lines = Other North East acute and mental health trusts

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Appendix C

GMC National Training Survey 2025: National Rank by Local Office/Deanery (UK)

		Learning Environment & Culture					Educational Governance & Leadership						Developing & Supporting Learners				Delivering Curricula & Assessments		
		Handover	Rota Design	Supportive Environment	Teamwork	Workload	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Induction	Reporting Systems	Facilities	Local Teaching	Regional Teaching	Study Leave	Adequate Experience	Feedback	Overall Satisfaction
North East & Yorkshire	North East	6	1	1	1	1	2	2	1	3	1	1	4	4	4	3	3	1	5
	Yorkshire and the Humber	10	12	13	11	5	13	14	14	13	9	11	11	14	15	14	12	11	13
East	East of England	14	16	15	15	14	15	16	15	15	14	16	5	7	11	15	15	14	15
London	North Central and East London	12	4	7	7	10	5	5	5	6	5	7	15	2	9	5	5	13	6
	North West London	5	3	3	2	7	1	1	4	4	4	2	14	13	16	8	7	9	4
	South London	3	2	6	5	8	4	3	6	8	6	5	9	1	7	4	4	6	3
Midlands	East Midlands	16	15	16	16	11	16	15	16	16	15	15	13	12	6	16	16	16	16
	West Midlands	8	7	14	14	6	12	12	13	11	13	13	7	9	1	12	13	10	14
North West	North West	7	6	5	8	2	10	8	8	10	8	9	6	8	2	6	9	12	8
South East	Kent, Surrey and Sussex	9	10	11	13	9	11	13	10	9	7	12	3	6	13	9	11	8	11
	Thames Valley	15	9	12	10	15	8	7	12	12	11	6	10	11	5	13	14	15	12
	Wessex	11	11	8	9	13	7	11	7	5	10	8	8	16	8	7	10	4	9
South West	South West	4	5	2	3	4	6	6	2	7	3	4	1	3	3	2	1	3	1
Other	Health Education and Improvement Wales	13	14	9	12	11	14	10	11	14	16	14	2	10	14	11	8	7	10
	NHS Education for Scotland	1	8	4	4	3	3	4	3	1	2	3	12	5	12	1	2	2	2
	Northern Ireland Medical & Dental Training Agency	2	13	10	6	16	9	9	9	2	11	10	16	15	10	10	6	5	7

This report provides results for all trainees based on their deanery/local office for the 2025 GMC national training survey. Each deanery/local office has been ranked by their mean score from 1 to 16 for each indicator compared to other deanery/local offices in the UK. Pharmaceutical Medicine Deanery and Defence Postgraduate Deanery are excluded.

Rank of mean

1 — 16

Appendix D

2025-26 Quality Cycle – Reporting Timeline and Planned Interactions

The annual Education and Training Cycle starts on 1st August 2025 and ends on 31st July 2026. The table below outlines key dates in the cycle and the scheduled activities and planned interactions between NHSE WTE NENC and its LEPs. The WTE NENC Quality Team is always available for consultation and should be contacted using its dedicated mailbox: england.quality.ne@nhs.net

2025 WTE 'End of Year' Annual Reports to be sent to LEPs	August 2025
2025-26 reporting documentation and guidance to be sent to LEPs	September 2025
WTE analysis and circulation of benchmarked data from 2025 GMC NTS Trainee & Trainer Surveys	September 2025
LEPs to submit mid-year QIP updates to WTE Quality Team	30 September 2025
NHSE National Education and Training Survey (NETS) scheduled	7 October 2025 (to be open for 8 weeks till 2 December 2025)
WTE Quality Team to offer meetings to LEPs to support annual reporting and to discuss any emerging issues or concerns	November 2025 to January 2026
LEPs to return completed 2025-26 reporting documentation (SAR/QIP/Unit reports) to WTE Quality Team	28 February 2026
2026 GMC NTS Trainee & Trainer Surveys – anticipated dates	April - May 2026
2026 Annual Dean's Quality Meetings (ADQMs) with LEPs	April - June 2026
2026 WTE Annual Reports to be sent to LEPs	From end July 2026

University Hospitals Tees

Medical Revalidation Annual Report

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 3.6

Report author: Dr Mike Ingram, Group Associate Medical Director (People)

Executive director sponsor: Dr Mike Stewart, Chief Medical Officer

Action required: Information

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. noncompliance, 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.

UHT Group structure provides opportunity for further development, with development of a single appraisal and revalidation team and Group policy. This will strengthen processes across group, developing the best practices from each Trust, and ensure a doctor has a single point of contact for medical appraisal whether working in a single site or cross sites. Quality assurance of medical appraisal requires resourcing at North Tees – this action is recognised and is incorporated in an ongoing review of CMO office funded roles. Alignment of medical governance policies including Maintaining High Professional Standards (MHPS) will ensure all doctors are managed with equity when concerns arise.

In support of Group structure, the RO is in discussion with the GMC Employment Liaison Advisor regarding UHT becoming a single designated body with the GMC.

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

Overall, based upon the evidence contained within this report, the Responsible Officer confirms assurance to the Board of the Trust's regulatory compliance with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013).

Successful roll out of an electronic appraisal system at North Tees, standardising appraiser training to a Nationally benchmarked quality, and a cross Group peer review process highlighting the best practices at each site to embed in Group development are exemplars of outstanding practice and development in the area of medical appraisal and revalidation.

Recommendations:

It is the recommendation of the RO that this report be accepted as assurance against regulatory requirements and escalated via the Board. The Board are to report to the NHS England level 2 Responsible Officer.

Medical Revalidation Annual Report

1. PURPOSE OF REPORT

The purpose of the report is to provide assurance that University Hospitals Tees professional standards processes meet the relevant statutory requirements and support quality improvement.

The Responsible Officer has a duty under the regulations to assure and improve their professional standards function for doctors with whom they hold a prescribed connection.

The report to the Board provides affirmation. The Group Board are asked to review the assurance and escalate to the Board. The Board are to report to the NHS England level 2 responsible officer.

2. RECOMMENDATIONS

It is the recommendation of the RO that this report, and associated Framework for Quality and Improvement NHSE template reports appended to this summary, be accepted as assurance against regulatory requirements and escalated via the Board. The Board are to report to the NHS England level 2 Responsible Officer.

3. BACKGROUND

Medical appraisal is regulated nationally by NHS England and has evolved to become a key part of the framework of support and supervision of all doctors regulated by the General Medical Council (GMC). Medical appraisal has input into, and supports the revalidation process for medical professionals in the UK, governed by the Medical Act 1983 and the General Medical Council (Licence to Practise and Revalidation) Regulations 2012. The Framework for Quality Assurance is a template report to submit to the level 2 Responsible Officer, providing assurance that as an organisation we are complying with the employer requirements for medical appraisal and governance of doctors.

The original Framework of quality assurance (FQA) for responsible officers and revalidation was first published in April 2014 to support implementation of, and compliance with the regulations, and assure the Secretary of State for Health that these were being enacted.

In 2019, a review of the annual organisational audit (AOA), Board report template and the Statement of compliance led to a slimmed down version of the AOA and a revised Board report template, which was combined with the Statement of compliance for efficiency and simplicity.

Following the pandemic, an annual Board report, modified to support reporting on appraisal rates, plus a statement of compliance, are the current mainstay of annual reporting. This revised framework is renamed as the NHS England framework for quality assurance and improvement (FQAI). This sets it in both the context of assurance and of improvement – the latter being increasingly important in professional standards work. This is the second year of this reporting format. Independent verification and networking to support consistency also continues, supported by the NHS England professional standards teams within regions.

The main body of the paper sets out a description of the framework and associated processes. The annexes set out details of the reporting and metrics to support the processes. With the Group formation of University Hospital Tees, and associated Group Peoples Committee, this paper collates the FQAI report for both Trusts, providing an overall summary of assurance.

Individual Trust FQAI reports (for submission to the level 2 Responsible Officer) with supporting detail and evidence are attached as annex to this report.

4. DETAIL

4.1 General

It can be assured to the Board that across the Group, there is an appropriately trained licensed medical practitioner appointed as Responsible Officer, and the role is appropriately resourced. Accurate records of all licenced medical practitioners with prescribed connections to both designated bodies are maintained, and policies are in place supporting medical revalidation. An electronic appraisal system (L2P), embedded in South Tees practice, was successfully rolled out to North Tees Q3 2024/25 such that both Trusts now utilise the same electronic platform. Configuration in the L2P system allows for reporting both at individual Trust level and at UHT Group level.

A cross-Group peer review process of the organisations appraisal and revalidation processes was undertaken in the final quarter of 2024/25. Highlighting the best practices of each system, this has strengthened appraisal and revalidation processes across the Group with the best practices being embedded across Trusts.

Planned policy review for 2025-26 will align appraisal policies across Group.

It can be assured to the Board that support for induction, continuing professional development, appraisal, revalidation and governance is provided to locum or short-term placement doctors in line with substantive appointments.

4.2 Appraisal

It can be assured to the Board that across the organisation, systems are in place to provide for a doctor's annual appraisal taking into account all relevant information and whole scope of practice. Engagement is supported by appropriate escalation policy at South Tees and by formal disciplinary action (in line with conduct policy) and/or reporting to the GMC at North Tees Trusts. Medical appraisal policies are in place, compliant with national policy, with an action to align appraisal policies across the Group over the next year. Metrics are included in the FQAI annex for each Trust – overall medical appraisal compliance rates across UHT are 89% (1075 appraisals conducted for 1205 connected doctors) with 8.3% approved missed appraisals (100) and 2.4% unapproved missed appraisals (29 (28 North Tees)). The unapproved missed appraisal rate reflects a small rise in appraisals for year 24-25 being delivered after 01 April 2025 due to system change from a paper-based appraisal system to electronic.

Both Trusts have an appropriate and proportionate number of trained medical appraisers with regular update training. Training is now commissioned through an external national provider at both Trusts assuring for quality and equity across the Group. Historically training has been delivered “in-house” at North Tees. Update training has been opened up across Group for all appraisers, providing increased opportunity for development in role.

The appraisal system in South Tees is subject to a quality assurance process. This utilises a validated national tool (PROGRESS) and is delivered by lead appraisers and the revalidation team, focussed on raising the standard of medical appraisal. The appraisal system at North Tees is **not** subject to a quality assurance process. This requires identification of resource (lead appraiser and funding) and is a requirement for implementation following the successful implementation of new appraisal software (L2P) within North Tees Trust. The Group restructuring of CMO Office roles will address the requirement for resourcing lead appraisers across all of University Hospital Tees, providing the capability to deliver quality assurance across the full spectrum of medical appraisal.

4.3 Recommendations to GMC

It can be assured to the Board, across both Trusts, appropriate and timely revalidation recommendations are made to the GMC. Metrics are included in the FQAI annex.

4.4 Medical Governance

It can be assured to the Board, across the Group, where revalidation and appraisal forms part of the broader clinical governance framework, clinical areas have governance systems and processes in place contributing to the wider clinical governance agenda and creating an environment delivering effective clinical governance for doctors. Conduct and performance of doctors utilises the DATIX system at South Tees and InPhase at North Tees. Whilst at South Tees, reports are extracted from digital systems (PALS and DATIX) by the revalidation team and provided to the doctor, at North Tees the responsibility has been with the doctor to request the reports. This variance in approach was an opportunity for Group standardisation with improvements to the provision of information to doctors in a convenient format to include at their appraisal (in line with Pearson report recommendations). It can be reported that this has been actioned from 01 September 2025.

Across the Group, there are policies in place in line with the NHS Maintaining High Professional Standards policy and the RO is supported in complex decisions regarding concerns about a doctor through the People MDT (North Tees) and Good Medical Practice Group (South Tees). A review of MHPS is ongoing across the Group to standardise to a single Group policy.

Trained case investigator numbers are appropriate across the group and case manager training delivered at University Hospital Tees has addressed a shortfall in case manager trained personnel over this reporting period. Recognising there will be significant change to clinical leadership, a further case investigator training course is scheduled for Q4 2025-26 to meet the need of new Clinical Service Unit Directors in delivering their role.

Analysis of numbers, types and outcomes of concerns, with appropriate recording and reporting, including such aspects as consideration of protected characteristics and the doctor's country of primary medical qualification requires further development across the Group.

Just culture framework is in place across the Group for when concerns arise, this approach standardising investigations across all healthcare professionals.

4.5 Employment Checks

The Board can be assured appropriate employment checks are carried out in both Trusts across all specialties and for all medical roles. Use of the Trac recruitment system and use of a master vendor / approved supplier framework supports the assurance of employment checks and compliance with the six mandatory NHS Employer Check standards.

4.6 Organisational Culture

South Tees – Through the leadership improvement and training academy, education is delivered to meet the needs of leadership, improvement, civility, human factors, non-technical skills, and psychological safety – all contributing as professional standards activities supporting appropriate organisational culture. Restorative just culture, supported by education, and the appointment of an EDI HRBP along with Freedom to speak up guardians support compassion, fairness, respect, diversity and inclusivity in the organisation. Trust values are widely embedded and mechanisms are in place for doctors to provide feedback around the organisations professional standards processes.

North Tees – The Patient Safety Incident response Framework supports a patient safety system integrating compassionate engagement, learning, considered and appropriate responses and supportive oversight. A Trust code of conduct for staff with training, supported by champions, cultural ambassadors and promoting freedom to speak up guardians (with a speaking up policy) supports appropriate organisational culture.

4.7 Calibration and Networking

Across the Group, the designated body takes steps to ensure its professional standards processes are consistent with other organisations through Responsible Officer network meetings, whilst lead appraisers and appraisal and revalidation managers regularly attend NHSE appraisal lead network meetings.

4.8 Metrics

The individual Trust FQAI details the full reportable metrics. Of note, the Board is to note the following in assurance:

Overall appraisal compliance (relating unapproved missed appraisals to total number of prescribed connections):

North Tees – 92.1%
South Tees – 99.9%

Total number of late recommendations:

North Tees – 6
South Tees – 0

Total number of deferrals made:

North Tees – 11 (of 69 recommendations) – 16%
South Tees – 22 (of 175 recommendations) – 13%

Total number of case investigators / case managers:

University Hospitals Tees – 54/21

5. CONCLUSION

South Tees

Based on the embedded systems and processes in place within the Trust, the Revalidation Team continues to work from a position of strength and can provide assurance that:

1. Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC.
2. Robust quality checking of appraisers is taking place.
3. Doctors are continually supported by the Revalidation Team with their appraisals and revalidation.
4. Outstanding appraisals are routinely addressed.
5. Appraisers have access to dedicated support and training to aid their roles as appraisers.

North Tees

Appraisal development has strengthened processes over the appraisal year. Linked to implementing electronic appraisal software, and changes to practice through peer review with South Tees. The Revalidation Team can provide assurance that:

1. Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC.
2. Doctors are continually supported by the Revalidation Team with their appraisals and revalidation.
3. Outstanding appraisals are routinely addressed.
4. Appraisers have access to dedicated support and training to aid their roles as appraisers.

Appraisal quality assurance is a development action at North Tees following UHT restructure of CMO roles.

Group

Across the Group, there is evidence of good practice within both Trusts in addition to areas for future development. Peer review identified areas of best practice at each site which will inform a Group Medical Appraisal Policy, in development. CMO Office Roles restructure will further align the appraisal and revalidation systems across the Group. Medical governance is also in process of Group alignment with a single MHPS policy in development.

Overall, based upon the evidence contained within this report, the Responsible Officer confirms assurance to the Board of the Trust's regulatory compliance with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013).

APPENDICES

- FQAI Report - North Tees
- FQAI Report - South Tees

Annex A
Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025.

1A – General

The board/executive management team of North Tees and Hartlepool NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Not applicable - no actions required for 2024-25.
Comments:	Dr Michael Ingram, Group Associate Medical Director – People (GMC 4182359) was appointed as Group Responsible Officer from 5 August 2024, following a handover from the Trust's previous Responsible Officer (Dr Elaine Gouk). Dr Ingram has previously completed Responsible Officer training in June 2021.
Action for next year:	Not applicable - no new actions identified.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Proceed with the electronic appraisal implementation plan, which is in place for North Tees and Hartlepool NHS Foundation Trust.

Comments:	The action for 2024-25 is now complete. Electronic Appraisal has been successfully implemented within the Trust and all users were issued with an account in December 2024. Following an initial transition period from paper to electronic for 2024/25, from 1 April 2025 all doctors are now required to complete/record their appraisal using the online platform. The Associate Medical Director for People (Responsible Officer) is supported by a team consisting of: - Medical Lead for Appraisal and Revalidation - Revalidation and Appraisal Officer - Medical Workforce Manager Whilst the response to Q1A(ii) is 'Yes', it was identified as part of the Peer Review process with South Tees that the Trust has a different structure in terms of identified 'lead' appraisers within directorates. The Trust does have a lead appraiser in certain areas such as Anaesthetics, however this is not consistent across all areas and they do not undertake the same duties as the lead appraisers at South Tees, such as quality assurance. This has had an impact on the Trust's ability to enhance quality assurance processes for 2024-25 and is a potential indicator that additional resource at Lead Appraiser level may be required.
Action for next year:	To review the Lead Appraiser structure following the changes to the wider clinical structures and the implementation of Clinical Service Units, to understand the resource required to deliver aligned medical appraisal and revalidation across the group.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	To ensure that the new electronic appraisal system reflects the prescribed connection list at all times, with new accounts created and old accounts archived in a timely manner.
Comments:	The action for 2024-25 is complete. The Trust has maintained compliance with this requirement and the existing processes that were in place prior to the implementation of an electronic system continue to be fit for purpose. This includes: - Monthly workforce reports from the Business Intelligence Team, with details of starters/leavers. - Consistency checks, comparing 'staff in post' reports from ESR against GMC Connect.

	In March 2025, the Trust was required to undertake a review of all prescribed connections, at the request of the Regional Responsible Officer (NHSE). The review provided assurance that the Trust's connections are appropriate, with only a minor number of adjustments required as a result of recent staff movements.
Action for next year:	Not applicable - no new actions identified.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	When reviewing the Trust's Appraisal and Revalidation Policy, consideration should be given to: - Implementing a process for the allocation of Appraisers. - Roles and Responsibilities for Appraisers. - Process for recruiting and selecting Appraisers.
Comments:	This action remains outstanding as the Trust's Policy was not due for review until 2025-2026. The review process has now commenced with comparison of the existing policies for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, with a view to implement an aligned policy across the University Hospital Tees Group. The Policy review has been aligned with the Peer Review process that took place in March 2025, to ensure that all recommendations identified from the peer review are defined in the new policy. It has been agreed that the process for allocating appraisers will continue to reflect existing processes, i.e. the doctor chooses their own appraiser. This is subject to the rules of: a maximum of 3 consecutive years, and not being able to undertake mutual appraisal of each other. Both Trusts are also undertaking a review of the MHPS Policy for 2025-26, to implement an aligned policy across the Group.
Action for next year	To implement new policies for Medical Appraisal & Revalidation and MHPS, which reflect aligned working practices across the University Hospital Tees Group.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes

Action from last year:	Complete a Peer Review of the Trust's Appraisal and Revalidation processes for 2024-25 with South Tees Hospitals NHS Foundation Trust.
Comments:	The action for 2024-25 is now complete. Peer Review took place in March 2025, whereby both organisations were invited to present their processes in relation to the key elements of medical appraisal and revalidation, to compare the different approaches taken and identify best practice. A number of recommendations were identified as an outcome of the review and an implementation plan agreed for 2025-26. Some of the recommendations have already been put into practice, and timescales have been identified for those actions that remain on-going.
Action for next year:	To implement the agreed actions resulting from the Peer Review process, by 31 March 2026.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust has effective systems in place to support all doctors with their continuing professional development, annual appraisal and clinical governance. This includes locum and short-term placement doctors. All directly employed locum doctors are required to attend the Trust's corporate Induction programme. Where the Trust holds the prescribed connection for revalidation of the doctor, the Trust will provide the doctor with an appraisal. The doctor will be required to complete the Trust's mandatory training programme and they will have access to the Trust's Study Leave fund, as would be the case for a substantively employed doctor (pro rata for the length of the contract). The doctor is provided with the relevant governance information that they require to complete the appraisal. This includes assurance for the whole scope of the doctor's practice, including any secondary employment that they may undertake outside of the Trust. Doctors who are employed by an Agency and are on placement with the Trust are required to complete an 'emergency local induction', the details of which are set out in the Trust's Appointment of Locum Medical & Dental Staff Policy (HR28). In such cases, the doctor will likely have a prescribed connection to another organisation for revalidation purposes. The Trust will provide the doctor with the

	necessary information that they need to submit to their main employer for appraisal (limited to the scope of practice within the Trust). If the doctor requests that the Trust complete the appraisal, this will be considered however, it will be subject to the length of the placement (i.e. 3 months+) and they will be required to complete the Trust's mandatory training programme.
Action for next year	Not applicable - no new actions identified.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	To review existing processes for ensuring that a summary of the doctor's governance information is obtained on behalf of the doctor in advance of the annual appraisal discussion.
Comments:	The action for 2024-25 is now complete. For all appraisals due from 1 September 2025 onwards, the doctor will receive a summary of their governance information which will be uploaded to their electronic appraisal in advance of the appraisal meeting. The information is accessed by the Revalidation Team on behalf of the doctor, with a specific page created on InPhase purely for this purpose. The Appraisal and Revalidation Officer and the Medical Workforce Manager have attended InPhase training to support this requirement.
Action for next year:	Not applicable - no new actions identified.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	To review existing processes for ensuring that a summary of the doctor's governance information is obtained on behalf of the doctor in advance of the annual appraisal discussion.
Comments:	The action for 2024-25 is now complete. For all appraisals due from 1 September 2025 onwards, the doctor will receive a summary of their governance information which will be uploaded to their electronic appraisal in advance of the appraisal meeting. The information is accessed by the Revalidation Team on behalf of the doctor, with a specific page created on InPhase purely for this purpose. The Appraisal and Revalidation Officer and the Medical Workforce Manager have attended InPhase training to support this requirement.
Action for next year:	Not applicable - no new actions identified.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	When reviewing the Trust's Appraisal and Revalidation Policy, consideration should be given to: - Implementing a process for the allocation of Appraisers. - Roles and Responsibilities for Appraisers. - Process for recruiting and selecting Appraisers.
Comments:	This action remains outstanding as the Trust's Policy was not due for review until 2025-2026. The review process has commenced with comparison of the existing policies for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, with a view to implement an aligned policy across the University Hospital Tees Group. The Policy review has been aligned with the Peer Review process that took place in March 2025, to ensure that all recommendations identified are defined in the new policy. It has been agreed that the process for allocating appraisers will continue to reflect existing processes, i.e. the doctor chooses their own appraiser. This is subject to the rules of: a maximum of 3

	consecutive years, and not being able to undertake mutual appraisal of each other. Both Trusts are also undertaking a review of the MHPS Policy for 2025-26, to implement an aligned policy across the Group.
Action for next year:	To implement a new policy for Medical Appraisal & Revalidation, which reflects the aligned working practices across the University Hospital Tees Group.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Monitor and report on the actual number of appraisals being carried out by each Trust appraiser. Undertake a quality review of the Trust's internal training programme.
Comments:	The actions for 2024-25 are now complete. **Number of Appraisals:** The Trust is able to use the functionality of L2P to report on appraiser activity, which also includes compliance with repeat appraisers (max of 3 years). **Review of Internal Training:** It has been agreed that the focus of the Trust's internal training programme will switch from delivering training to new appraisers, to post-training induction with the Medical Lead for Appraisal and Revalidation. The Medical Lead will continue to deliver update sessions across the year, which will be opened up to all appraisers across the UHT group. New appraiser training will be delivered externally through MIAD Healthcare and the Trust has already put forward names of individuals who will undertake this training from August 2025. The Trust currently has 47 appraisers delivering appraisal to 359 doctors, which equates to a 1:8 appraiser/doctor ratio. This sits comfortably within the 'working benchmark' of between 5 and 20 appraisals per year.
Action for next year:	Not applicable - no new actions identified.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Complete a Peer Review of the Trust's Appraisal and Revalidation processes for 2024-25 with South Tees Hospitals NHS Foundation Trust, to identify improvements and sharing of best practice in relation to the quality assurance of medical appraisers. Produce a documented procedure that outlines the recruitment process to be followed when appointing new appraisers.
Comments:	The actions for 2024-25 have been extended to 2025-26 and an update is provided below. **Quality Assurance:** Peer Review took place in March 2025, whereby both organisations were invited to present their processes in relation to the key elements of medical appraisal and revalidation. It was identified that the Trust has a different structure in terms of identified 'lead' appraisers within directorates, when compared with South Tees. Whilst the Trust does have a lead appraiser in certain areas such as Anaesthetics, this is not consistent across all areas and they do not undertake the same duties as the lead appraisers at South Tees, such as quality assurance. This has had an impact on the Trust's ability to enhance quality assurance processes for 2024-25 and therefore due to the potential resource implications, it has been agreed that the action relating to quality assurance will be taken forward as one of the recommendations identified as part of the Peer Review and this forms part of the agreed implementation plan for 2025-26. **Recruitment process for new appraisers:** The recruitment process will be documented in the new UHT policy for medical appraisal and revalidation, noting that this already forms part of the South Tees policy. It has been agreed that the Trust will adopt this process, as recommended by the Peer Review. The policy is not due for review until 2025-26 therefore the previous recommendation has been extended to 2025-26. **General Update:** Medical Appraiser update sessions take place throughout the year to update appraisers on any changes to policy/process or national updates. More recently, North Tees appraisers have been invited to attend update sessions delivered at South Tees to cascade learning and share experiences across the group. The same will apply to ST appraisers and they will be invited to attend any update sessions delivered on the NT site.

	The Medical Lead for Appraisal and Revalidation, the Appraisal and Revalidation Officer and the Medical Workforce Manager are all members of the Northern Regional Medical Appraisal Lead Network.
Action for next year:	To implement the agreed action relating to quality assurance of appraisers, as identified during the Peer Review process, by 31 March 2026.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	No
Action from last year:	Continue to explore development of a robust programme of quality assurance for the appraisal process/system.
Comments:	The action for 2024-25 is partially complete, in terms of the Trust has explored the development of a robust programme of QA, however this has not yet been implemented for the following reasons. Peer Review took place in March 2025, whereby both organisations were invited to present their processes in relation to the key elements of medical appraisal and revalidation. It was identified the Trust has a different structure in terms of identified 'lead' appraisers within directorates, when compared with South Tees. Whilst the Trust does have a lead appraiser in certain areas such as Anaesthetics, this is not consistent across all areas and they do not undertake the same duties as the lead appraisers at South Tees, such as quality assurance. Due to the potential resource implications, it was agreed that the previous action of quality assurance will be taken forward as one of the recommendations identified as part of the Peer Review and this forms part of the agreed implementation plan for 2025-26.
Action for next year:	To implement the agreed action relating to quality assurance of appraisers, as identified during the Peer Review process, by 31 March 2026.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes

Action from last year:	Review and align processes for recommendation decisions as part of the Group model and in line with the appointment of the Group AMD (RO).
Comments:	The action for 2024-25 is complete. The Trust has participated in a Peer Review process with South Tees and this was held in March 2025. Whilst there are some similarities across the group structure in relation to the way in which recommendation decisions are made, there are slight differences such as verification from the clinical director and workforce people manager. There are no further actions required from the North Tees site, although processes will continue to be reviewed and enhanced as the Trust proceeds to implement the new Clinical Service Unit structure.
Action for next year:	Not applicable - no new actions identified.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	Effective processes continue to be in place to ensure that recommendations for revalidation are submitted to the GMC in a timely manner. The Trust's Responsible Officer and Medical Lead for Appraisal and Revalidation each undertake a review of the appraisal summary and outputs of appraisal in the proceeding period leading up to the revalidation date. All documentation is now contained within the online appraisal portal (L2P) which has further enhanced the accessibility of information and timeliness of reviews. Monthly meetings take place with the RO to discuss forthcoming revalidation dates to ensure that everything is on track for the recommendation for revalidation to be made ahead of the due date. Where it is necessary for a recommendation of deferral to be made, this is communicated to the doctor before the recommendation is submitted. Concerns regarding non-engagement are discussed at the monthly RO meeting, with immediate notification to the CD and

	follow-up actions agreed. Where necessary, the Trust will escalate concerns regarding non-engagement to the GMC using the Rev6 route, although in the first instance, concerns will be discussed with the Trust's Employer Liaison Advisor at the GMC.
Action for next year:	Not applicable - no new actions identified.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To review existing processes for ensuring that a summary of the doctor's governance information is obtained on behalf of the doctor in advance of the annual appraisal discussion.
Comments:	The action for 2024-25 is now complete. For all appraisals due from 1 September 2025 onwards, the doctor will receive a summary of their governance information which will be uploaded to their electronic appraisal in advance of the appraisal meeting. The information is accessed by the Revalidation Team on behalf of the doctor, with a specific page created on InPhase purely for this purpose. The Appraisal and Revalidation Officer and the Medical Workforce Manager have attended InPhase training to support this requirement. **General Update:** The Trust has various processes in place to support delivery of effective clinical governance for doctors. This includes clinical governance and risk management meetings at both organisational and service level and this extends to patient safety forums and quality assurance panels. All significant events and complaints are recorded by the Trust's clinical governance system (InPhase) and this information is reviewed as part of the annual appraisal. A nil-return must be submitted where applicable.
Action for next year:	Not applicable - no new actions identified.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.

Comments:	All cases relating to the conduct and performance of doctors (both informal and formal) are recorded on the Employee Relations (ER) Case Tracker, which is held and maintained by the Workforce Team. The Trust continues to adopt a robust approach to decision making when concerns about a doctor arise, using a structured MDT approach. Subsequent MDT meetings may be scheduled to review any new information or concerns that may come to light to ensure that the previously determined approach continues to be appropriate. Confirmation of suitability for a positive recommendation is sought from the doctor's Clinical Director and the Workforce Business Manager as part of the revalidation decision-making process. Quarterly meetings take place between the RO and Medical Lead for Revalidation, and the GMC's Employer Liaison Advisor. The meeting also includes attendance from the Group CMO, Head of Employee Relations, Revalidation Officer and Medical Workforce Manager. The meeting includes discussion of any new concerns about a doctor, including review of any ongoing cases/concerns. Both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust are undertaking a review of the MHPS Policy for 2025-26, to implement an aligned policy across the Group.
Action for next year:	To implement a new MHPS policy, which reflects the aligned working practices across the University Hospital Tees Group.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	To review existing processes for ensuring that a summary of the doctor's governance information is obtained on behalf of the doctor in advance of the annual appraisal discussion.
Comments:	The action for 2024-25 is now complete. For all appraisals due from 1 September 2025 onwards, the doctor will receive a summary of their governance information which will be uploaded to their electronic appraisal in advance of the appraisal meeting. The information is accessed by the Revalidation Team on behalf of the doctor, with a specific page created on InPhase purely for this purpose. The Appraisal and Revalidation Officer and the Medical Workforce Manager have attended InPhase training to support this requirement.
Action for next year:	Not applicable - no new actions identified.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Undertake a review of the Trust's Policy – Responding to Concerns Regarding the Conduct, Performance & Health of Medical & Dental Staff (HR42). Head of Workforce to attend formal Case Investigator Training in September 2024. Consider the 'pooling' of resources with South Tees Hospital NHS Foundation Trust in respect of access to appropriately trained Case Managers and Case Investigators.
Comments:	Two of the three actions identified for 2024-25 are complete. **Training:** The Head of Workforce has attended Case Investigator training in 2024. **Pooling of Resources:** This action has been strengthened through the restructuring of the People Directorate, with a Group Deputy Director of Workforce and Group Head of Workforce with responsibility for ER cases across both organisations. Both NT and ST are now starting to appoint case investigators from the alternative site, particularly where there is a lack of resource at the host Trust or where there may be a conflict of interest or previous involvement in the case. **Policy:** This action has been extended to 2025-26 due to the requirement to undertake a wider review of the existing policies for both North Tees and Hartlepool and South Tees. A draft policy has been produced with the aim of implementing an aligned policy across the Group. This will be taken forward to be ratified in Q3 2025-26.
Action for next year:	To implement a new MHPS policy, which reflects the aligned working practices across the University Hospital Tees Group.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes

Action from last year:	Consider the most appropriate method of recording the country of primary medical qualification for doctors so that this information can be extracted for monitoring and reporting purposes. Enhance current reporting processes to include analysis of the type and outcome of concerns, including consideration of protected characteristics of the doctor and country of primary medical qualification.
Comments:	The actions for 2024-25 have been implemented, however it is recognised that these could be further enhanced therefore they have been extended to 2025-26. The Trust continues to adopt a robust approach to decision making when concerns about a doctor arise, using a structured MDT approach. Subsequent MDT meetings may be scheduled to review any new information or concerns that may come to light to ensure that the previously determined approach continues to be appropriate. This process supports the findings of the Fair to Refer (2019) report, which is aimed at reducing the disproportionality in fitness to practice concerns reported to the GMC. The Trust continues to promote a formal case review process to support effective quality assurance of the policy and process. The Trust continues to participate in the Cultural Ambassador (CA) programme, and ensures that a CA is identified to support any cases where concerns are raised regarding an individual from a BAME ethnicity. Processes are in place to report on the number of formal employee relations cases via the ER Tracker, which includes monitoring in respect of timescales for conclusion of the case and reported outcome. Reports are submitted to and discussed at People Committee, which is a sub-committee of the Board. The ER Tracker contains a 'flag' to identify where an individual has disclosed a relevant protected characteristic.
Action for next year:	Continue to enhance existing reporting processes to include analysis of the type and outcome of concerns, including consideration of protected characteristics of the doctor and country of primary medical qualification.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.

Comments:	The Trust has adopted the Medical Practice Information Transfer (MPIT) form for sharing information and concerns (where applicable) between responsible officers. Where the Trust holds the prescribed connection for revalidation of the doctor, the Trust seeks assurance for the whole scope of the doctor's practice, including any secondary employment outside of the Trust. This is a mandatory part of appraisal. Where the doctor has a prescribed connection to another organisation for revalidation, the Trust will provide the doctor with the necessary information that they need to submit to their main employer for appraisal (limited to the scope of practice within the Trust). It is the external organisation's responsibility to ensure that they seek confirmation of this information, including a 'nil return' where appropriate.
Action for next year:	Not applicable - no new actions identified.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust's MHPS Policy incorporates the principles of a Just and Learning Culture and sets out the process to be followed when concerns are initially identified, including a structured MDT review to establish the most appropriate way forward, i.e. informal monitoring/feedback or formal investigation. Both North Tees & Hartlepool and South Tees Trusts are undertaking a review of the MHPS Policy for 2025-26, to implement an aligned policy across the Group. The Trust is compliant with HSC 2003/012 Maintaining High Professional Standards in the Modern NHS, i.e. appropriately trained Case Manager and Case Investigator, and appointment of a Designated Board Member, which promotes fair processes that, are free from bias and discrimination. The Trust continues to participate in the Cultural Ambassador (CA) programme, which ensures that a CA is identified to support any cases where concerns are raised regarding an individual from a BAME ethnicity.
Action for next year:	To implement a new MHPS Policy, which reflects aligned working practices across the University Hospital Tees Group.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust has effective processes in place to ensure that national reviews/reports/enquiries are considered to identify opportunities for shared learning. On publication of such reviews/reports, a detailed gap analysis is undertaken by the relevant stakeholder in the organisation to understand the current position and develop a plan to implement any recommendations where appropriate. These would then normally be discussed at the relevant Committee, such as People Committee, Patient Safety Committee, etc. Examples of reports include: - Freedom to Speak Up (2015) - Learning Lessons to Improve our People Practices (2019) - NHSI Just Culture Guide (2019) - Ockenden Review (2022) - National WRES and WDES reports (annually)
Action for next year:	Not applicable – no new actions identified.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Messenger Review makes recommendations on improvements as to how health and social care is led and managed in England. Everyone who works in health and social care is united in a common purpose to provide the very best care to patients and service users, however each profession has their own professional standards and is therefore regulated by their defined Regulatory body. The review identifies the need for all leaders to commit to promoting equality of opportunity and fairness standards. The Trust aims to comply with this recommendation by ensuring consistent practice amongst all staff groups, particularly in relation to responding to concerns.

	The Trust's MHPS Policy (HR42) was significantly updated in 2022 to reflect learning from employment tribunal cases. It incorporates the principles of a Just and Learning Culture and sets out the process to be followed when concerns are initially identified. This includes a structured MDT approach to establish the most appropriate way forward, i.e. informal monitoring or formal investigation. This process has since been rolled out across all staff groups across the Trust to ensure consistent practice/process. Both North Tees & Hartlepool and South Tees Trusts are currently undertaking a review of the MHPS Policy for 2025-26, to implement an aligned policy across the Group. The Trust is compliant with HSC 2003/012 Maintaining High Professional Standards in the Modern NHS, i.e. appropriately trained Case Manager and Case Investigator, and appointment of a Designated Board Member, which promotes fair processes that, are free from bias and discrimination. The Trust continues to participate in the Cultural Ambassador (CA) programme, which ensures that a CA is identified to support any cases where concerns are raised regarding an individual from a BAME ethnicity. To implement a new MHPS Policy, which reflects aligned working practices across the University Hospital Tees Group.
Action for next year:	To implement a new MHPS Policy, which reflects aligned working practices across the University Hospital Tees Group.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust is fully compliant with the six mandatory NHS Employer Check Standards, with processes clearly documented within the Employment Checks Policy. Compliance is monitored through the Trac Recruitment System, which requires completion of all mandatory checks before the individual is cleared to commence employment. This applies to all staff groups and includes short-term contracts. The Trust only engages locum doctors from agencies that are on the approved Supplier Framework, which requires the agency to

	undertake employment checks at a level that is compliant with the six employer check standards. Confirmation of satisfactory employment checks is sought from the agency prior to booking, with further verification as appropriate (i.e. GMC and Right to Work).
Action for next year:	Not applicable – no new actions identified.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust's Leadership Faculty delivers a range of professional standards and activities that are aimed at promoting a positive and effective working environment. This includes promoting wellbeing, strong leadership, clear communication and a commitment to equality, diversity and inclusion.
Action for next year:	Not applicable – no new actions identified.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Develop an Inclusive Language Guide and promote across all Trust employees/staff groups.
Comments:	The action for 2024-25 is complete. The Trust has developed an Inclusive Language Guide and this has been rolled out across the organisation during 2024. The Trust continues to make significant and demonstrable progress to promote compassion, fairness, respect, diversity and inclusion. In 2024-25, the Trust has: - Implemented an Inclusive Language Guide. - Continued to promote a Code of Conduct for Staff, which sets out the Trust's expectations and acceptable standards in respect of conduct and behaviour. - Continued commitment to the Sexual Safety Charter (NHS England). - Continued to publish information and implement action plans in respect of the Workforce Race and Disability Equality

	Standards (WRES and WDES), Gender Pay Gap, Equality Delivery System (EDS3). - Continues to participate in the Cultural Ambassador Programme for cases involving staff from an ethic minority. - Ongoing promotion of the Trust's Staff Networks. - Ongoing promotion of the Speaking Up Guardian and network of Champions.
Action for next year:	Not applicable – no new actions identified.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust's Speaking Up Policy (RM36) is based upon the national policy as recommended by NHS England and the National Guardian Office. The Speaking Up Guardian continues to promote the Speaking Up service and a number of Speaking up Champions have been appointed as part of the Trust's Speaking Up Network. The Trust continues to apply the Patient Safety Incident Response Framework (PSIRF) approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The Trust's MHPS Policy incorporates the principles of a Just and Learning Culture and adopts an MDT approach when concerns about a doctor are raised.
Action for next year:	To implement a new MHPS Policy, which reflects aligned working practices across the University Hospital Tees Group.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Not applicable – no actions identified for 2024-25.
Comments:	The Trust complies with the duty to assure and improve processes linked to the professional standards for doctors. A case review process is undertaken for formal employment relations cases, which includes the opportunity to seek feedback

	from the individual concerned. This enables those who are responsible for policies related to conduct, capability and health to understand the actual impact on individuals and consider if the process could have been handled differently. All staff groups, including doctors are encouraged to raise any concerns regarding the professional standards processes with their manager so that this may be reviewed and responded to in a timely manner. In the event of serious/significant concerns, the individual may wish to submit a request for resolution in accordance with the Trust's Resolution Policy (HR2). Doctors are encouraged to discuss any concerns regarding processes with the Trust's RO and the Appraisal and Revalidation Lead (Consultant). Support is also available from the Speaking up Guardian and network of Champions, as well as the various Staff Networks that exist within the Trust.
Action for next year:	Not applicable – no new actions identified.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Consider the most appropriate method of recording the country of primary medical qualification for doctors so that this information can be extracted for monitoring and reporting purposes.
Comments:	The actions for 2024-25 have been implemented, however it is recognised that these could be further enhanced therefore they have been extended to 2025-26. The Trust continues to publish information and implement action plans in respect of the Workforce Race Equality Standard (WRES), which includes specific monitoring of workplace experience in relation to formal disciplinary cases for White staff and staff who are from an ethnic minority. The Trust has implemented the Cultural Ambassador (CA) programme, which ensures that a CA is identified to support any cases where concerns are raised regarding an individual who is from an ethnic minority background. Processes are in place to report on the number of formal employee relations cases via the ER Tracker, which includes monitoring in respect of timescales for conclusion of the case and reported outcome. Reports are submitted to and discussed at People Committee, which is a sub-committee of the Board. The ER Tracker contains a 'flag' to identify where an individual has disclosed a relevant protected characteristic.

Action for next year:	Continue to enhance existing reporting processes to include consideration of protected characteristics of the doctor and country of primary medical qualification.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Ensure continued attendance at all RO Revalidation Network Meetings. Complete a Peer Review of the Trust's Appraisal and Revalidation processes for 2024-25 with South Tees NHS Foundation Trust.
Comments:	The Medical Lead for Appraisal and Revalidation, the Appraisal and Revalidation Officer and the Medical Workforce Manager are all members of the Northern Regional Medical Appraisal Lead Network. Peer Review took place in March 2025, whereby both organisations were invited to present their processes in relation to the key elements of medical appraisal and revalidation. A number of recommendations were identified as an outcome of the review and an implementation plan agreed for 2025-26. Some of the recommendations have already been put into practice, and timescales have been identified for those actions that remain on-going.
Action for next year:	To implement the agreed actions resulting from the Peer Review process, by 31 March 2026.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	354
Total number of appraisals completed	305
Total number of appraisals approved missed	21
Total number of unapproved missed	28
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	80
Total number of late recommendations	6
Total number of positive recommendations	69
Total number of deferrals made	11
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	54 (Group)
Total number of trained case managers	21 (Group)
Total number of concerns received by the Responsible Officer[2]	5
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	310 days
Median duration of concerns processes closed (working days)[3]	N/A no cases closed
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	69
Total number of new employment checks completed before commencement of employment	69 doctors
Total number claims made to employment tribunals by doctors	0 (no new claims, but 2 in progress)
Total number of these claims that were not upheld[4]	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

	One claim not upheld, decision made June 2024 but the claim was made in 2023-24 not 24/25)

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

Significant work has been undertaken during the reporting period of 1 April 2024 to 31 March 2025 to progress the actions identified within the previous FQAI report (2023-24).

This is reflected in comparison with the number of actions to be taken forward for 2025-26, noting that the number is greatly reduced, and is therefore noted as an indicator of the number of enhancements made.

The implementation of electronic medical appraisal has been a major achievement for the Trust and this has undoubtedly contributed to the successful achievement of the majority of actions. The electronic system is now fully embedded and feedback from our doctors has been resoundingly positive: the process is much improved and information is easily accessible and allows the doctor to gather supporting evidence throughout the appraisal year in advance of the appraisal meeting. There are also benefits in terms of automated reminders and reporting functionality which supports the team to reinvest their time to undertake quality improvement initiatives, such as the timely provision of governance information to doctors, noting that this was previously the doctor's responsibility to collect.

The Peer Review with colleagues from South Tees Hospitals NHS Foundation Trust is a further example of an area of excellence and this has also supported the team to achieve a number of actions. The peer review has been a positive exercise which has enabled both Trusts to identify and share areas of good practice across the two organisations. It has also strengthened our commitment towards collaborative working across the Group structure, with standardised processes embedded to support the Group Associate Medical Director - People (Responsible Officer).

It is noted that collaborative working also extends beyond the appraisal and revalidation team, with aligned working practices now in place across the workforce team including: responding to concerns and MHPS processes.

Actions still outstanding

Whilst there are some actions that remain outstanding for 2024-25, this is in the main due to the need to agree new policies in relation to Medical Appraisal and Revalidation and Responding to Concerns Regarding the Conduct, Performance & Health of Medical & Dental Staff (MHPS). Both of these policies were not due for review until 2025-26 therefore it has been necessary to extend the following associated actions to the following year:

- When reviewing the Trust's Appraisal and Revalidation Policy, consideration should be given to the following areas:

    - Implementing a process for the allocation of Appraisers.
    - Roles and Responsibilities for Appraisers.
    - Process for recruiting and selecting Appraisers.

- Produce a documented procedure that outlines the recruitment process to be followed when appointing new appraisers.

- Undertake a review of the Trust's Policy – Responding to Concerns Regarding the Conduct, Performance & Health of Medical & Dental Staff (HR42).

A further two actions were linked to the Peer Review process which was completed in March 2025:

- Complete a Peer Review of the Trust's Appraisal and Revalidation processes for 2024-25 with South Tees Hospitals NHS Foundation Trust, to identify improvements and sharing of best practice in relation to the quality assurance of medical appraisers.

- Continue to explore development of a robust programme of quality assurance for the appraisal process/system.

The Peer Review identified that the Trust has a different structure in terms of identified 'lead' appraisers within directorates, when compared with South Tees. Whilst the Trust does have a lead appraiser in certain areas such as Anaesthetics, this is not consistent across all areas and they do not undertake the same duties as the lead appraisers at South Tees, such as quality assurance. Due to the potential resource implications, it was agreed that the above actions will be taken forward as part of the Peer Review implementation plan for 2025-26.

Current issues

The Peer Review conducted in March 2025 identified different structures in terms of the available resources to deliver medical appraisal and revalidation. This is an issue in terms of the Trust's ability to undertake effective quality assurance of medical appraisers and is the reason why this action has not progressed during 2024-25.

Under the current structure at North Tees, responsibility for QA would sit with the Trust's Medical Lead for Appraisal and Revalidation as a sole responsibility, due to the lack of 'formally appointed' Lead Appraisers.

It is anticipated that this resource implication will be resolved as part of the clinical services review and the implementation of Clinical Service Units.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- To review the Lead Appraiser structure following the changes to the wider clinical structures and the implementation of Clinical Service Units, to understand the resource required to deliver aligned medical appraisal and revalidation across the group.

- To implement a new policy for Medical Appraisal & Revalidation, which reflects the aligned working practices across the University Hospital Tees Group.

- To implement a new MHPS policy, which reflects the aligned working practices across the University Hospital Tees Group.

- To implement the agreed actions resulting from the Peer Review process, by 31 March 2026.

- To implement the agreed action relating to quality assurance of appraisers, as identified during the Peer Review process, by 31 March 2026.

- Continue to enhance existing reporting processes to include analysis of the type and outcome of concerns, including consideration of protected characteristics of the doctor and country of primary medical qualification.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Based upon the evidence contained within this report, the Responsible Officer confirms assurance to the Board of the Trust's regulatory compliance with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013).

A significant number of actions were identified within the previous report (2023-24) and it is a measure of success that the majority of those actions have been successfully completed and embedded into business as usual processes.

The Trust continues to ensure that all doctors are engaged with their responsibilities in relation to appraisal and revalidation. Appraisals are undertaken appropriately and in accordance with national/local policies, procedures and guidelines in order for the RO to make informed revalidation recommendations to the GMC.

Doctors continue to receive full support from the Revalidation Team with their appraisals and revalidation and this has been strengthened during 2024-25 through the implementation of electronic software for the management of appraisals and revalidation recommendations.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
(Chief executive)

Official name of the designated body:	North Tees and Hartlepool NHS Foundation Trust

Name:	Stacey Hunter
Role:	Group Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period:

1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:
South Tees Hospitals NHS Foundation Trust
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**Dr Michael Ingram – GMC 4182359 (Group Associate Medical Director) appointed Responsible Officer 05/08/2024 after handover from previous Responsible Officer – Dr Michael Stewart - with Responsible Officer training previously completed by Dr Ingram in June 2021**
Action for next year:	**Maintain compliance**

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	**Yes**
Action from last year:	**Maintain skills and resources within the team**
Comments:	**Responsible Officer leads a fully resourced Revalidation Team consisting of:-** - **Medical Lead for Appraisal & Revalidation** - **Lead Appraisers x 4** - **Revalidation Manager** - **Revalidation Advisor**
Action for next year:	**Maintain skills and resources within the team, also exploring how the team can potentially further evolve under our new proposed University Hospitals Tees (UHT) group structure**

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**The Trust utilises the L2P appraisal system to maintain a database of all Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust. The system is continually maintained and cross-checked with GMC Connect by the Revalidation Manager and Revalidation Advisor**
Action for next year:	**Maintain compliance**

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	**Yes**
Action from last year:	**Continue to actively monitor Trust policies and review in line with any changes in national guidance**
Comments:	**Trust policy for Medical Appraisal & Revalidation fully revised and updated in December 2021; Trust policy for Remediation fully revised and updated in June 2022; Trust's MHPS policy fully revised and updated in June 2023.** **Each policy is usually reviewed once every three years, or sooner should any changes to national guidance occur. However, with our ever-evolving new UHT structure, the intention is to amalgamate both Trust's policies over the next year with current policies rolled over until the group review of policies takes place.**
Action for next year	**Amalgamate both Trust's policies for Medical Appraisal & Revalidation, Remediation and MHPS over the next year whilst continuing to actively monitor Trust policies in order to respond to any changes in national guidance**

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	**Yes**
Action from last year:	**Undertake a peer review of our organisation's appraisal and revalidation processes with North Tees & Hartlepool NHS Foundation Trust**
Comments:	**Peer review undertaken with North Tees & Hartlepool NHS Foundation Trust over the course of the last year – several learning areas identified which will help to bring about consistency in our policies and processes as our UHT structure continues to develop**
Action for next year:	**Follow up on actions identified as a result of the peer review process undertaken**

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	**Yes**
Action from last year:	**Maintain compliance and engagement**
Comments:	**All Locum Doctors directly employed by the Trust are expected to participate fully in the appraisal process and agree a PDP within their first three months of joining; Locum Doctors employed for three or more months should undertake a full appraisal. Locum Doctors with a prescribed connection to another organisation e.g. Locum Agency, are afforded the opportunity to have their appraisal with the Trust which can be requested via their Clinical Director.** **Short term placement Doctors i.e. Locally Employed Non-Training Grade Doctors, receive the same level of support from the Revalidation Team as our Consultants. The Trust have an identified Lead Appraiser as the main point of contact for Locally Employed Non-Training Grade Doctors with specifically targeted appraisal training sessions also held for this group of Doctors three times a year. A specifically designed slide pack detailing the appraisal and revalidation process is shared with all new Locally Employed Doctor appointments upon their commencement in post with the Trust.**
Action for next year	**Maintain compliance and engagement**

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**The Trust ensures its Doctors undertake annual appraisal in accordance with local policies and procedures and GMC requirements. The Trust utilises the PALS & DATIX Risk Management Systems for the logging of complaints and significant events; reports are extracted from the systems by the Revalidation Team which are forwarded to the Doctor for upload to their appraisal. Doctors are also requested to include any details on complaints or significant events which haven't been captured on the PALS & DATIX Risk Management Systems but which they are aware of. Where a Doctor works for any organisation outside of the Trust, they are asked to complete a separate Whole Scope of Practice Form, declaring the additional duties they undertake, the nature and frequency of these duties and whether or not they have been named in any complaints or significant events within the appraisal period; the form must be completed and signed by the external organisation and uploaded to the Doctor's appraisal** **With increased cross-site working between neighbouring Trusts as part of the North East and North Cumbria Integrated Care System (ICS), Doctors are now also expected to complete a Whole Scope of Practice form for any work undertaken at different NHS Trusts to ensure full transparency and sharing of information between organisations**
Action for next year:	**Maintain compliance**

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	**Yes**
Action from last year:	**Continue to enforce Trust's escalation policy where appropriate**
Comments:	**A record of missed or incomplete appraisals is kept with the Revalidation Manager working closely with the Medical Lead for Appraisal & Revalidation to establish the reasons why and enforcing the Trust's escalation policy for non-participation in appraisal where necessary**
Action for next year:	**Continue to enforce Trust's escalation policy where appropriate**

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	**Yes**
Actions from last year:	**Update medical appraisal policy alongside North Tees' policy to ensure consistency across the group moving forward**
Comments:	**The planned update to the Trust's policy did not take place last year with new group structure arrangements with North Tees & Hartlepool NHS Foundation Trust still being worked through. It is envisaged that the review of the Trust's Revalidation and Appraisal policy will take place in 2025-2026 - ensuring consistency across the group moving forward**
Action for next year:	**Amalgamate South Tees' and North Tees' Revalidation and Appraisal policies to ensure consistency across the group moving forward**

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	**Yes**
Action from last year:	**Continue to undertake targeted recruitment of appraisers within specialities where the appraiser to appraisee ratio is not currently at the desired level**
Comments:	**There are currently 162 appraisers in the Trust (up from 156 reported last year) to undertake appraisals for 800+ Doctors (including Trust employed military Doctors and those with GDC registration rather than GMC). All 162 appraisers have undergone full revalidation and appraisal training and are assigned to a member of our Lead Appraisal Team for on-going support and mentorship** **Our list of appraisers is regularly reviewed to ensure each specialty are adequately represented and maintain an acceptable ratio of number of appraisees vs number of appraisers**
Action for next year:	**Continue to undertake targeted recruitment of appraisers within specialities where the appraiser to appraisee ratio is not currently at the desired level**

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	**Yes**
Action from last year:	**Continue to hold meetings for all appraisers throughout the year and attend regional network meetings**
Comments:	**There is on-going training and support from the Revalidation Team. Several workshops led by the Medical Lead for Appraisal & Revalidation, Lead Appraisers and Revalidation Manager have taken place in the last 12 months to allow all appraisers to meet, discuss any issues and share best practice. Our Medical Lead for Appraisal & Revalidation, Lead Appraisers and Revalidation Manager also regularly attend the Northern Regional Medical Appraisal Lead Network meetings, using Trust workshops to cascade learning**
Action for next year:	**Continue to hold meetings for all appraisers throughout the year, revising our approach to hold joint meetings for all appraisers across both South Tees and North Tees under the banner of UHT, and continue to attend regional network meetings**

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	**Yes**
Action from last year:	**Continue to implement targeted areas for appraiser development – building upon learning taken from PROGRESS tool analysis and utilising the appraiser feedback resources available within the L2P appraisal software**
Comments:	**Reports for Board are produced on a bi-annual basis covering all aspects of appraisal and revalidation.** **Quality assurance processes have been developed and strengthened in line with National practice, providing feedback to our appraisers on an annual basis, thus driving up the standards of appraisal within the Trust. Appraiser quality assurance utilises a validated national tool (PROGRESS) and is delivered by lead appraisers and the revalidation team. Appraisers are encouraged to use and reflect on this feedback as part of their own annual appraisal. In addition, individual quality assurance common themes/lessons learnt are directly circulated to appraisers via our regular revalidation newsletters.** **Appraisers also receive their appraisee feedback report on an annual basis, generated via our L2P appraisal system, enabling further discussion and reflection at their own appraisal meeting**
Action for next year:	**Continue to implement targeted areas for appraiser development – building upon learning taken from PROGRESS tool analysis and utilising the appraiser feedback resources available within the L2P appraisal software**

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**Recommendations are always timely with the Revalidation Manager ensuring Doctor's portfolios are reviewed in collaboration with the Medical Lead for Appraisal & Revalidation in advance of their revalidation date to ensure that all necessary supporting information required to facilitate a positive revalidation recommendation has been captured and to confirm that no fitness to practice concerns outside of the appraisal process are on-going** **The Trust are continuing to utilise the extended 12-month revalidation recommendation window, regularly communicating with all Doctors under notice over the following 12 month period and recommending revalidation for individuals ahead of time where appropriate to do so**
Action for next year:	**Maintain compliance whilst also considering a revision of our approach arising from recommendations resulting from the peer review process**

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**All Doctors receive a confirmation email from the Revalidation Manager informing them of their revalidation recommendation as soon as this has been processed on GMC Connect. Where the recommendation is one of deferment, the Revalidation Manger ensures appropriate liaison with the individual concerned, clearly communicates the reason for deferral and establishes a plan with the Doctor to ensure a positive revalidation recommendation can be submitted in line with their revised revalidation date. The Trust hasn't submitted any non-engagement recommendations in the last year but would follow the same process described for deferrals should the situation arise**
Action for next year:	**Maintain compliance**

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	**Yes**
Action from last year:	**Ensure continued effectiveness**
Comments:	**Revalidation and appraisal forms part of the broader clinical governance framework present in the Trust. Each clinical area has their own systems and processes relating to clinical governance with risk management meetings, directorate meetings, collaborative board meetings, patient safety groups and quality assurance forums all contributing to the wider clinical governance agenda. Robust systems and processes in place ensure relevant information is communicated to the right individuals and escalated to our partners and regulators where appropriate. The Trust encourages individuals to highlight any areas of concern through our DATIX Risk Management System as well as our Raising Concerns (Freedom to Speak Up) policy**
Action for next year:	**Ensure continued effectiveness**

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**The Trust utilises the DATIX Risk Management System for the logging of complaints and significant events** **Our appraisal platform has also been updated in the last year so that appraisers can immediately flag concerns to the Responsible Officer at the click of a button from within the system** **Our Responsible Officer continually monitors any conduct or performance concerns arising in relation to any of our prescribed connections – where any concerns do arise, the Good Medical Practice Group (GMPG) meets as and when required to review and decide upon any appropriate next steps**
Action for next year:	**Maintain compliance**

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	**Y**
Action from last year:	**Maintain compliance**
Comments:	**Reports are extracted from the DATIX Risk Management System by the Revalidation Team which are forwarded to the Doctor for upload to their appraisal**
Action for next year:	**Maintain compliance**

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	**Yes**
Action from last year:	**Continue to actively monitor Trust MHPS policy and review in line with any changes in national guidance**
Comments:	**The Trust follows the Department of Health Maintaining High Professional Standards in the Modern NHS framework with a local adaptation of the framework adopted as Trust policy – fully revised and updated in June 2023**
Action for next year:	**Amalgamate both Trust's policies for MHPS over the next year whilst continuing to actively monitor current Trust policy in order to respond to any changes in national guidance**

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	**Yes**
Action from last year:	**Ensure completion of Case Investigator Training and Case Manager Training and continue to utilise the GMPG where appropriate** **Further develop analysis of Doctors in areas of protected characteristics / country of primary medical qualification etc. in relation to responding to concerns**
Comments:	**The above forms part of our local case investigation process following our local MHPS policy. 54 individuals across both South Tees and North Tees have undertaken full Case Investigator Training - providing the Trust with broad knowledge and resilience in this area. A further training session is planned for March 2026, being hosted at South Tees, with invites to be circulated to our neighbouring Trusts – this will provide a further 24 fully trained Case Investigators across the region once completed.** **Case Manager training was also hosted at South Tees in March 2025 with 21 individuals now trained across both South Tees and North Tees** **The Trust's MHPS policy was fully revised and updated in June 2023** **As and when appropriate, our "Good Medical Practice Group" (GMPG) meets to review any new concerns reported within the organisation. The GMPG provides further assurance through a formally recognised decision making group for the organisation - supporting the Responsible Officer when considering and managing concerns regarding medical staff. The GMPG also ensures that support is in place and provided to those Doctors where concerns have been raised and ensures due process, equity and fairness are followed in all proceedings.**
Action for next year:	**Continue to develop analysis of Doctors in areas of protected characteristics / country of primary medical qualification etc. in relation to responding to concerns**

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	**Yes**
Action from last year:	**Continue timely completion of forms where required**
Comments:	**The Trust completes the NHS England Medical Practice Information Transfer (MPIT) form where information or concerns need to be shared between respective Responsible Officers**
Action for next year:	**Continue timely completion of forms where required**

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	**Yes**
Action from last year:	**Maintain safeguards**
Comments:	**The Trust and senior management uphold good practices relating to handling of concerns about clinical practice based on the GMC governance handbook. Our Responsible Officer deputises for all matters relating to the GMC with quarterly meetings held locally with our GMC Employer Liaison Advisor**
Action for next year:	**Maintain safeguards**

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**The Trust's Regulatory and Compliance (Risk and Governance) Manager performs monthly horizon scanning across key stakeholder websites/newsletters in order to keep up to date with the latest national guidance and any legislative changes – ensuring all key personnel within the organisation are kept up to date and policy / procedural reviews enacted as and when required**
Action for next year:	**Maintain compliance**

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	**As we review and develop medical workforce policies across the new University Hospital Tees Group, this should be done in collaboration with nursing and AHP leads, assuring a fair and consistent approach to investigations when concerns arise.**
Comments:	**By developing adopting the "South Tees Way" as a Just Culture framework for when concerns arise, this approach standardises the approach to professional standards investigations across all healthcare professionals within the Trust.**
Action for next year:	**Continue to review and develop medical workforce policies across the new University Hospital Tees Group**

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Yes**
Action from last year:	**Maintain compliance**
Comments:	**Appropriate pre-employment background checks are carried out by the Trust's recruitment team. HCRG (a.k.a. HCL Doctors) are used as the master vendor for providing Medical Locums across all specialties for all medical roles**
Action for next year:	**Maintain compliance**

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	**Yes**
Action from last year:	**Continue to embed and enhance**
Comments:	**Through the leadership improvement and training academy, education is both procured and in house - delivered to meet the needs of leadership, improvement, civility, human factors, non-technical skills for surgeons (NOTSS) and psychological safety training for all doctors - regardless of their stage in training**
Action for next year:	**Continue to embed and enhance**

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	**Yes**
Action from last year:	**Continue to embed and enhance**
Comments:	**Through the work of staff networks, the application of a restorative just and learning culture, training at large scale education days in leadership, safety and improvement, and the work of the Equality, Diversity and Inclusion Human Resources Business Partner, along with Freedom To Speak Up Guardians - a compassionate, respectful and supportive culture is actively promoted at South Tees, aligning to the Trust values of respect, support and care.** **Our appraisal platform now includes the ability for appraisees to log their welfare score on a scale of 1-10 – discussions are on-going with our software provider to ascertain the ability for low welfare scores to be automatically flagged up to the Responsible Officer with the aim of further enhancing our Trust's supportive culture**
Action for next year:	**Continue to embed and enhance**

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	**Yes**
Action from last year:	**Continue to embed and enhance**
Comments:	**From induction onwards, the Trust values are embedded across all staff groups, with all education and training open to all staff, independent of grade**
Action for next year:	**Continue to embed and enhance**

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	**Yes**
Action from last year:	**Continue to encourage feedback from Doctors and explore further mechanisms to obtain feedback**
Comments:	**Doctors are able to provide feedback around the organisation's professional standards processes via several different means – not just via the Trust's formal complaints procedure. The Junior Doctor's Forum, The Senior Medical Staff Forum and The Joint Local Negotiating Committee all provide the mechanism for Doctor's to provide feedback; our Guardian of Safe Working is also highly visible across the Trust. Our Group Responsible Officer very much operates an "open-door" policy and encourages feedback from all connected Doctors in either a formal or informal setting.**
Action for next year:	**Continue to encourage feedback from Doctors and explore further mechanisms to obtain feedback**

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	**Yes**
Action from last year:	**Further develop and analyse data reported to People Committee regarding Doctors involved in concerns and disciplinary processes**
Comments:	**The Responsible Officer discusses any Doctors involved in concerns and disciplinary processes with our Group People Officer via our Group Head of Workforce with meetings between the two held on a regular basis. Non-Exec Directors are updated on individuals as deemed appropriate should they need to be identified as the named "supportive contact" in any particular case. Details on the background of individuals involved in concerns and disciplinary processes is to be further developed and analysed over the coming year**
Action for next year:	**Continue to further develop and analyse data regarding Doctors involved in concerns and disciplinary processes**

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	**Yes**
Action from last year:	**Continue attendance at regional meetings and undertake peer review process**
Comments:	**Our Responsible Officer, Medical Lead for Appraisal & Revalidation, Lead Appraisers and Revalidation Manager regularly attend the Northern Regional Medical RO Network meetings and Appraisal Lead Network meetings** **In line with our newly formed group structure with North Tees & Hartlepool NHS Foundation Trust – both Trusts have worked together to undertake a peer review in the last year of both organisation's appraisal and revalidation processes**
Action for next year:	**Continue attendance at regional meetings and consider recommendations arising from peer review**

Section 2 – metrics

Year covered by this report and statement: **1 April 2024 – 31 March 2025** .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	**850**
Total number of appraisals completed	**770**
Total number of appraisals approved missed	**79**
Total number of unapproved missed	**1**
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	**197**
Total number of late recommendations	**0**
Total number of positive recommendations	**175**
Total number of deferrals made	**22**
Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**N/A**
Total number of trained case investigators	**54**
Total number of trained case managers	**21**
Total number of concerns received by the Responsible Officer[2]	**18**
Total number of concerns processes completed	**18**
Longest duration of concerns process of those open on 31 March (working days)	**315 days**
Median duration of concerns processes closed (working days)[3]	**221 days**
Total number of doctors excluded/suspended during the period	**2**
Total number of doctors referred to GMC	**2**

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	**0**
Total number of these appeals that were upheld	**N/A**
Total number of new doctors joining the organisation	**173**
Total number of new employment checks completed before commencement of employment	**173**
Total number claims made to employment tribunals by doctors	**1** **(in this reporting period)**
Total number of these claims that were not upheld[4]	**0** **(in this reporting period)**

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
- **Peer review of our organisation's appraisal and revalidation processes undertaken in collaboration with North Tees & Hartlepool NHS Foundation Trust** - **Case Investigator Training and Case Manager Training completed in the last year with GMPG continuing to be utilised where appropriate**
Actions still outstanding
- **Update of medical appraisal policy did not take place in the last year with discussions over our group structure continuing to take place – this is an action for the year ahead to ensure consistency across the group moving forward** - **Further develop analysis of Doctors in areas of protected characteristics / country of primary medical qualification etc. in relation to responding to concerns**
Current issues
Nil

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
- **Amalgamate both Trust's policies for Medical Appraisal & Revalidation, Remediation and MHPS** - **Follow up on actions identified as a result of the peer review process undertaken** - **Revise our approach to in-house appraiser update/training sessions with plans to hold joint meetings for all appraisers across both South Tees and North Tees under the banner of UHT four times per year** - **Consider a revision of our approach to evaluating appraisee portfolios ahead of revalidation recommendations linked to actions resulting from the peer review process** - **Continue to review and develop medical workforce policies across the new University Hospital Tees Group** - **Continue to explore further mechanisms to obtain feedback from Doctors about the organisation's professional standards processes** - **Explore how the Revalidation team can potentially further evolve under our new proposed University Hospitals Tees (UHT) group structure** - **Seek to improve upon mechanisms of data flow between Human Resources team and Responsible Officer's team**
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The Trust continues to ensure all Doctors engage in appraisal with the Revalidation Team aiming to fully optimise the L2P appraisal software for the management of appraisals and revalidation recommendations. **Based on the embedded systems and processes in place within the Trust, the Revalidation Team continues to work from a position of strength and can provide assurance that:-** - **Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC** - **Robust quality checking of appraisers is taking place** - **Doctors are continually supported by the Revalidation Team with their appraisals and revalidation** - **Outstanding appraisals are routinely addressed** - **Appraisers have access to dedicated support and training to aid their roles as appraisers**

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body:	**South Tees Hospitals NHS Foundation Trust**

Name:	**Stacey Hunter**
Role:	**Chief Executive Officer**
Signed:	
Date:	

Name of the person completing this form:	**James Auty – Revalidation Manager** **(on behalf of the Responsible Officer)**
Email address:	**jamesauty@nhs.net**

Resources Committee

24 September and 29 October 2025

Connecting to: Group Board

Chair of Committee: David Redpath

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.

Finance

The financial position for Month 6 2025/26 is a deficit of £5.4m for the Group, which is a favourable variance of £21k against the year-to-date plan.

The reported position includes over-performance of ERF income of £5.1m (at risk above commissioner affordable levels within contract mandates) and additional non-recurrent measures totalling £5m year-to-date across the Group.

WTE and Agency

Month 5 shows a net overall decrease of 55.89 WTE worked across the Group, compared to the previous month. WTEs worked in month were 168.06wte lower than the average of the previous financial year. Compared to the same period last year (Month 6) WTEs were lower by 107.39wte. WTEs worked remains higher than the average deployed during 2019/20 (preCovid), by 2,372.11wte (18.4%). 3 Reductions in premium pay expenditure continue, with Agency spend £0.7m (16%) less and Bank spend £1.2m (13% less) than that incurred at the same point in the previous year (adjusted for inflation).

CIP

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission. However, at the end of the reporting period £2.1m of the CIP programme remains defined as 'Opportunity' and £9.5m of the programme remains as High Risk. Across the Group, overall year-to-date reported CIP delivery is £32.9m (98% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £4.1m behind plan at the end of Month 6.

Continuous Improvement Business case
A business case was presented for approval for investment for external support and development / implementation of a continuous improvement business case.

Performance

The Committee were alerted to areas of focus for NTHT in relation to 4-Hour A&E Standard as the agreed plan is higher than the current expected performance variation. Cancer 31 Day Standard for NTHFT as performance has deteriorated and is outside of expected variance in August 2025. Cancer 62 Day Standard for NTHFT as performance has deteriorated since February 2025 with plans in place for all three areas to recover the position.

For STHFT Cancelled Operations Not Rebooked in 28 Days and Diagnostic 6 Week standard remain escalated to the Committee with focused plans in place.

The Committee noted that the Chief Delivery Officer will be establishing oversight groups on Cancer and RTT which will provide assurance into the Committee which was welcomed.

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.

Capital Cash Application

The committee approved the submission of Capital support application to NHSE amounting to £5.9m

Digital

The committee had a deep dive session into digital and would like to note the significant improvement into reporting.

Business case for EPR will be considered in the coming period

Procurement

A Joint North Tees and Hartlepool and South Tees report was submitted, and the Committee noted the good progress towards delivery of the procurement savings targets and the progress made on joint working.

Ophthalmology Biologics Business case

This was not considered by the committee as scheduled as the paper was not presented for consideration. As the business case is an invest to save opportunity it is important this is progressed at pace.

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 Committee also received assurance reports on

- Clinical coding
- Sustainability
- Estate and PFI
- Digital
- Capital programme

Month 6 2025-26 Finance Report

Meeting date: *6 November 2025*

Reporting to: Board of Directors

Agenda item No: *4.2*

Report author: *Chris Hand, Chief Finance Officer*

Executive director sponsor: *Chris Hand, Chief Finance Officer*

Action required: *Assurance*

Delegation status: *Jointly delegated item to Group Board*

Previously presented to: *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 6 2025/26 is a deficit of £5.4m for the Group, which is a favourable variance of £21k against the year-to-date plan.

The reported position includes over-performance of ERF income of £5.1m year-to-date (at risk above commissioner affordable levels within contract mandates) and additional non-recurrent measures.

Continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTE and expenditure run-rates will be essential throughout the remainder of the financial year to ensure delivery of the financial control total.

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. Quarter 3 deficit support funding has now been confirmed.

Additional national guidance has recently been published outlining the performance expectations for medium-term planning across the NHS. Draft plans are required for submission during December, with final plan submissions during February. Further detailed planning guidance, allocations and planning templates are due to be published imminently.

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.

Significant risks at Month 6 include ERF income, industrial action, CIP delivery and unfunded inflationary pressures.

Month 6 shows a net overall decrease of 55.89 WTE worked across the Group, compared to the previous month. WTEs worked in month were 168.06wte lower than the average of the previous financial year. Compared to the same period last year (Month 6) WTEs were lower by 107.39wte. WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,372.11wte (18.4%)

Reductions in premium pay expenditure continue, with Agency spend £0.7m (16%) less and Bank spend £1.2m (13% less) than that incurred at the same point in the previous year (adjusted for inflation).

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission. However, at the end of the reporting period £2.1m of the CIP programme remains defined as 'Opportunity' and £9.5m of the programme remains as High Risk. Across the Group, overall year-to-date reported CIP delivery is £32.9m (98% of target). However, this position includes a number of non-recurrent schemes.

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.

The CEO chairs FROG meetings, with expanded membership to include wider representation from the Executive team, to ensure continued focus and prioritisation of de-risking of the efficiency programme.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 6 2025/26.

Group Board of Directors
6 November 2025

Month 6 2025/26 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 6 of 2025/26.

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 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.

3. MONTH 6 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 6 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	213,056	212,219	(837)	475,981	475,692	(289)	**689,037**	**687,911**	**(1,126)**
Other operating income	17,382	18,714	1,332	35,158	35,066	(92)	**52,540**	**53,780**	**1,240**
Employee expenses	(154,519)	(160,107)	(5,588)	(303,941)	(305,323)	(1,382)	**(458,460)**	**(465,430)**	**(6,970)**
Operating expenses excluding employee expenses	(74,203)	(70,533)	3,670	(195,855)	(197,888)	(2,033)	**(270,058)**	**(268,421)**	**1,637**
OPERATING SURPLUS/(DEFICIT)	**1,716**	**293**	**(1,423)**	**11,343**	**7,547**	**(3,796)**	**13,059**	**7,840**	**(5,219)**
FINANCE COSTS									
Finance income	1,128	1,567	439	1,297	2,030	733	**2,425**	**3,597**	**1,172**
Finance expense	(355)	(357)	(2)	(10,818)	(10,743)	75	**(11,173)**	**(11,100)**	**73**
PDC dividends payable/refundable	(1,602)	(1,602)	0	0	0	0	**(1,602)**	**(1,602)**	**0**
NET FINANCE COSTS	**(829)**	**(392)**	**437**	**(9,521)**	**(8,713)**	**808**	**(10,350)**	**(9,105)**	**1,245**
Other gains/(losses) including disposal of assets	0	830	830	0	1	1	**0**	**831**	**831**
Corporation tax expense	(48)	(17)	31	(6)	0	6	**(54)**	**(17)**	**37**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**839**	**714**	**(125)**	**1,816**	**(1,165)**	**(2,981)**	**2,655**	**(451)**	**(3,106)**
Add back all I&E impairments/(reversals)	0	0	0	0		0	**0**	**0**	**0**
Remove capital donations/grants I&E impact	0	136	136	(3,804)	(815)	2,989	**(3,804)**	**(679)**	**3,125**
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0	0	0	**0**	**0**	**0**
Remove PFI revenue costs on an IFRS 16 basis	0	0	0	32,271	31,971	(300)	**32,271**	**31,971**	**(300)**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(36,525)	(36,223)	302	**(36,525)**	**(36,223)**	**302**
Adjusted financial performance surplus/(deficit)	**839**	**850**	**11**	**(6,242)**	**(6,232)**	**10**	**(5,403)**	**(5,382)**	**21**

At the end of Month 6 2025/26 the Group is reporting a year-to-date (YTD) favourable variance of £21k, with a variance of £11k relating to NTH and £10k relating to STH.

The main drivers of the **NTH Month 6 position** are:

- Clinical Income is behind plan by £0.8m. This is due a net-neutral reclassification of hosted UTC income, which has been offset by ERF assumptions for YTD activity and drugs & devices income. The YTD position assumes payment of £1.6m ERF income above the levels included in commissioner contract mandates, assuming payment in line with PbR rules.
- Other operating income (excluding donated asset income) is £1.3m ahead of plan, mainly relating to education income.
- Interest receivable is ahead of plan by £0.4m, reflecting current interest rates and cash balances.
- Pay is £5.6m behind plan due to increased demand for Enhanced Care, weekend working linked to activity, industrial action, pay award pressures and slippage on CIP delivery.
- Non-Pay is underspent by £3.7m, relating to hosted UTC expenditure which is offsetting increases in clinical supplies and drugs, linked to activity levels alongside slippage on CIP delivery.
- The year-to-date position includes the impact of additional non-recurrent measures of £2.0m, ahead of the phased plan.

The main drivers of the **STH Month 6 position** are:

- Clinical Income is behind plan by £0.3m. This relates to assumed ERF income of £3.5m above commissioner contract mandates, in line with PbR rules. However, this has been offset by the under-recovery of planned income for the FHN surgical hub, depreciation funding, and NHSE thoracic surgery expansion.
- The Other Operating Income variance mainly relates to the Salix grant income which is removed from the Trusts reported control total position.
- Pay is overspent by £1.1m, including the YTD pressure relating to a funding shortfall for the national pay award and the costs of industrial action in July. Bank staff underspends continue to offset an adverse variance on agency expenditure.
- Non-Pay is £2.0m overspent, with overspends on clinical supplies and drugs, part offset by underspends against energy and premises.
- Interest receivable is ahead of plan by £0.7m, reflecting higher than plan cash balances.
- The year-to-date position includes the impact of additional non-recurrent measures of £3.0m, ahead of the phased plan.

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 6, 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 £3.7m. This was £1.0m higher than plan, largely relating to Consultant agency which was £0.4m over at STH and at £0.4m over at NTH. However, total agency expenditure was £0.7m (16%) less than the agency expenditure incurred at the same point in the previous year (adjusted for inflation), largely relating to nursing agency reductions at NTH.

Across the Group, **YTD bank** expenditure was £14.2m. This was £0.8m less than plan, largely relating to Nursing and HCA Bank at STH which was under by £1.2m overall. Total bank expenditure was £2.1m (13%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	520	50	-470	1,386	-1,336	-96%
AHP and S&T	161	335	174	210	125	59%
Other Clinical	0	0	0	0	0	-
Consultants	394	779	385	960	-181	-19%
Career/staff grades	0	12	12	24	-12	-50%
Trainee grades	0	31	31	0	31	-
Non Clinical	0	34	34	28	6	20%
TOTAL	**1,075**	**1,241**	**166**	**2,610**	**-1,369**	**-52%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	2,383	2,610	227	2,525	85	3%
AHP and S&T	330	370	40	380	-10	-3%
Other Clinical	2,406	2,840	434	2,519	321	13%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	363	314	-49	461	-147	-32%
TOTAL	**5,482**	**6,134**	**652**	**5,884**	**250**	**4%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	103	54	-49	149	-95	-64%
AHP and S&T	120	424	304	154	270	175%
Other Clinical	21	1	-20	1	0	-5%
Consultants	1,345	1,777	432	1,410	367	26%
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	28	153	125	0	153	-
TOTAL	**1,617**	**2,409**	**792**	**1,713**	**696**	**41%**

BANK YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	4,437	3,707	-730	4,804	-1,097	-23%
AHP and S&T	105	77	-28	91	-14	-15%
Other Clinical	3,771	3,263	-508	4,269	-1,006	-24%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	846	649	-197	781	-132	-17%
Non Clinical	435	403	-32	482	-79	-16%
TOTAL	**9,594**	**8,099**	**-1,495**	**10,427**	**-2,328**	**-22%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	623	104	-519	1,535	-1,431	-93%
AHP and S&T	281	759	478	364	395	108%
Other Clinical	21	1	-20	1	0	-5%
Consultants	1,739	2,556	817	2,370	186	8%
Career/staff grades	0	12	12	24	-12	-50%
Trainee grades	0	31	31	0	31	-
Non Clinical	28	187	159	28	159	561%
TOTAL	**2,692**	**3,650**	**958**	**4,323**	**-673**	**-16%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	6,820	6,317	-503	7,328	-1,011	-14%
AHP and S&T	435	447	12	471	-24	-5%
Other Clinical	6,177	6,103	-74	6,788	-685	-10%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	846	649	-197	781	-132	-17%
Non Clinical	798	717	-81	942	-225	-24%
TOTAL	**15,076**	**14,233**	**-843**	**16,311**	**-2,078**	**-13%**

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 6 (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.

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.	Q1 Avg 25/26	Mth 4 25/26	Mth 5 25/26	Mth 6 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from M6 24/25
NTH												
Agency	20.38	63.89	35.17	16.66	14.85	18.61	12.45	-6.16	-7.93	-51.44	-22.72	-11.69
Bank	186.45	234.11	247.00	240.89	248.04	259.90	236.36	-23.54	49.91	2.25	-10.64	-12.55
Substantive	4,659.47	5,130.23	5,325.94	5,293.57	5,255.78	5,215.96	5,210.30	-5.66	550.83	80.07	-115.64	-123.63
Sub Total	**4,866.30**	**5,428.23**	**5,608.11**	**5,551.11**	**5,518.67**	**5,494.47**	**5,459.11**	**-35.36**	**592.81**	**30.88**	**-149.00**	**-147.87**
STH												
Agency	25.51	34.62	18.73	15.84	21.17	18.39	21.50	3.11	-4.01	-13.12	2.77	6.38
Bank	198.01	393.05	347.40	275.69	312.62	295.15	273.09	-22.06	75.08	-119.96	-74.31	-76.74
Substantive	7,836.68	9,235.07	9,492.43	9,597.58	9,582.45	9,546.49	9,544.91	-1.58	1,708.23	309.84	52.48	110.84
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,889.11**	**9,916.24**	**9,860.03**	**9,839.50**	**-20.53**	**1,779.30**	**176.76**	**-19.06**	**40.48**
UHT GROUP												
Agency	45.89	98.51	53.90	32.50	36.02	37.00	33.95	-3.05	-11.94	-64.56	-19.95	-5.31
Bank	384.46	627.16	594.40	516.58	560.66	555.05	509.45	-45.60	124.99	-117.71	-84.95	-89.29
Substantive	12,496.15	14,365.30	14,818.37	14,891.14	14,838.23	14,762.45	14,755.21	-7.24	2,259.06	389.91	-63.16	-12.79
Grand Total	**12,926.50**	**15,090.97**	**15,466.68**	**15,440.23**	**15,434.91**	**15,354.50**	**15,298.61**	**-55.89**	**2,372.11**	**207.64**	**-168.06**	**-107.39**

Month 6 shows a net overall decrease of 55.89wte worked across the Group, compared to the WTE worked reported in the previous month, largely apparent in lower bank staff WTE. The in-month change in WTE was a 35.36wte decrease at NTH and a 20.53wte reduction at STH

WTEs worked in month were 168.06wte lower than the average of the previous financial year. Compared to the same period last year (Month 6) WTEs were lower by 107.39wte. WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,372.11wte (18.4%)

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.	Q1 Avg 25/26	Mth 4 25/26	Mth 5 25/26	Mth 6 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from M6 24/25
NTH												
Nursing & Midwifery	1,381.12	1,607.51	1,682.30	1,698.86	1,698.04	1,701.16	1,694.93	-6.23	313.81	87.42	12.63	35.12
Medical & Dental	535.14	555.47	585.95	600.51	592.79	584.46	582.95	-1.51	47.81	27.48	-3.00	12.92
AHP, Sci., Ther.&Tech.	540.32	588.28	603.99	562.54	567.12	562.56	569.15	6.59	28.83	-19.13	-34.84	-47.97
HCAs & Support Staff	949.52	1,051.64	1,050.01	1,021.43	1,019.64	1,028.79	1,010.56	-18.23	61.04	-41.08	-39.45	-55.55
Non Clinical	1,460.20	1,625.34	1,685.87	1,667.77	1,641.08	1,617.50	1,601.52	-15.98	141.32	-23.82	-84.35	-92.39
Sub Total	**4,866.30**	**5,428.24**	**5,608.11**	**5,551.11**	**5,518.67**	**5,494.47**	**5,459.11**	**-35.36**	**592.81**	**30.87**	**-149.00**	**-147.87**
STH												
Nursing & Midwifery	2,506.06	2,958.13	3,095.50	3,145.89	3,170.34	3,149.63	3,133.08	-16.55	627.02	174.95	37.58	78.31
Medical & Dental	1,242.76	1,318.94	1,376.28	1,392.44	1,392.04	1,375.64	1,417.80	42.16	175.04	98.86	41.52	44.72
AHP, Sci., Ther.&Tech.	1,225.20	1,484.76	1,570.58	1,574.89	1,586.08	1,603.30	1,599.23	-4.07	374.03	114.47	28.65	39.78
HCAs & Support Staff	1,424.35	1,755.65	1,672.69	1,642.68	1,655.97	1,637.49	1,621.49	-16.00	197.14	-134.16	-51.20	-54.43
Non Clinical	1,661.83	2,145.27	2,143.50	2,133.21	2,111.81	2,093.97	2,067.90	-26.07	406.07	-77.37	-75.60	-67.90
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,889.11**	**9,916.24**	**9,860.03**	**9,839.50**	**-20.53**	**1,779.30**	**176.76**	**-19.06**	**40.48**
UHT GROUP												
Nursing & Midwifery	3,887.18	4,565.64	4,777.80	4,844.75	4,868.38	4,850.79	4,828.01	-22.78	940.84	262.37	50.21	113.43
Medical & Dental	1,777.90	1,874.41	1,962.23	1,992.95	1,984.83	1,960.10	2,000.75	40.65	222.85	126.34	38.52	57.64
AHP, Sci., Ther.&Tech.	1,765.52	2,073.04	2,174.57	2,137.43	2,153.20	2,165.86	2,168.38	2.52	402.86	95.34	-6.19	-8.19
HCAs & Support Staff	2,373.87	2,807.29	2,722.71	2,664.11	2,675.61	2,666.28	2,632.05	-34.23	258.18	-175.24	-90.66	-109.98
Non Clinical	3,122.03	3,770.61	3,829.37	3,800.99	3,752.89	3,711.47	3,669.42	-42.05	547.39	-101.19	-159.95	-160.29
Sub Total	**12,926.50**	**15,090.98**	**15,466.68**	**15,440.23**	**15,434.91**	**15,354.50**	**15,298.61**	**-55.89**	**2,372.11**	**207.63**	**-168.07**	**-107.39**

The Month 6 position includes a reduction of 160.29wte Non-Clinical staff compared to the same period last financial year, with an in-month reduction of 42.05wte across the Group.

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	18,189	9,433	208%	2,187	48,002	45,815	2195%	10,943	66,191	55,248	605%
Plans in Progress	2,961	3,648	687	123%	42,072	498	-41,574	1%	45,033	4,146	-40,887	9%
Opportunity	4,839	2,736	-2,103	57%	4,241	0	-4,241	0%	9,080	2,736	-6,344	30%
Unidentified	8,017	0	-8,017	0%	0	0	0	-	8,017	0	-8,017	0%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,073**	**0**	**100%**
High Risk	12,860	2,801	-10,059	22%	24,305	6,702	-17,603	28%	37,165	9,503	-27,662	26%
Medium risk	2,426	3,709	1,283	153%	13,403	10,731	-2,672	80%	15,829	14,440	-1,389	91%
Low Risk	9,287	18,063	8,776	194%	10,791	31,066	20,275	288%	20,078	49,129	29,051	245%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,073**	**0**	**100%**

There continues to be positive movement in development of schemes and de-risking of the programme since Final Plan submission in March, 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 £2.1m remains defined as 'Opportunity'. £9.5m of the programme remains as High Risk (which is a reduction of £27.6m since plan submission).

The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 6 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	7,236	4,771	-2,465	66%	6,909	6,987	78	101%	14,145	11,758	-2,387	83%
Non Pay	3,758	4,006	248	107%	12,593	12,629	36	100%	16,351	16,635	284	102%
Income	699	2,276	1,577	326%	2,498	2,186	-312	88%	3,197	4,462	1,265	140%
Total	**11,693**	**11,053**	**-640**	**95%**	**22,000**	**21,802**	**-198**	**99%**	**33,693**	**32,855**	**-838**	**98%**
Recurrent	6,630	6,604	-26	100%	17,229	13,142	-4,087	76%	23,859	19,746	-4,113	83%
Non-recurrent	5,063	4,449	-614	88%	4,771	8,659	3,888	181%	9,834	13,108	3,274	133%
Total	**11,693**	**11,053**	**-640**	**95%**	**22,000**	**21,801**	**-199**	**99%**	**33,693**	**32,854**	**-839**	**98%**
Recurrent %	57%	60%	3%	-	78%	60%	-18%	-	71%	60%	-11%	-

Across the Group, overall year-to-date delivery is £32.9m (98% of target). Delivery of recurrent savings is £4.1m behind plan at the end of Month 6, constituting 60% of YTD delivery across the Group. The Month 6 position continues the trend of improved levels of recurrent CIP being reported YTD (up from 55% at Month 5).

Work continues through the site leadership teams to identify and deliver efficiency savings to meet the targets, with escalation meetings held with Care Groups, Collaboratives and Corporate Services, and with oversight from the UHT FROG meeting. FROG is now chaired by the CEO and membership has been expanded to include wider representation from the Executive team, to ensure continued focus and prioritisation of de-risking of the efficiency programme.

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 totals £37.9m, including ICS approved Constitutional Standards/Estates Safety schemes (that are funded through additional national PDC).

In addition, NTH has received an additional £4m of bonus CDEL resource in relation to urgent and emergency care performance in 2024/25; however, this is not cash-backed.

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 Public Dividend Capital (PDC) of £6.5m, RAAC eradication work and replacement of Linacs. The plan includes de-carbonisation schemes, 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 6 amounted to £17.7m, 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	1,089	1,917	828	8,012	3,052	1,158	-1,894	**14,078**	**4,141**	**3,075**	**-1,066**
Digital	5,117	1,956	1,956	0	2,080	914	1,181	267	**7,197**	**2,870**	**3,137**	**267**
Estates	10,211	1,530	2,304	774	3,844	1,260	1,585	325	**14,055**	**2,790**	**3,889**	**1,099**
PFI	0	0	0	0	8,163	4,059	3,982	-77	**8,163**	**4,059**	**3,982**	**-77**
Decarbonisation	1	0	0	0	13,928	6,966	3,822	-3,144	**13,929**	**6,966**	**3,822**	**-3,144**
RAAC	1,300	195	262	67	2,900	500	10	-490	**4,200**	**695**	**272**	**-423**
IFRS 16	876	-81	-486	-405	4,313	0	0	0	**5,189**	**-81**	**-486**	**-405**
Total Gross Capital	**23,571**	**4,689**	**5,953**	**1,264**	**43,240**	**16,751**	**11,738**	**-5,013**	**66,811**	**21,440**	**17,691**	**-3,749**

This is £3.7m slippage against the phasing of the 2025/26 year-to-date plan, largely relates to Salix grant funded schemes at STH.

The Group is currently forecasting outturn capital expenditure in line with CDEL allocations (including the additional £4m UEC incentive allocation received by NTH).

Liquidity

The cash balance at the end of Month 6 stood at £98.3m for the Group. The month end cash balance at NTH was £51.6m (equating to 42 operating expenditure days) and £46.7m at STH (equating to 17 operating expenditure days). 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.

Deficit cash support for Q1, Q2 and Q3 has now been confirmed for NENC ICS. The Q4 deficit support funding is expected to be assessed against the Month 8 position.

This additional uncertainty relating to deficit support funding means that continued close monitoring of cash will be essential throughout the course of the financial year. Weekly meetings of the STH cash committee are held to monitor cash flows and manage creditor and debtor balances within forecast cash resources.

The continued strong cash balances have supported good compliance with the Better Payment Practice Code for both trusts, as shown in the tables below:

Better Payment Practice Code	NTH		STH		GROUP	
	YTD Number	YTD Value £000	YTD Number	YTD Value £000	YTD Number	YTD Value £000
Total bills paid in the year	36,048	98,262	51,898	358,899	87,946	457,161
Total bills paid within target	35,385	96,209	50,840	340,118	86,225	436,327
Percentage of bills paid within target	**98.2%**	**97.9%**	**98.0%**	**94.8%**	**98.0%**	**95.4%**

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 6:

	NTH £000	STH £000
Non-current assets		
Intangible assets	2,350	6,965
On-SoFP IFRIC 12 assets	0	142,198
Other property, plant and equipment (excludes leases)	147,218	168,619
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	17,003	34,442
Receivables: due from NHS and DHSC group bodies	607	1,231
Receivables: due from non-NHS/DHSC Group bodies	1,341	2,090
Credit Loss Allowances	0	(2,760)
Total non-current assets	**168,519**	**352,785**
Current assets		
Inventories	6,992	15,063
Receivables: due from NHS and DHSC group bodies	2,363	25,504
Receivables: due from non-NHS/DHSC Group bodies	26,351	39,071
Credit Loss Allowances	(3,511)	(957)
Other Assets	0	3,558
Cash and cash equivalents: GBS/NLF	51,542	43,745
Cash and cash equivalents: commercial/in hand/other	94	2,925
Total current assets	**83,831**	**128,909**
Current liabilities		
Trade and other payables: capital	(450)	(8,847)
Trade and other payables: non-capital	(59,209)	(148,423)
Borrowings	(5,338)	(21,543)
Other financial liabilities	0	0
Provisions	(2,621)	(1,220)
Other liabilities: deferred income including contract liabilities	(5,532)	0
Total current liabilities	**(73,150)**	**(180,033)**
Total assets less current liabilities	**179,200**	**301,661**
Non-current liabilities		
Borrowings	(30,311)	(259,242)
Provisions	(1,578)	(1,348)
Total non-current liabilities	**(31,889)**	**(260,590)**
Total net assets employed	**147,311**	**41,071**
Financed by		
Public dividend capital	196,047	470,376
Revaluation reserve	12,937	32,806
Other reserves	0	26,476
Income and expenditure reserve	(61,673)	(488,587)
Total taxpayers' and others' equity	**147,311**	**41,071**
Debtor Days	**24.3**	**24.3**
Creditor Days	**177.8**	**158.1**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 6 2025/26

University Hospitals Tees

Integrated Performance Report (reporting to end August 2025)

Meeting date: 6 November 2025

Reporting to: Board of Directors

Agenda item No: 4.3

Report author: Lucy Tulloch, Group Director Planning & Intelligence and Lynsey Atkins, Associate Director Planning, Performance & Improvement

Executive director sponsor: Neil Atkinson, Chief Delivery Officer

Action required: Discussion

Delegation status: Jointly delegated item to Group Board

Previously presented to: Resources Committee, Quality Assurance Committee, 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:

Quality and Safety

People

Finance

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 IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26 published June 2025.

The IPR for reporting month of August 2025 is presented for information and discussion on the metrics for which the Board is alerted, advised or assured of performance.

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 seven performance metrics remain as Alert.

- *E. coli* infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Still birth rate
- Breast feeding at first feed
- Readmission rate
- Sickness Absence

In addition, for NTHFT four metrics have been regraded to Alert, from Advise:

- MSSA infections
- 4-Hour A&E standard
- Cancer 31-day standard
- Cancer 62-day standard

For STHFT, the following six performance metrics remain as Alert assurance:

- MRSA infections
- *Pseudomonas* infections
- Breast feeding at first feed
- Cancelled Operations Not Rebooked in 28 Days
- Diagnostic 6 Week standard
- Mandatory Training

In addition, for STHFT two metrics have been regraded to Alert, from Advise:

- RTT 52-week waits
- RTT time to first appointment

Healthcare acquired infections (HCAI) trigger Alert where the number of cases year to date is 20% or more above trajectory (noting that plans can be in single figures). MSSA infections regraded to Alert from Advise for NT due to five new cases in August, above the trajectory of three. 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.

Cancer 31 Day Standard for NTHFT is regraded to Alert from Advise as performance has deteriorated and is outside of expected variance in August 2025. Plans are in place in challenged tumour groups. There is a strategic focus, with discussions with the ICB to develop a wider regional response to the breast pathway pressures.

Cancer 62 Day Standard for NTHFT is regraded to Alert from Advise as performance has deteriorated since February 2025. As above, there is wider strategic discussion taking place with the ICB on a longer-term regional response to challenges in the breast pathway. Respiratory and Urology are also challenged, however it is expected that recent pathway improvements will improve this position in the coming months.

4-Hour A&E Standard for NTHFT is regraded to Alert from Advise as the agreed stretching plan at Trust level is higher than the current expected performance variation. There is a continued focus on improving flow, both within the trust and with partners. Performance remains assured above the 78% national operational standard.

52-Week Waits for STHFT is regraded to Alert from Advise. Recovery plans have been refreshed within pressured specialities and additional capacity in neurology, ENT and OMFS.

RTT time to first appointment is regraded to Alert from Advise as performance is not keeping pace with required improvement trajectory as per agreed elective recovery plans.

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 majority of IPR metrics remain graded Advise, for both Trusts.

In the SAFE domain, for STHFT **Never Events** is regraded to Advise from Alert as no new events reported in August. For STHFT, **MSSA infections** is regraded to Advise from Assure after 11 new cases in August 2025, comparted to an in-month trajectory of 6 new cases, year-to-date. In maternity services at NTHFT, **Neonatal Mortality Rate** is regraded to Advise from Assure after 2 months of higher-than-expected variation. However, the NTHFT mortality rate remains lower than peers.

In the RESPONSIVE domain, for NTHFT **Community 52-week waits** is regraded to Advise from Assure following a decline in performance. For STHFT **Cancer 31 Day Standard** is regraded to Advise from Alert as performance has stabilised at the new lower level and is no longer deteriorating. For STHT **Community UCR 2 Hour Response** is regraded to Advise from Assure. Recent months' response rates have been close to the expected lower limits of performance. However, STHFT consistently meets national 70% target for this metric.

In the EFFECTIVE domain, there are no changes in assurance levels for NTHFT or STHFT. In the WELL LED domain, for STHFT **Sickness absence** is regraded to Advise from Alert as improvement is evident since February 2025, although the target not achieved.

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

For NTHFT, assurance continues for eight metrics:

- Never Events
- *C. difficile* infections
- MRSA infections
- Ambulance Handover within 45 minuets
- Summary Hospital-Level Mortality Indicator
- Feedback Acknowledged in 3 days
- Staff Turnover
- Annual Appraisal

For STHFT, assurance continues for four metrics:

- *Klebsiella* infections
- Community UCR 2 Hour Response
- Community 52-week waits
- Staff Turnover

In the EFFECTIVE domain, for STHFT **Outpatient Experience** is regraded to Assure from Advise as performance stabilised in August, after a slight deterioration in 7 months prior. The plan is consistently exceeded throughout.

In the RESPONSIVE domain, for NTHFT **Cancelled operations not rebooked in 28 days** is regraded to Assure from Advise; the zero-tolerance standard was achieved.

In the SAFE domain, for STHFT **MSSA infections** is regraded to Assure from Advise. The number of cases year-to-date is below the new trajectory that reflects NHSE standards.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for the reporting period August 2025.
- Note that separate agenda items into the Committees, as set out in the annual cycles of business, 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: August 2025

Caring Better Together

Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. The IPR is underpinned by a broader range of metrics and evidence for clinical governance and operational management.

- **SAFE:** Patient Safety Incident Response Framework is embedded across UHT and thematic reviews are used to derive learning from incidents and near misses. NTHFT report ten consecutive months with no Never Events, and eight consecutive months without a case of MRSA. There is continued focus on reducing healthcare acquired infections across UHT, with the focus on antimicrobial stewardship and medical leadership. Maternity metrics are reviewed against regional and 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 and data quality checks are being undertaken to understand whether this variation is appropriate for the pathways of care, with oversight and monitoring via the Audit & Clinical Effectiveness Council. Discharge delay metric highlights differences in access to social care provision across our footprint. There is a focus on utilisation of Home First in cases of delays.

- **RESPONSIVE:** Whilst the NHS constitutional standards remain, each Trust has an agreed plan for recovery towards the 25/26 operational standard or improvement ‘stretch’ trajectory relative to 24/25 performance in each metric. This contributes to the regional performance position.

- Ambulance handover delays are reported against a 45-minute standard, with an improvement trend evident at STHFT and >98% compliance with handovers within 45 minutes at NTHFT. 4-hour standard and 12-hour breaches performance are stable.

- Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. There is ongoing focus on ensuring the very longest waiters receive their treatment, there is not yet 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 in place. STHFT receive additional performance scrutiny and support for improvement in cancer treatment waiting times under the NHS England performance management regime (Tier 2). There are early signs of improvement in the cancer 62-day standard for July and August 2025 at STHFT arising from diagnostic pathway changes from the action plans.

- **CARING:** The IPR demonstrates that both Trusts perform well in patient feedback surveys, around or above national average feedback scores across care settings. 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. Reduced staff turnover, assured below target, is embedded at both Trusts, and appraisal compliance improvement trends continue at both Trusts. However, sickness absence and mandatory training remain improvement priorities. An in-depth absence plan and focus on whole time equivalent reduction (e.g. non-essential bank and agency work, scrutiny of recruitment requests) supports the Group's obligation to deliver the agreed financial position. Financial performance is on plan; papers on finance and productivity are presented to Resources Committee.

Regulation and Compliance

Regulated by CareQuality Commission

North Tees & Hartlepool Hospitals NHS Foundation Trust has an overall rating of Requires Improvement. Since the 2022 inspection, the CQC recommendations have been addressed and action plan completed. Independent audit is scheduled for October 2025 to provide further assurance relating the actions from Must Do's. Preparation work has commenced.

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 have seen significant progress in assurance on Resuscitation and Safeguarding training in ED, and improvements in SDR compliance across the Friarage Hospital and Community Services. These actions will continue to be monitored monthly by the CQC Compliance Group. until sustained improvement is evidenced.

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.

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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	RTT - 52+ ww %age of WL	RTT - Time to 1st Appt	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 25/26 v 24/25	1st OP - YTD growth 25/26 v 24/25	Total elective - YTD growth 25/26 v 24/25	Diagnostic activity 25/26 v 24/25	Diagnostic 6 week waits	Cancer 62 day	Cancer 62 day backlog	Cancer treatments (first and subsequent)	Cancer 28 day FD
Data period	Aug-25	Aug-25	Aug-25	Aug-25	Aug-25	Jul-25	Jul-25	Aug-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Jul-25	Aug-25	Jul-25	Jul-25
25/26 Ambition	78%	Zero	25/26 Plan			25/26 Plan	< 1%	25/26 Plan	25/26 Plan	Zero	Zero	Zero	25/26 Plan					<=5%	75%			80%
North Tees & Hartlepool NHSFT	84.6%	6	0.0%	112	10	74.2%	0.9%	80.0%	199	0	0	0	21,231	112%	115%	106%	82%	3.4%	52.0%	119	264	78.4%
South Tees Hospitals NHSFT	77.9%	11	4.7%	437	98	61.8%	2.8%	63.9%	1,568	83	2	0	56,969	106%	102%	98%	107%	13.1%	67.2%	145	853	77.0%
NENC ICS Provider level *(including IS providers)*	79.4%	380	3.8%	2,228	464	70.7%	1.3%	74.8%	4,754	178	13	0	368,603	102%	106%	102%	101%	12.1%	69.9%	1,138	4,059	74.6%
North East & Yorkshire	77.3%		4.8%			66.3%												18.8%	68.2%			74.3%
National	75.9%		8.9%			61.3%												21.9%	69.2%			76.6%

Urgent and emergency care metrics continue to show good performance for NTHFT in August compared to regional and national benchmarks. STHFT performed better than regional and national benchmarks but this standard 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 improving patient experience by developing alternatives to ED pathways.

Elective care metrics show an RTT 18-week standard at NTHFT that met plan and exceeds the national and ICS average. STHFT met plan in and exceeds the national average. 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 on increasing outpatient productivity. NTHFT focus is on ensuring patients wait no longer than 52 weeks whilst STHFT services are working to eliminate waits above 65 weeks. This remains very challenging whilst demand and capacity imbalances in several specialties are addressed.

Cancer 62-day standard is a strategic risk for both Trusts. STHFT has been in tiering support with NHS England for the 62-day standard since February 2025. Actions and progress are discussed fortnightly, providing NHSE with assurance that all relevant actions are in hand. 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. An improvement trend in STHFT 62-day standard is now evident. NTHFT performance shows the impact of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025 on cancer standard compliance. The team are working closely with CDDFT and the Cancer Care Alliance to support a collaborative approach to service delivery in the short / medium term and longer-term models of delivery across the system.

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
Total births
Still Births Rate (Rolling 12 months, per 1000 Births)
Neonatal Mortality Rate (rolling 12 months, per 1,000 births)
Breast Feeding at First Feed (%)
PPH >= 1500ml Rate per 1,000 births
3rd/4th Degree Tear (%)

EFFECTIVE DOMAIN
Responsibility: Quality Assurance Committee

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)
Discharge Delays Average (days)

RESPONSIVE DOMAIN
Responsibility: Resources Committee

NEAS Handovers – Over 45 mins (%)
4-Hour A&E Standard (%)
12-Hour ED Breaches Rate (%)
Community UCR 2 Hour Response (%)
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 (%)
Community over 52-week Waiters (%)
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)

North Tees & Hartlepool assurance summary

ALERT

No change in assurance

- *E. coli* infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Breast feeding at first feed
- Still birth rate
- Readmission rate
- Sickness absence (%)

New ALERT indicators

- **MSSA infections** regraded from Advise as 20% above trajectory YTD.
- **4-hour A&E standard** regraded from Advise due to under-performing against agreed plan, however performance exceeds 25/26 operational standard.
- **Cancer 31 Day Standard** regraded from Advise due to a decline in performance outside of expected variance.
- **Cancer 62 Day Standard** regraded from Advise due to a deteriorating performance trend.

ADVISE

No change in assurance

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Falls with Harm per 1000 Bed Days
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- 12-Hour ED Breaches Rate (%)
- Discharge Delay average days
- Community UCR 2 Hour Response (%)
- Cancer Faster Diagnosis
- Diagnostic 6 Week Standard
- RTT Incomplete Pathways

ADVISE

- RTT 52 Week Waiters (%)
- RTT time to first appointment (%)
- A&E Experience (%)
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

New ADVISE indicators

- **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** regraded from Assure as June and July rates were outside expected variation, whilst remaining below benchmark.
- **Community 52-week waits** regraded from Assure following a decline in performance.

ASSURE

No change in assurance

- Never Events
- *C. difficile* Infections
- MRSA Infections
- Summary Hospital-Level Mortality Indicator

ASSURE

- Ambulance handover within 45 minutes
- Feedback Acknowledged in 3 days
- Staff Turnover
- Annual Appraisal (%)

New ASSURE indicators

- **Cancelled operations not rebooked in 28 days** regraded from Advise, achieving the zero-tolerance standard in-month.

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South Tees Hospitals assurance summary

No change in assurance	ALERT	New ALERT indicator
• MRSA infections • *Pseudomonas* infections • Breast feeding at first feed • Cancelled operations not rebooked in 28 days	• Diagnostic 6 Weeks Standard (%) • Mandatory training (%)	• **RTT 52 Week Waiters (%)** regraded from Advise as the rate is stable against the agreed reducing trajectory of the NHSE plan. • **RTT time to first appointment (%)** regraded from Advise as performance is not keeping pace with required improvement trajectory.

No change in assurance	ADVISE	New ADVISE indicator
• Incidents per 1000 Bed Days • Patient Safety Incident Investigations • Falls with Harm per 1000 Bed Days • *C. difficile* infections • *E. coli* infections • Still birth rate • Neonatal Mortality Rate (rolling 12 months, per 1,000 births) • PPH >= 1500ml rate per 1,000 births • 3rd/4th Degree Tear (%) • Summary Hospital-Level Mortality Indicator • Readmission rate • Discharge delay average days • Ambulance handovers within 45 minutes	• 4-Hour A&E Standard (%) • 12-Hour ED Breaches Rate (%)Cancer Faster Diagnosis • Cancer 62 Day Standard • RTT Incomplete Pathways • A&E Experience (%) • Inpatient Experience (%) • Maternity Experience (%) • Feedback Acknowledged in 3 Days (%) • Complaints Closed Within Target (%) • Annual Appraisal (%) • Cumulative YTD Financial Position (£Millions)	• **Never Events** regraded from Alert, no new events recorded in August 2025. • **MSSA infections** regraded from Assure after 11 new cases in August 2025, in-month trajectory of 6 new cases, year-to-date position is now over (worse than) trajectory. • **Cancer 31 Day Standard** regraded from Alert. Performance stable at new lower level. • **Community UCR 2 Hour Response (%)** regraded from Assure, recent months close to expected lower limits of performance but consistently meets national target. • **Sickness absence (%)** regraded from Alert as improvement is evident since February 2025, but target not achieved.

No change in assurance	ASSURE	New ASSURE indicator
• *Klebsiella* infections • Community Experience (%)	• Staff Turnover • Community over 52-week Waiters (%)	• **Outpatient Experience (%)** regraded from Advise after performance stabilised in August from a slight deterioration in 7 months prior. Plan consistently exceeded throughout.

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SAFE DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

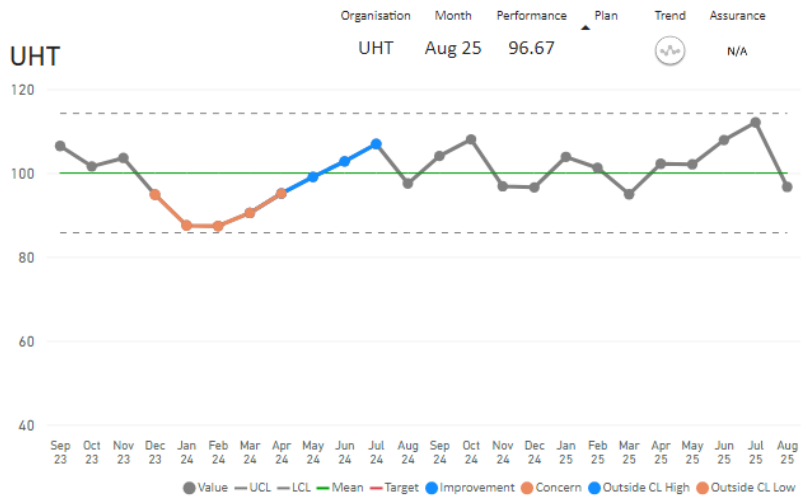
An external evaluation of the Group's implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These form the measures within one of the Group's Quality Priorities. The reporting of incidents is seen as a positive indicator of a safety culture.

Healthcare-acquired infections (HCAI) plans have been updated to reflect NHS England target trajectories. HCAI continue to be closely tracked by the Infection Prevention Committee and an Improvement Plan developed and initiated, this is also aligned to the Trust Quality Priorities for 2025/26. The focus continues in respect of embedding the actions across the organisation into practice. The *C. difficile* and MRSA care pathways are now live in the STHFT electronic patient record system, MIYA, with the digitisation of remaining infection prevention and control pathways in development, and an audit is planned around the implementation of these. The Antimicrobial Working Group is also being re-established with a clear focus on NHS England KPIs aligned to prescribing to support with the reduction of HCAIs, this is set to take place 28th October, defined medical leadership is a pre-requisite for this.

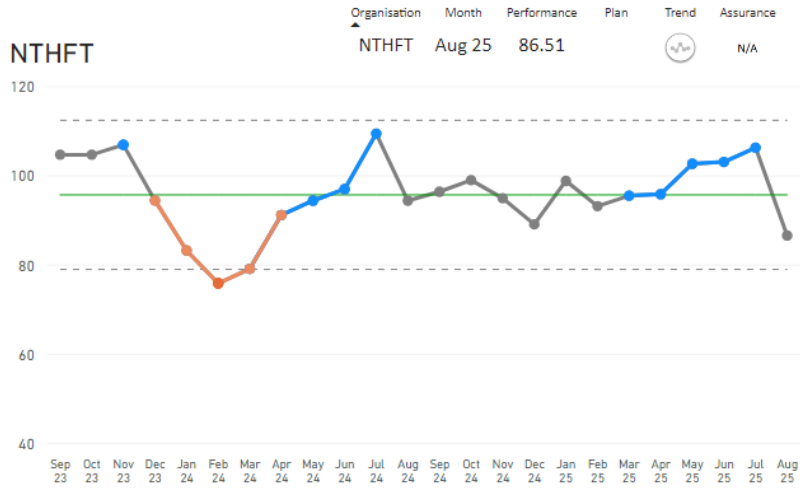
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Incidents Per 1000 Bed Days		96.33	98.92	94.86	89.01	98.76	93.1	95.44	95.77	102.61	103.01	106.22	86.51
Patient Safety Incident Investigations		1	3	2	0	1	0	1	0	1	1	3	1
Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.28	0.07	0.27	0.14	0.19	0.37	0.27	0	0.28	0.29	0.14	0.21
C-Difficile	6	3	9	2	1	5	6	7	6	1	4	4	6
MRSA	0	1	1	1	1	0	0	0	0	0	0	0	0
E-Coli	7	13	13	5	3	6	6	4	8	10	6	12	12
MSSA	3	5	6	4	6	9	2	1	3	3	4	3	5
Klebsiella	4	3	4	2	2	1	0	5	4	4	4	2	0
Pseudomonas	1	0	2	2	2	2	0	2	4	3	1	2	0

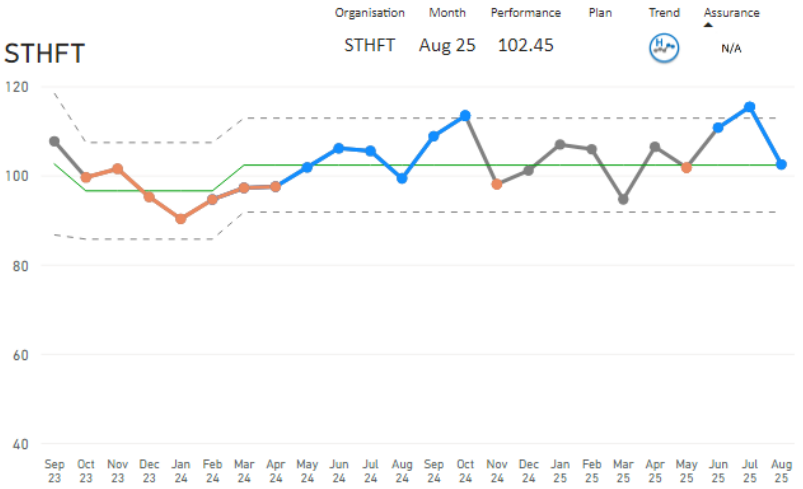
South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Incidents Per 1000 Bed Days		108.78	113.38	98.01	101.06	106.9	105.86	94.61	106.4	101.73	110.69	115.35	102.32
Patient Safety Incident Investigations		0	1	0	1	0	0	0	1	0	1	2	1
Never Events	0	0	2	0	1	0	0	0	0	0	0	2	0
Falls With Harm Rate (Per 1000 Bed Days)		0.04	0.16	0.21	0.24	0.12	0.25	0.28	0.37	0.12	0.17	0.21	0.08
C-Difficile	10	9	11	17	11	13	15	10	13	11	11	9	8
MRSA	0	0	0	1	0	0	0	3	0	0	1	1	1
E-Coli	12	11	17	12	14	18	10	17	16	11	14	14	14
MSSA	6	8	11	4	6	5	9	11	3	10	5	8	11
Klebsiella	4	6	8	1	3	5	4	2	4	2	3	4	5
Pseudomonas	1	1	3	1	0	1	1	3	3	3	1	4	1

SAFE Incidents Per 1000 Bed Days

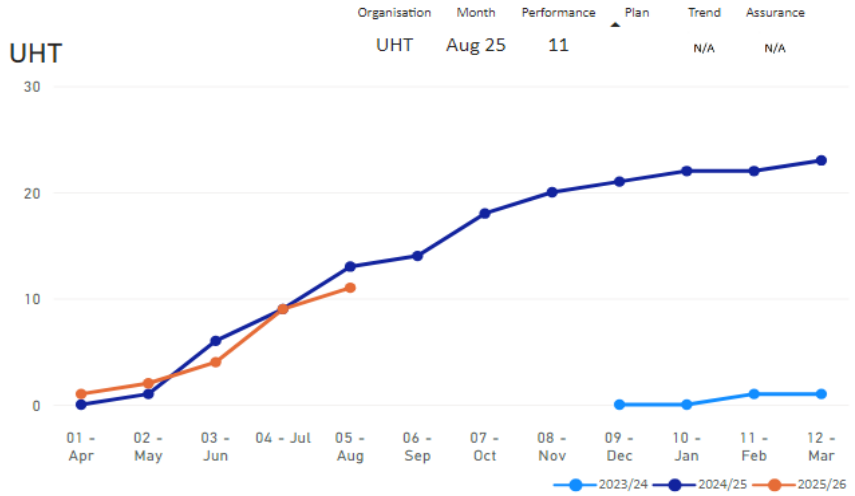


Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Overview of incident reporting.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: Increasing from April to July consecutively, however, latest month number of incidents reported below the average. STHFT: June and July had higher numbers of incidents reported, at the limits of expected variation. Rate in August is at the usual monthly average.
Assurance: n/a.
Action taken: National data is not yet available for comparison on the LFPSE platform, but discussions ongoing with ICB colleagues to determine if benchmarking can be done regionally.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

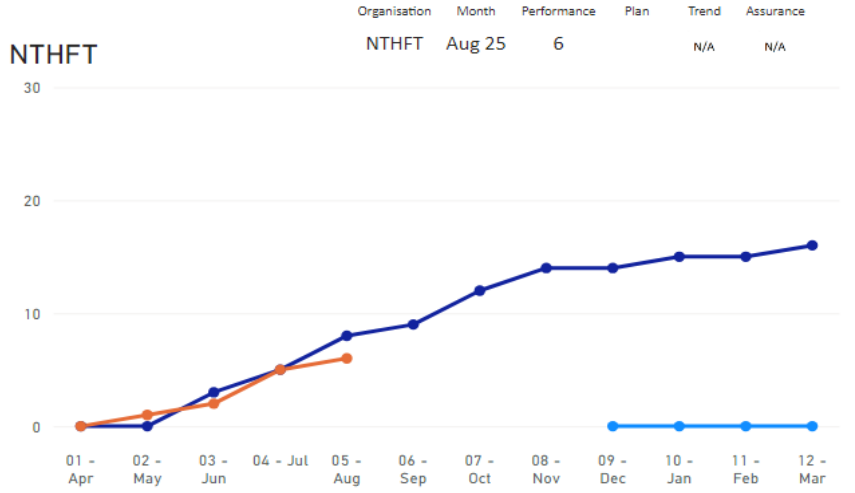


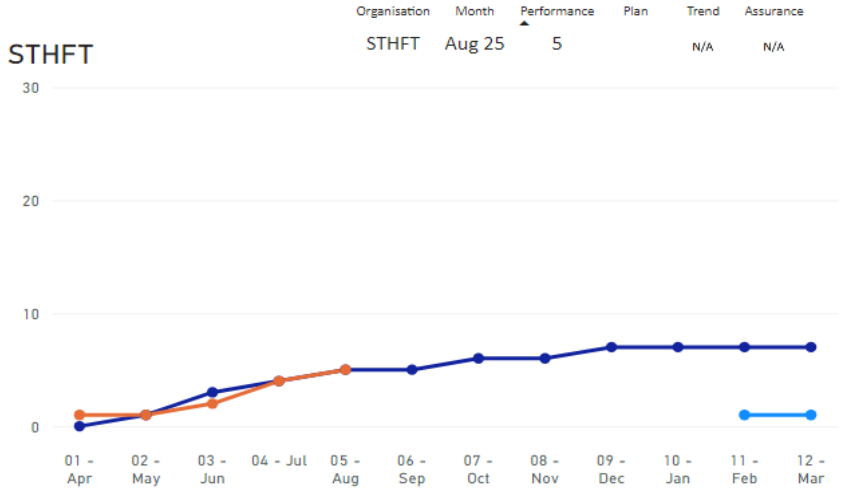


SAFE Patient Safety Incident Investigations (YTD)



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: 1 PSII in August 2025, 6 PSIIs year to date. STHFT: 1 PSII in August 2025, 5 PSIIs year to date.
Assurance: n/a
Action taken: Incidents are reviewed at weekly site panels to determine how they are investigated under PSIRF. An external evaluation of PSIRF across UHT concluded in July 2025; and recommendations are being actioned.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

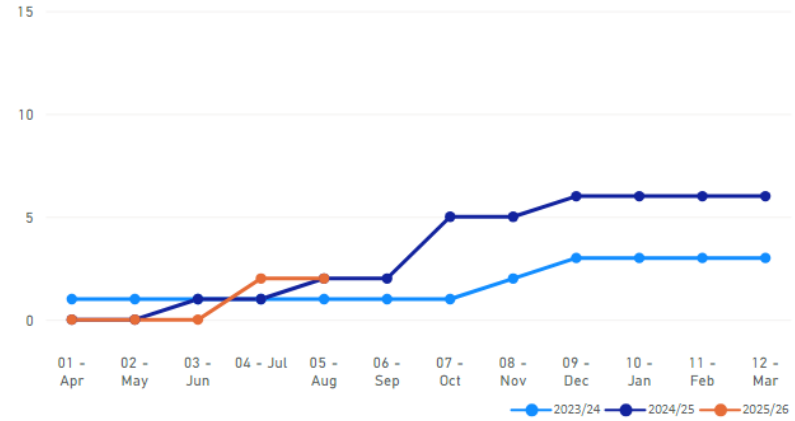




SAFE Never Events (YTD)

UHT

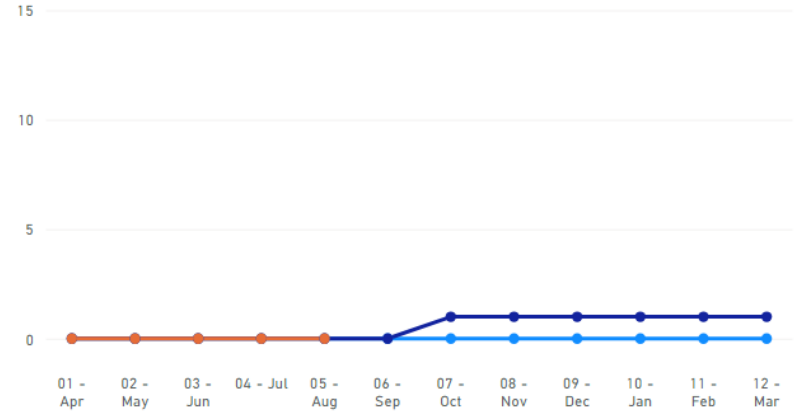
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	2		N/A	N/A



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: No Never Events YTD. STHFT: two Never Events YTD, none recorded in August.
Assurance: NTHFT: Assure, no new events for 10 months. STHFT: Advise. Two new Never Events in July 2025, no events in August 2025.
Action taken: Work is underway to promote the involvement of patients in safety checks prior to procedures in addition to strengthening the Group's approach to using LocSSIPs (local safety standards for invasive procedures).
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

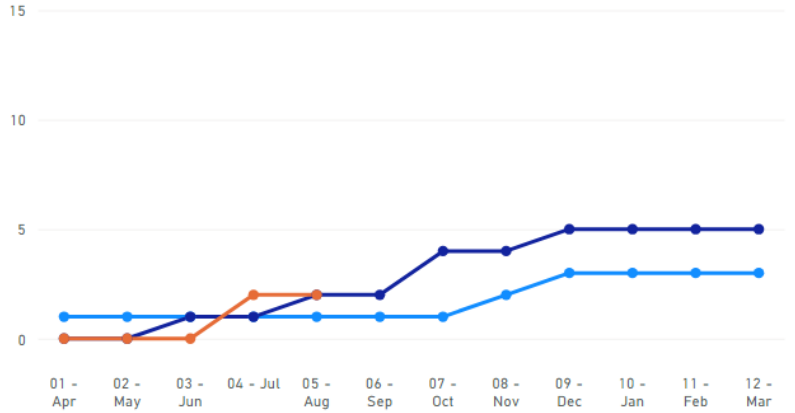
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	0	0	N/A	N/A



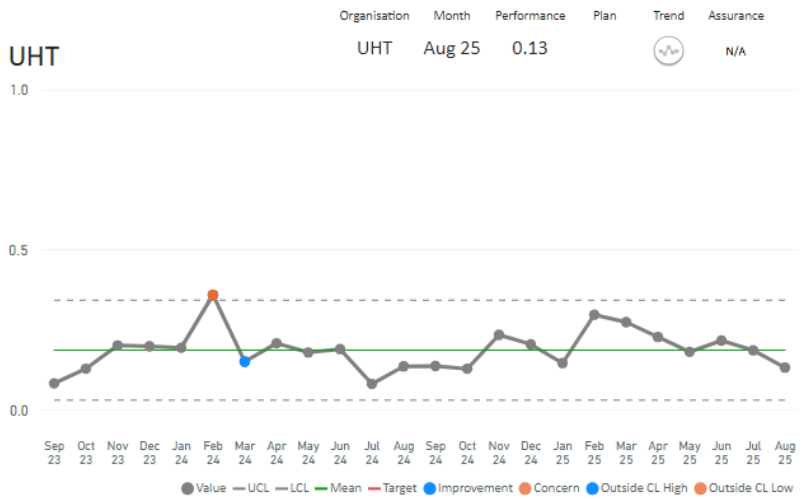
STHFT

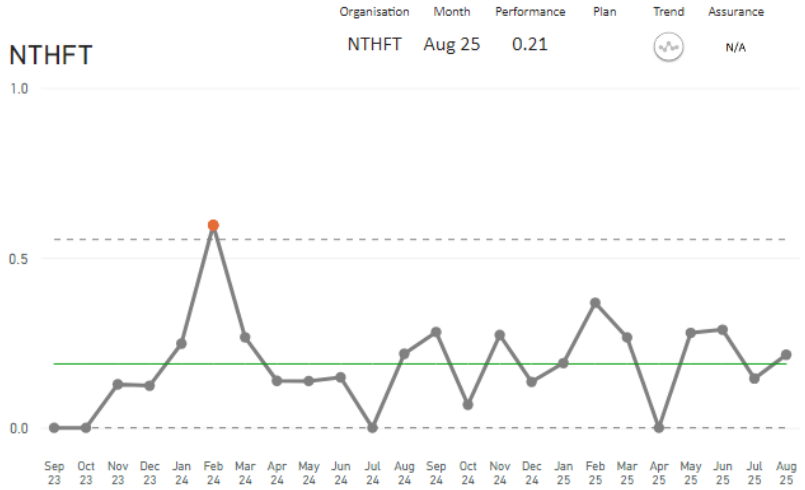
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	2	0	N/A	N/A

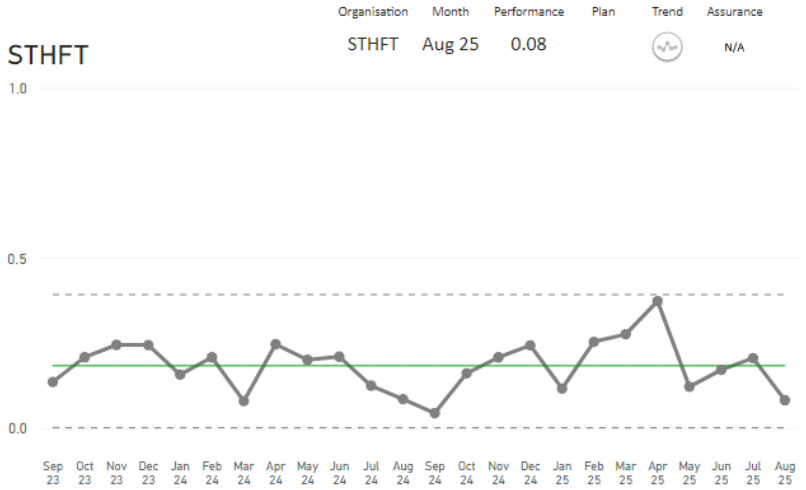


SAFE Falls With Harm Rate (Per 1000 Bed Days)

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. A review has been completed to ensure that the calculation of falls with harm rate is standardised across UHT. This alignment has brought the reported falls with harm per 1000 bed days to comparable mean rates across UHT.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: The focus is on thematic learning from falls, targeted interventions and bringing together a single UHT approach to improve care for patients at risk of falls.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





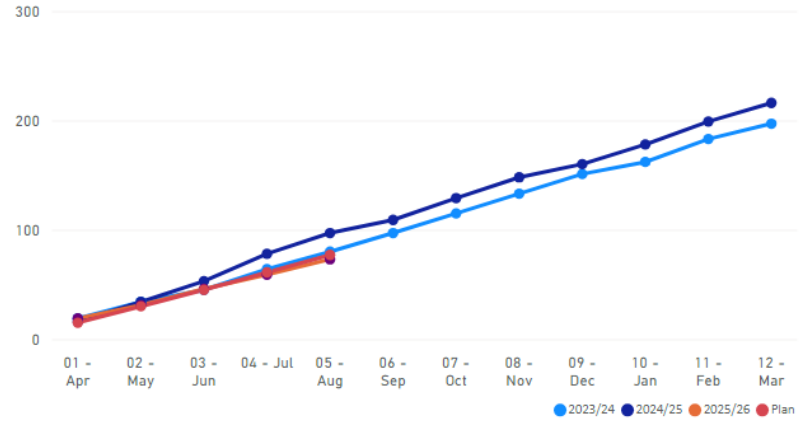


Caring Better Together

SAFE C-Difficile (YTD)

UHT

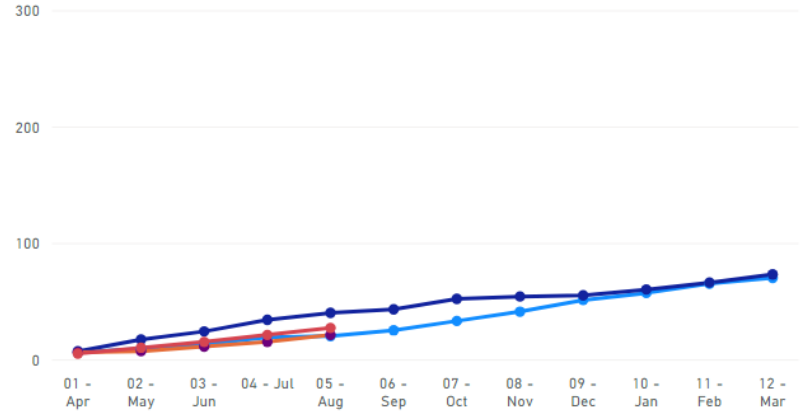
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	73	77	N/A	N/A



Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 new cases in August (trajectory of 6). STHFT: 8 new cases in August (trajectory of 10).
Assurance: NTHFT: Assure, better than trajectory YTD. STHFT: Advise; 4%, 2 cases, worse than trajectory YTD.
Action taken: Focus on Antimicrobial stewardship is a priority with an antimicrobial working group planned for October and defined medical leadership to be established. Hydrogen peroxide fogging continues after all *C. diffiicile* infections as gold standard.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

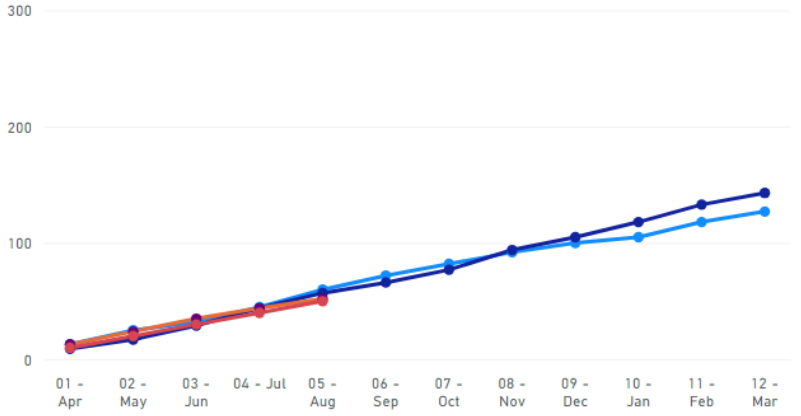
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	21	27	N/A	N/A



STHFT

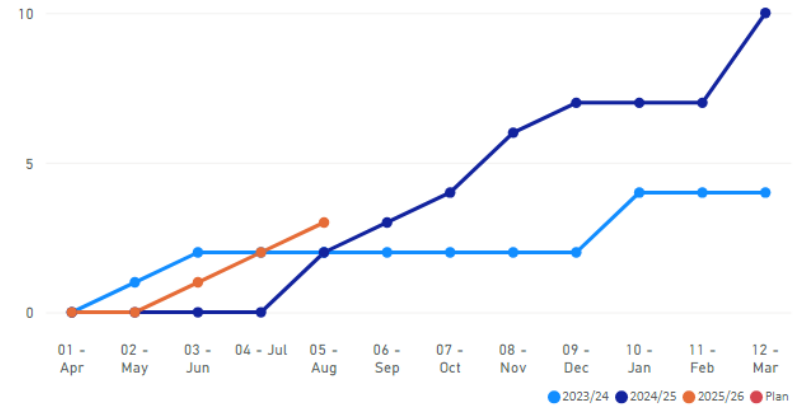
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	52	50	N/A	N/A



SAFE MRSA (YTD)

UHT

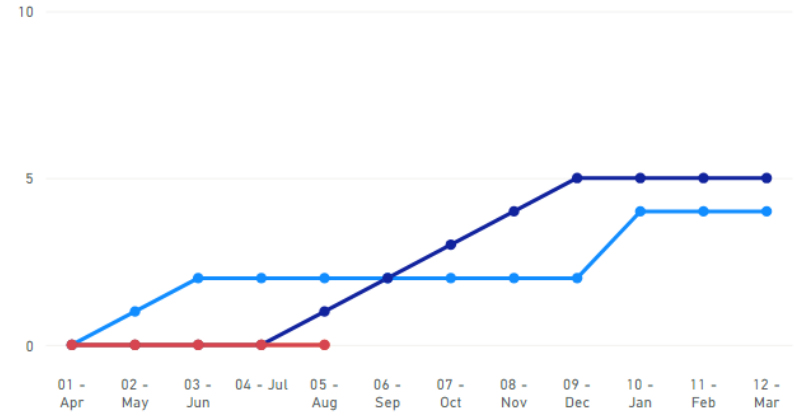
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	3		N/A	N/A



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 August 2025. STHFT: 1 new case in August 2025.
Assurance: NTHFT: Assure, 8 months without a case. STHFT: Alert, 1 new case and 3 cases YTD.
Action taken: Pathway implemented in STHFT electronic patient record to align screening adherence. The new case in August 2025 was unavoidable due to patient condition. New MRSA/MSSA process developed focused on learning.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

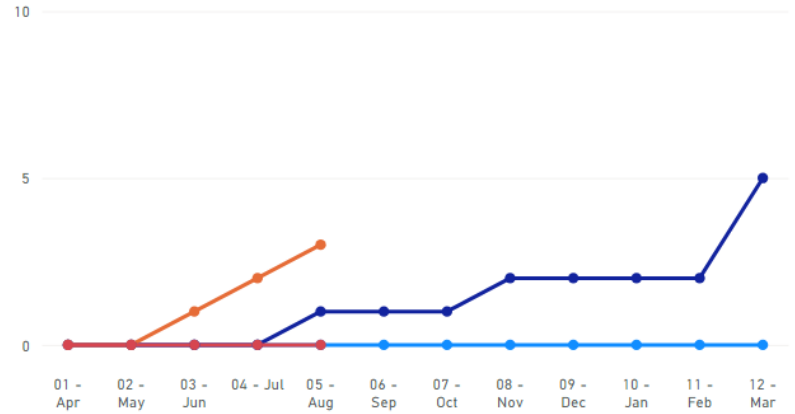
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	0	0	N/A	N/A

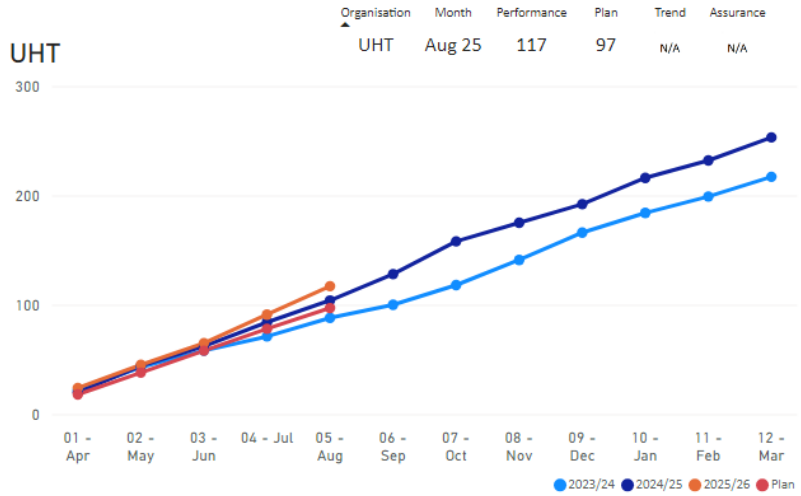


STHFT

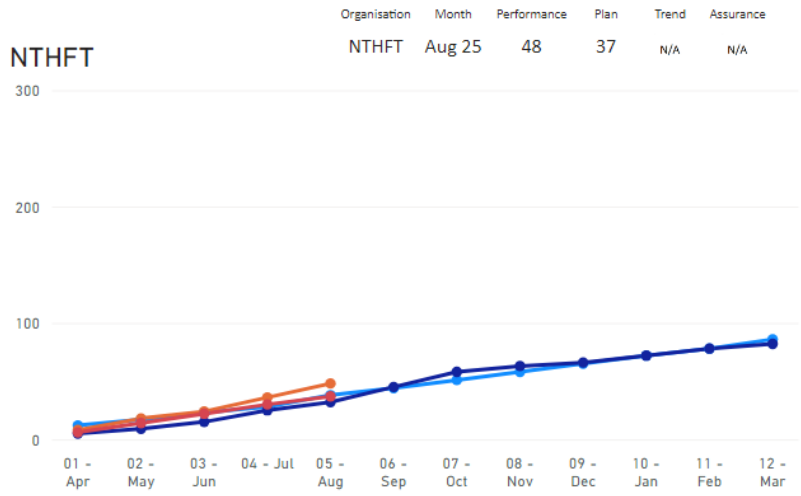
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	3	0	N/A	N/A

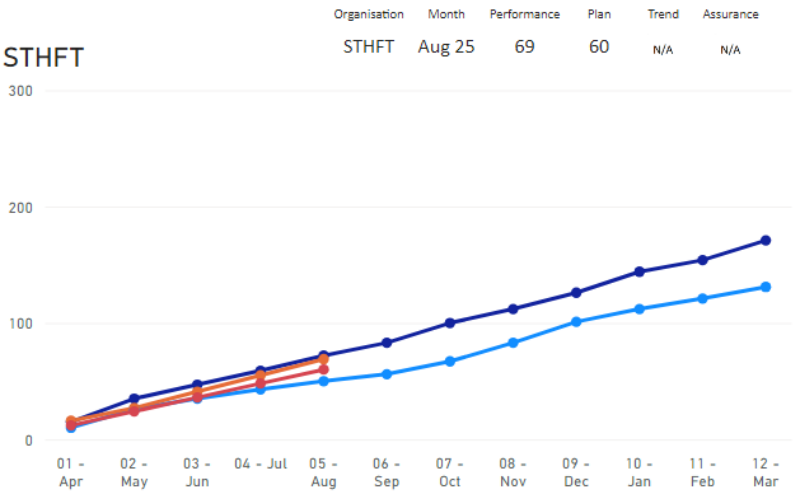


SAFE E-Coli (YTD)



Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 12 cases in August 2025 (trajectory of 7). STHFT: 14 cases in August 2025 (trajectory of 12).
Assurance: NTHFT: Alert, 30% worse than trajectory YTD. STHFT: Advise, 15% worse than trajectory YTD.
Action taken: Catheter-associated urinary tract infection action group established. Links also to the promotion of robust antimicrobial stewardship across the organisation.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



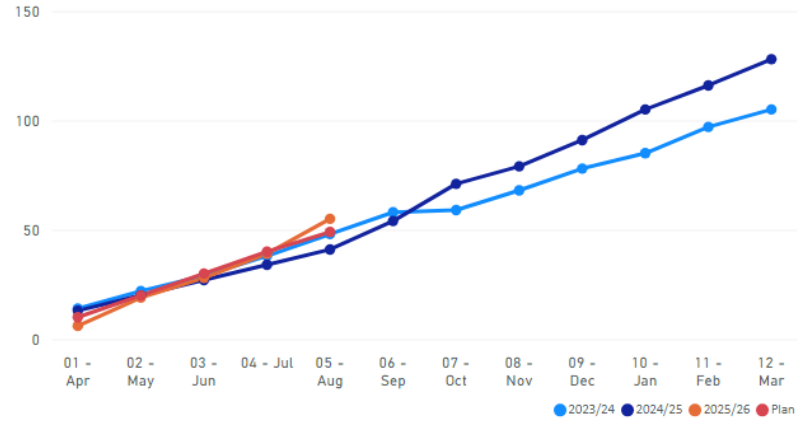


Caring Better Together

SAFE MSSA (YTD)

UHT

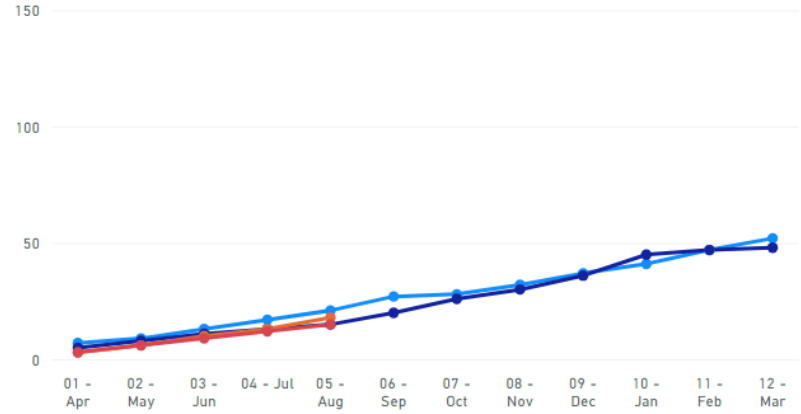
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	55	49	N/A	N/A



Metric: Healthcare associated cases of MSSA annually from April.
Plan: Local plan for 1 case fewer than 2024/25 (no contractual plan).
Rationale: In line with other NHS Contract indicators.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 5 new cases in August (trajectory of 3). STHFT: 11 new cases in August (trajectory of 6).
Assurance: NTHFT: Alert, 3 cases, 20% worse than trajectory YTD. STHFT: Advise, 3 cases, 9% worse than trajectory YTD.
Action taken: Learning identified regarding line care. Organisational directive led by heads of nursing and supported by IPC. Implemented electronic visual infusion phlebitis chart to support best practice in line care.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

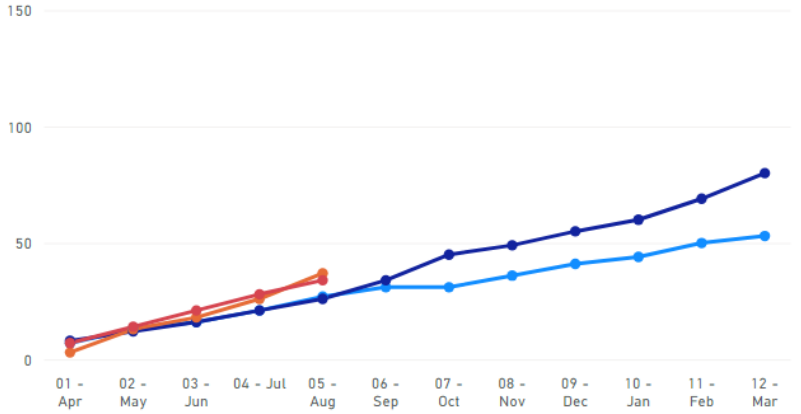
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	18	15	N/A	N/A

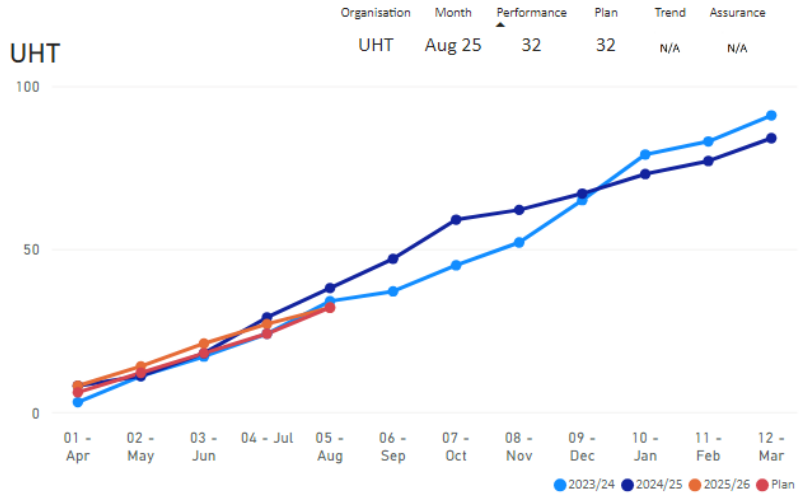


STHFT

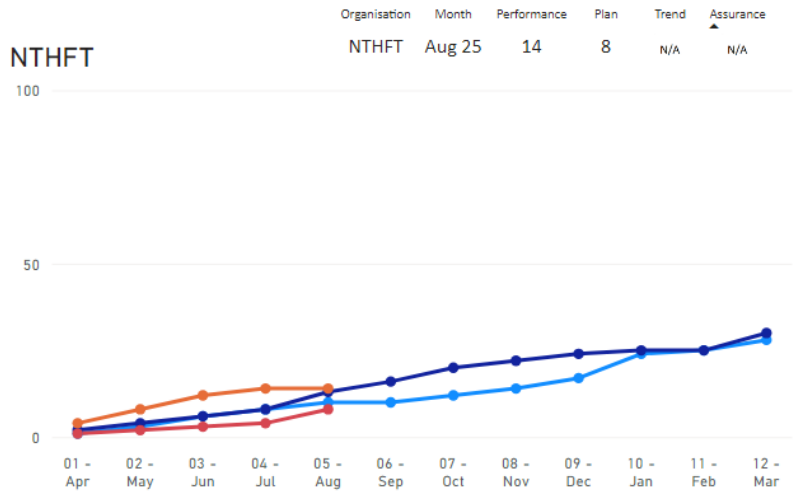
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	37	34	N/A	N/A

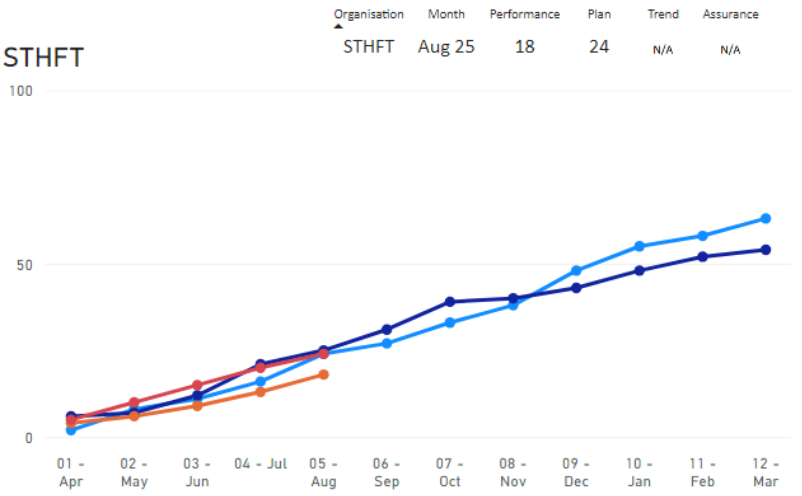


SAFE Klebsiella (YTD)



Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases in August (trajectory of 4). STHFT: 5 new cases in August (trajectory of 4).
Assurance: NTHFT: Alert, 6 cases more, 75% worse than trajectory YTD. STHFT: Assure, 6 cases fewer (better) than trajectory YTD.
Action taken: Hepatobiliary focus at NTHFT around recent cases. Deep dive underway regarding this. Further development of the UHT 'hot' gall bladder service planned.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

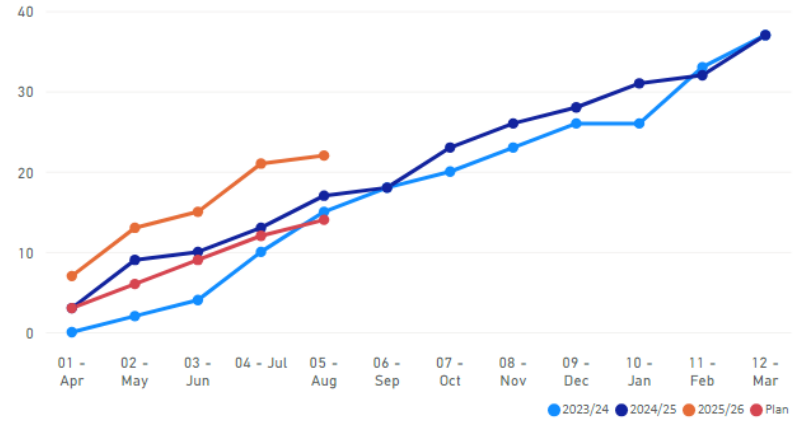




SAFE Pseudomonas (YTD)

UHT

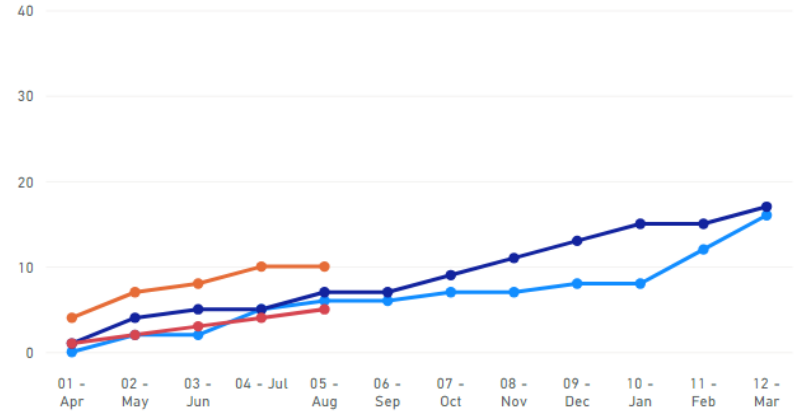
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	22	14	N/A	N/A



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases in August against trajectory of 1. STHFT: 1 new case in August (trajectory of 1).
Assurance: NTHFT: Alert, 5 cases, 100%, worse than trajectory YTD. STHFT: Alert, 3 cases more, 33% worse than trajectory YTD.
Action taken: Visit to CDDFT regarding safely reducing the water outlets in areas of concern for water associated infections, particularly in augmented care. Focus on water safety through IPC Committees.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

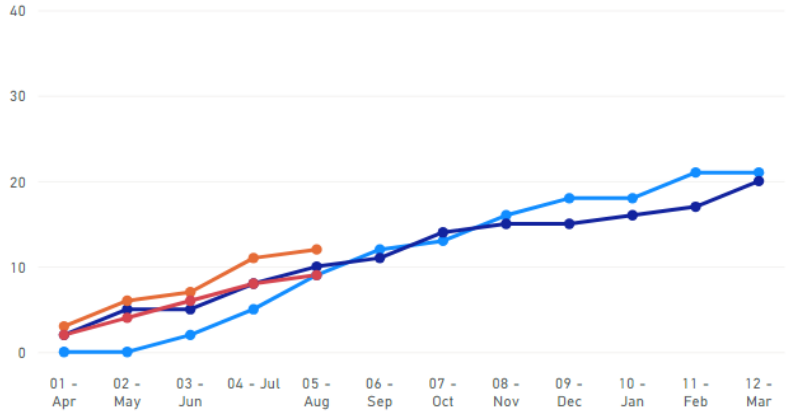
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	10	5	N/A	N/A



STHFT

STHFT	Aug 25	12	9	N/A	N/A



SAFE MATERNITY SUMMARY

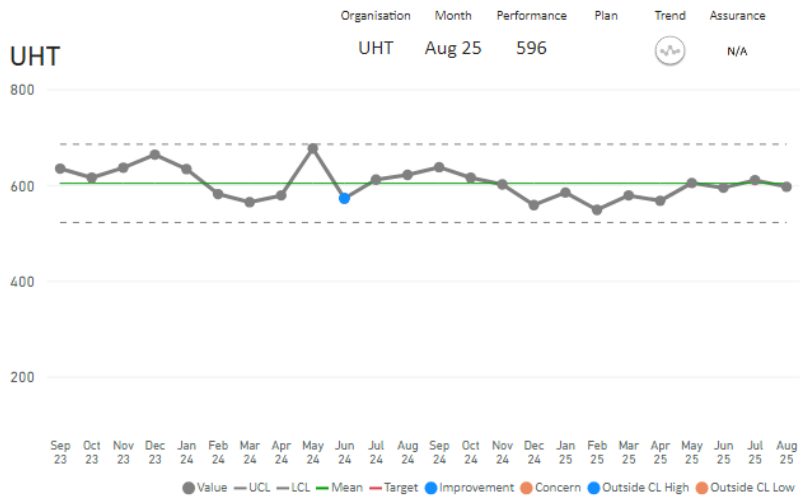
Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

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. The stillbirth rate at NTHFT triggers Alert due to a deteriorating trend, whilst a stable rate is seen at STHFT. Neonatal mortality rate triggers Advise due to recent incidence however provides assurance of performance compared to peers (noting that NTHST and STHFT have different case mix peer groups). Breastfeeding rates are alerted to Board for both Trusts. Infant feeding specialists are providing a continued focus to support and promote breastfeeding. Maternity service across UHT 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.

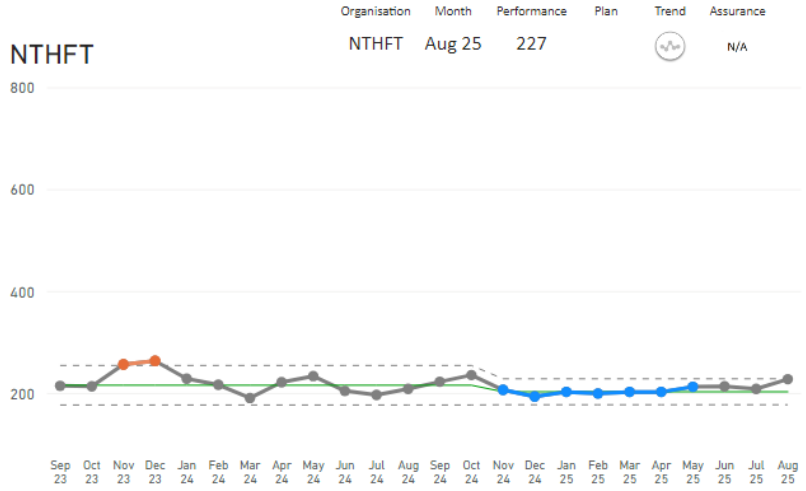
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Total Births		222	235	206	193	202	199	202	202	212	213	208	227
Still Birth Rate (Rolling 12 months, per 1000 births)	2.91	1.89	2.62	3.05	2.74	3.17	3.19	3.97	4	3.63	3.61	4.4	3.97
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1	0.4	0.4	0	0	0	0	0	0	0	0	0.4	0.4
Breast Feeding at First Feed	72.3%	50%	48.5%	52.7%	53.9%	52.2%	51.5%	53%	51.5%	50.9%	46.2%	49.5%	46.3%
PPH >= 1500ml Rate per 1000 Births	31	27	25.4	34.1	25.5	40	45.5	24.8	29.6	37.7	32.9	24	13.2
3rd/4th Degree Tear (%)		3.8%	2.1%	1.6%	2.7%	0.9%	3.4%	0.8%	2.7%	5.8%	2.9%	8.9%	3.2%

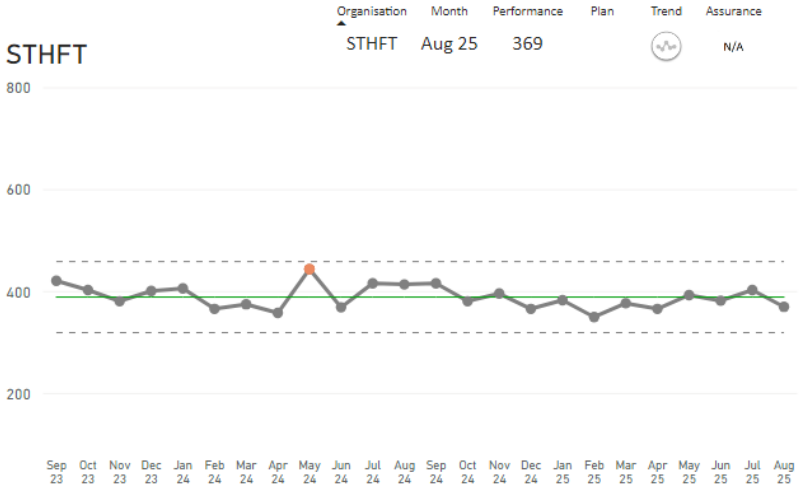
South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Total Births		415	380	395	365	382	349	376	365	392	381	402	369
Still Birth Rate (Rolling 12 months, per 1000 births)	3.6	3.8	4.03	4.23	4.26	3.64	3.87	3.22	3.43	3.25	3.24	3.68	3.72
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1.8	1.3	1.3	1.3	1.5	1.5	1.7	1.7	1.7	1.3	1.7	2	1.5
Breast Feeding at First Feed	77.1%	70.1%	67.2%	66.3%	67.8%	64.3%	63.4%	68.2%	63.9%	65.3%	64.5%	62.3%	63.5%
PPH >= 1500ml Rate per 1000 Births	31	31.9	51.4	36.2	30.6	26.8	32.4	29.6	28.1	28.6	32.1	25.4	27.9
3rd/4th Degree Tear (%)		1.8%	2.3%	4%	2.8%	0.9%	2.6%	5.7%	2.4%	1.3%	3.4%	1.3%	1.8%

SAFE Total Births

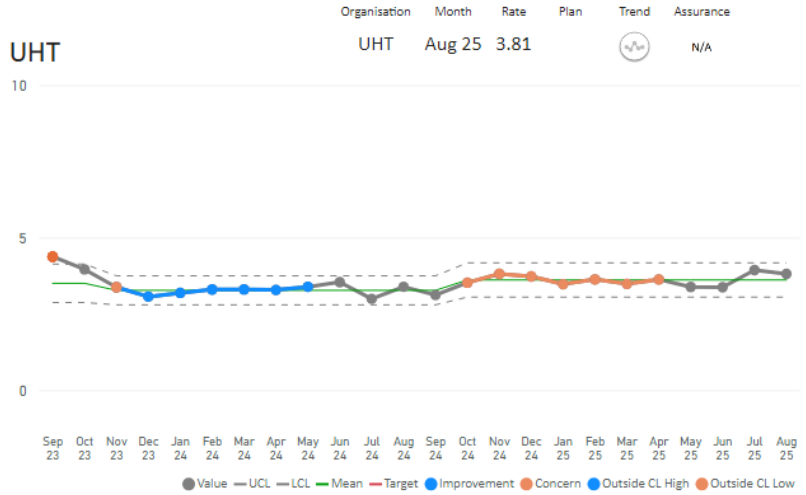


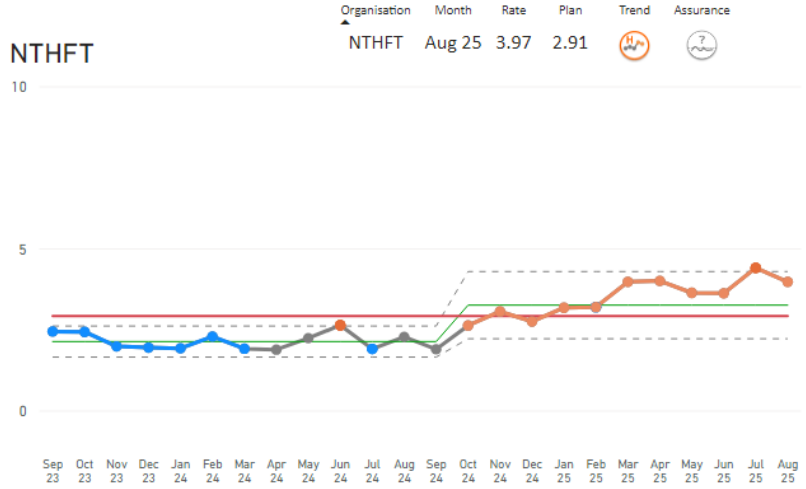
Metric: Total births (includes all registerable live and still births) under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: Number of births at NTHFT and STHFT is relatively stable over 2-year timeframe with births at NTHFT demonstrating a lower monthly average since November 2024.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

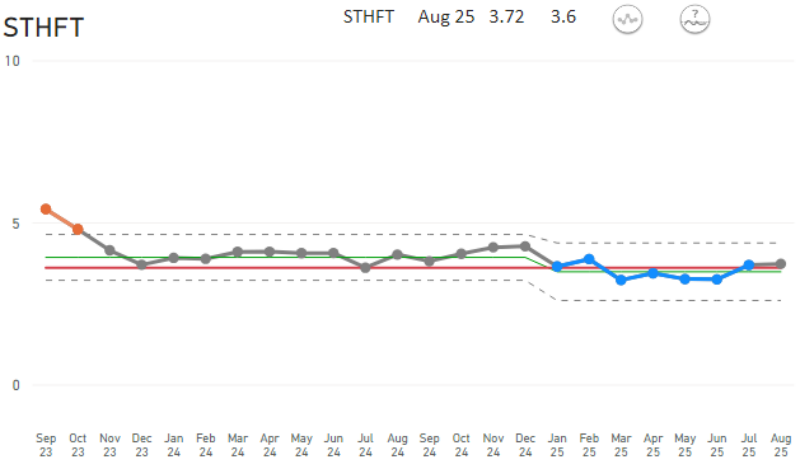




SAFE Still Birth Rate (Rolling 12 months, per 1000 births)

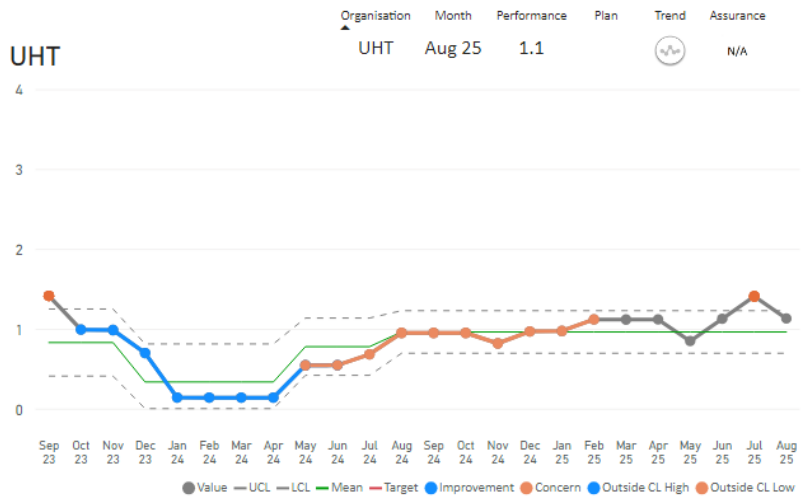




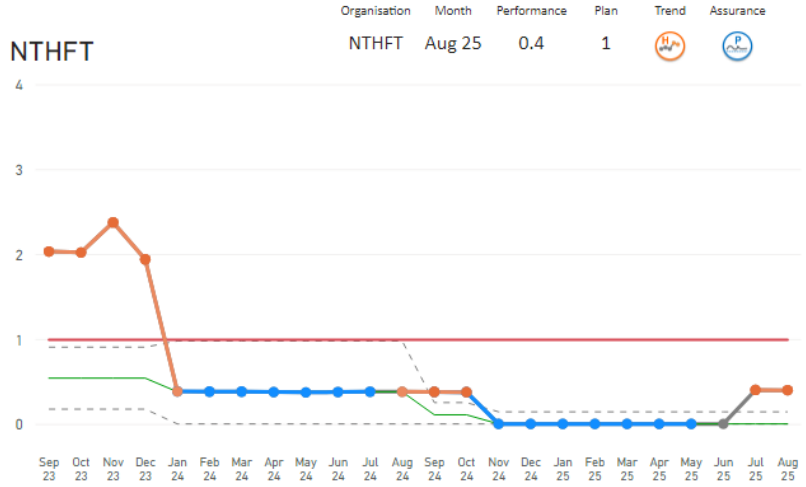


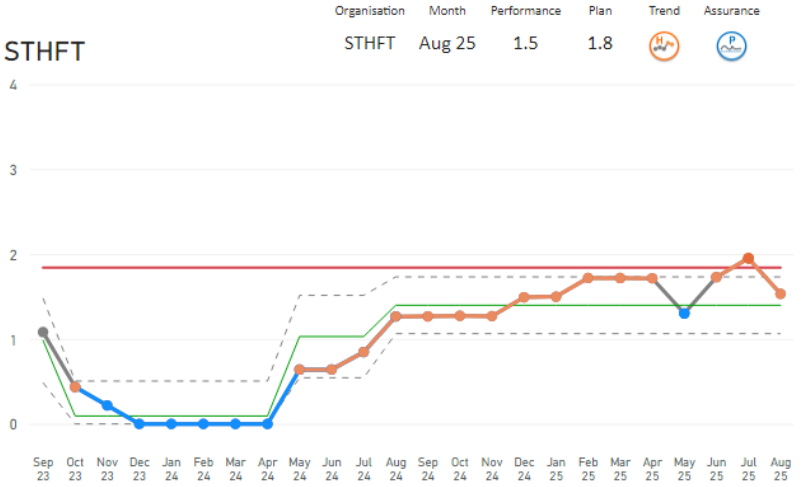
Metric: Still birth rate (rolling 12 months per 1000 births).
Plan: MBRRACE comparator group crude average 2023.
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: Higher (worse) than expected trend, however within variance in August. STHFT: Improvement trend from January 2025 has now stabilised.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Perinatal losses are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team. An external review was completed for NTHFT stillbirths in 2024, reported to Quality Assurance Committee in September.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)



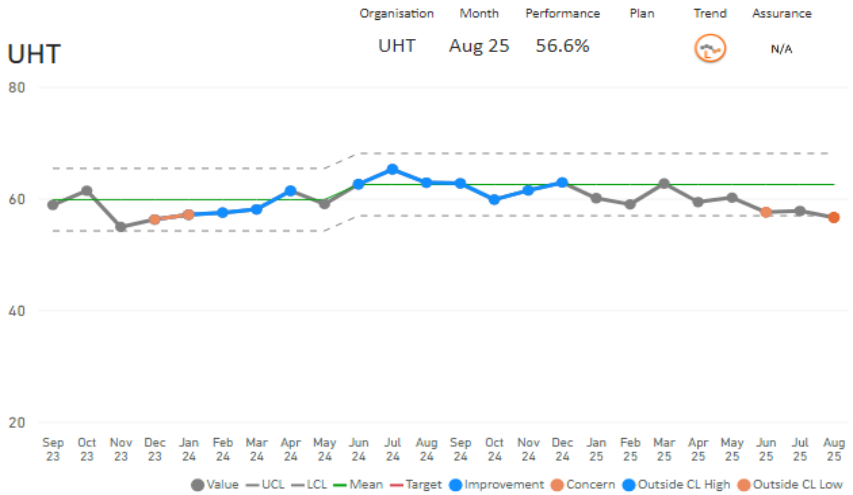
Metric: Neonatal mortality rate**,** rolling 12 months per 1,000 births.
Plan: Local plan 25/26, MBRRACE audit peer group average.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: NTHFT: Increasing trend, following an extended period with no neonatal deaths. STHFT: Increasing trend since May 2024, with 2 of last 3 months higher than expected variation.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: All perinatal deaths are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



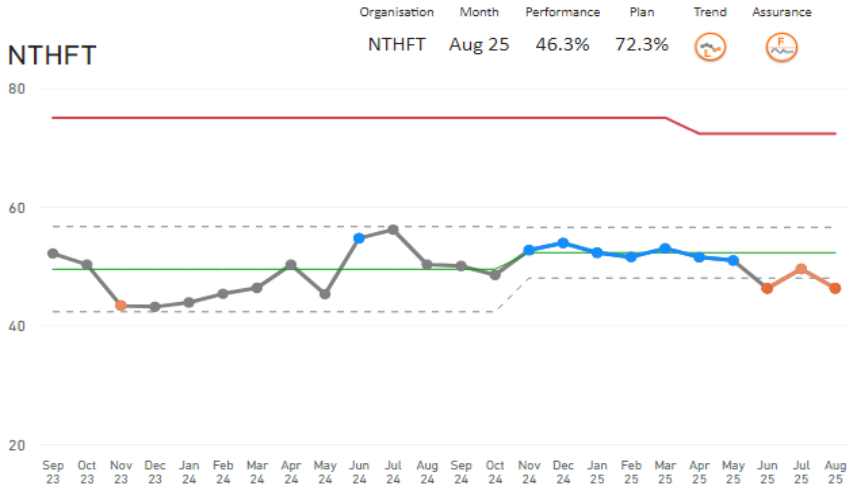


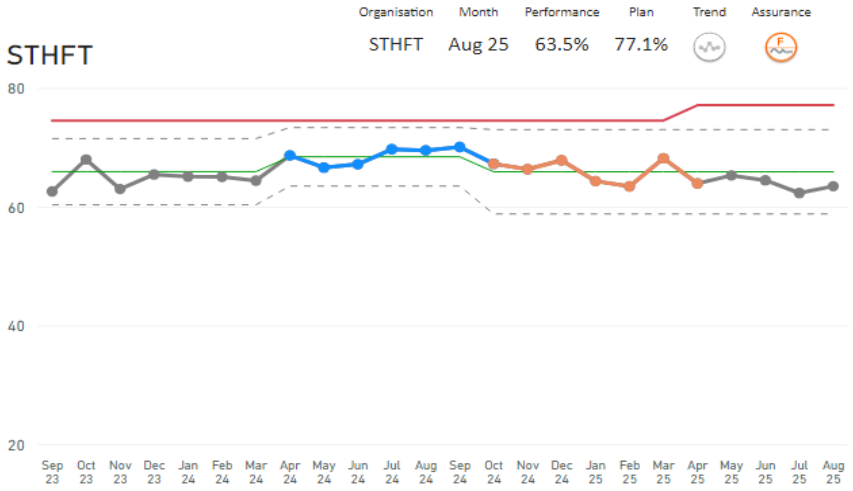
Caring Better Together

SAFE Breast Feeding at First Feed

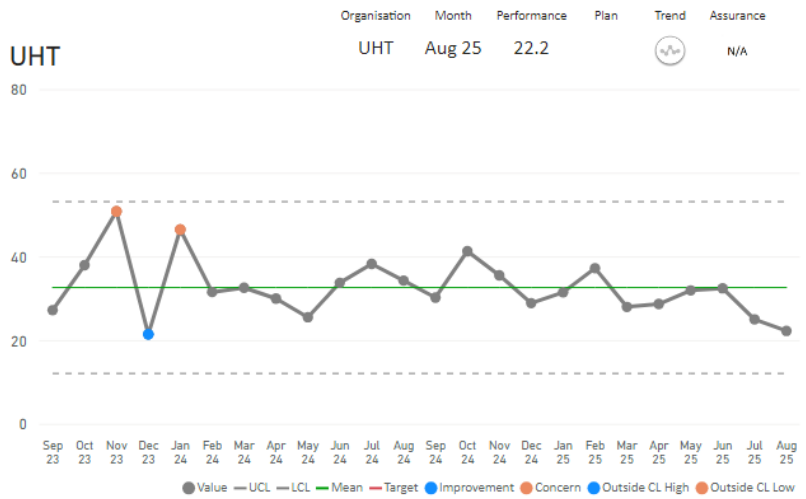


Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 25/26 to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: National maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: Performance has declined since June 2025 and rate remains outside (worse than) expected variance. STHFT: No trend, lower rate stabilised.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: NTHFT are collaborating with STHFT infant feeding team, as a learning opportunity to support an increase in breast feeding.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

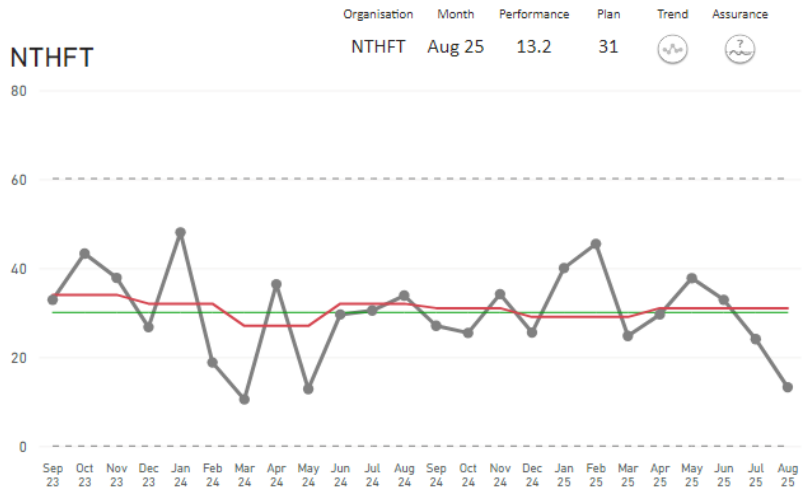


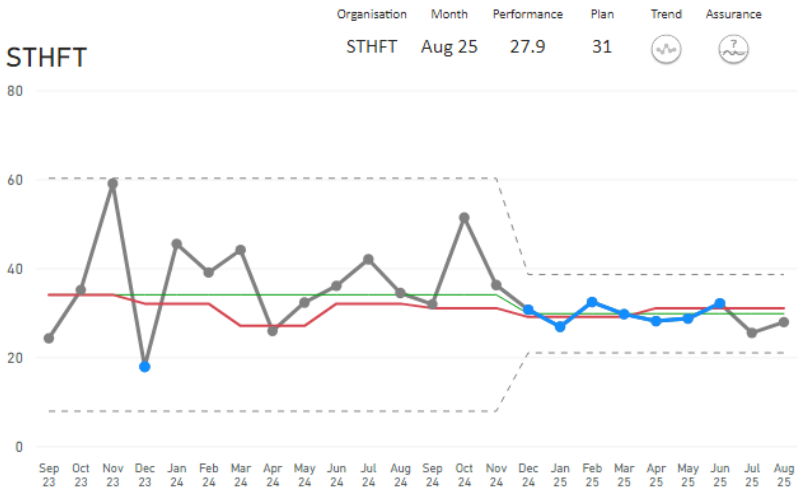


SAFE PPH >= 1500ml Rate per 1000 Births

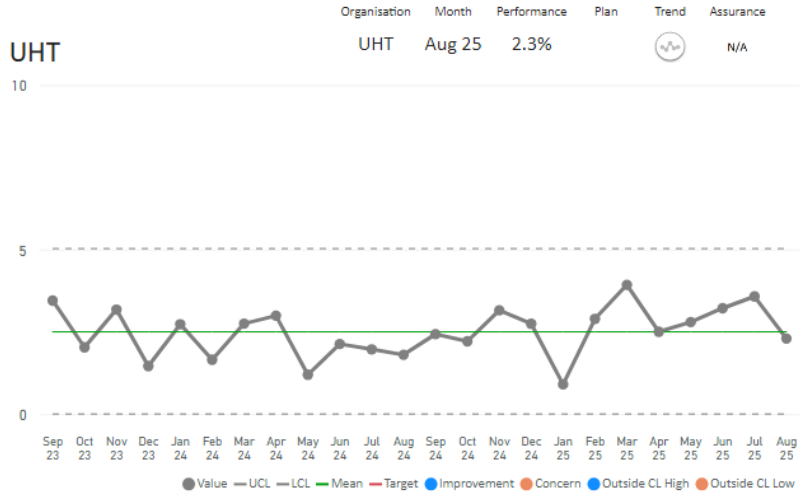


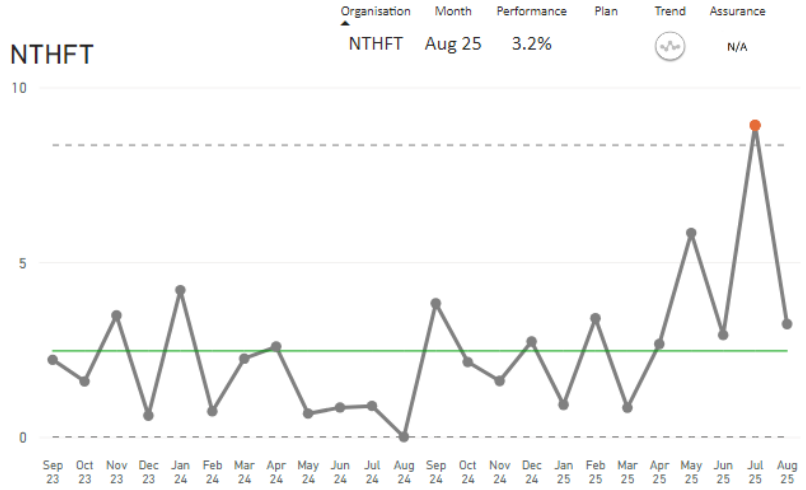
Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births.
Plan: North East and North Cumbria ICB regional average.
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend, more consistent performance demonstrated after variable performance prior to December 2024.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT and STHFT participate in a research study on effectiveness of interventions to reduce PPH.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

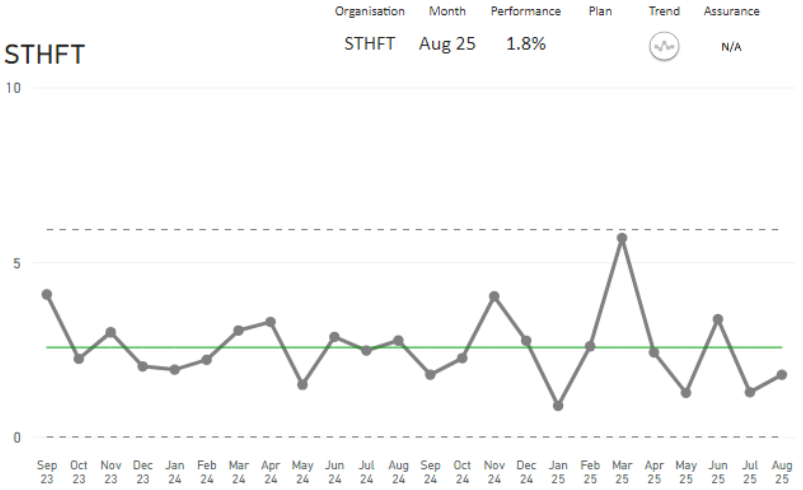




SAFE 3rd/4th Degree Tear (%)







Metric: Percentage of births with 3rd/4th degree maternal tear.
Plan: n/a.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data. NTHFT data descriptor amended to reflect national descriptor, from July 2025, new rate close to limits of previous range of variation.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: All cases have a joint review to identify any learning points; no common themes have emerged.
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.

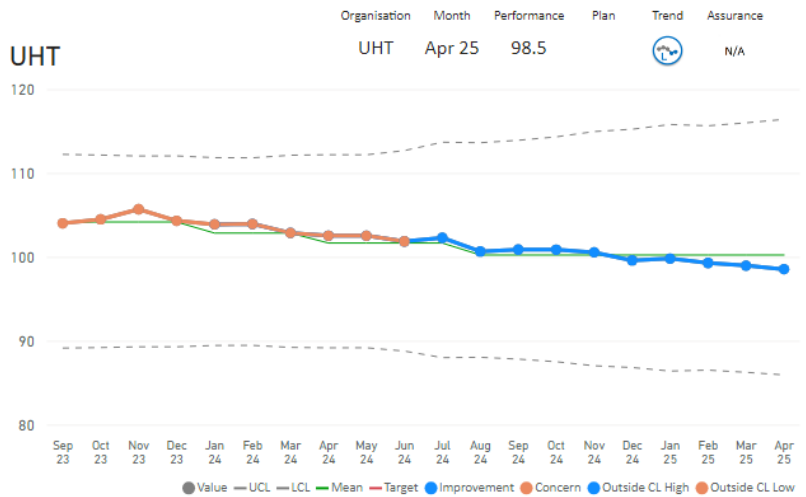
Both trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. This is focusing initially on readmissions of patients with a diagnosis of COPD, as this cohort of patients has a higher readmission rate. The IPR reports a standardised metric to enable benchmarking.

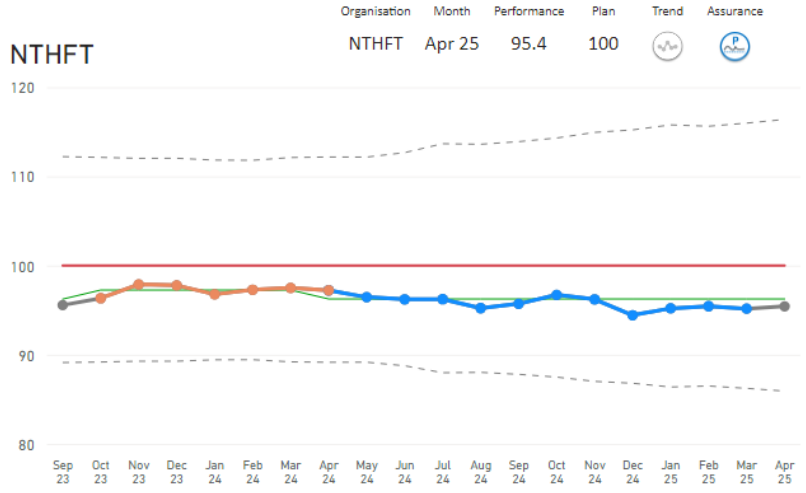
Discharge Delay Average (days) is reported to align to the National Oversight Framework. This metric highlights differences in access to social care provision across our footprint. There is a focus on utilisation of Home First in cases of delays. This metric will be under further review following changes in national guidance.

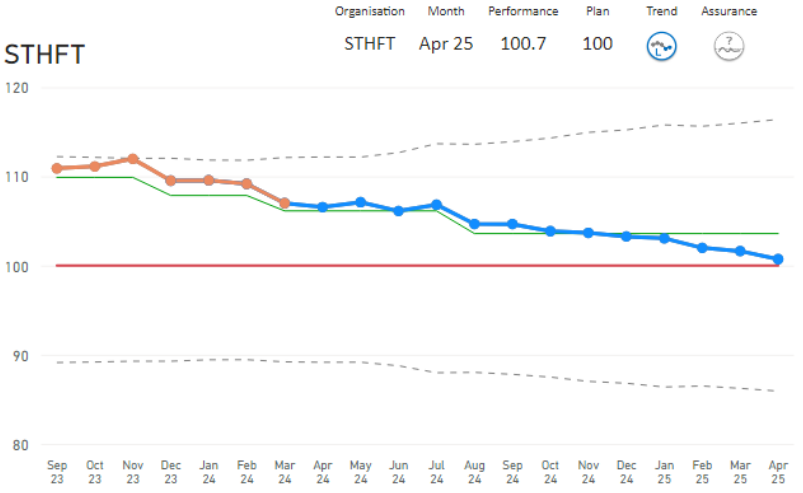
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Summary Hospital-Level Mortality Indicator	100	95.7	96.7	96.2	94.4	95.2	95.4	95.2	95.4				
Readmission Rate (%)	8.4%	10.4%	10.5%	11.1%	11.2%	11.2%	10.6%	11.6%	11.3%	10.2%			
Discharge Delay Average (days)	6.2	2.9	2.6	2.9	3.1	2.7	2.8	2.9	3	3.2	3	3.2	3.2

South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Summary Hospital-Level Mortality Indicator	100	104.6	103.9	103.7	103.3	103.1	102	101.6	100.7				
Readmission Rate (%)	8.4%	9.1%	9.1%	8%	8.9%	8.4%	8.8%	8.7%	8.8%	8.3%			
Discharge Delay Average (days)	6.2	5.4	6.2	6	6.5	6.7	8	7	6.8	7.7	6.2	6.7	6.8

EFFECTIVE Summary Hospital-Level Mortality Indicator

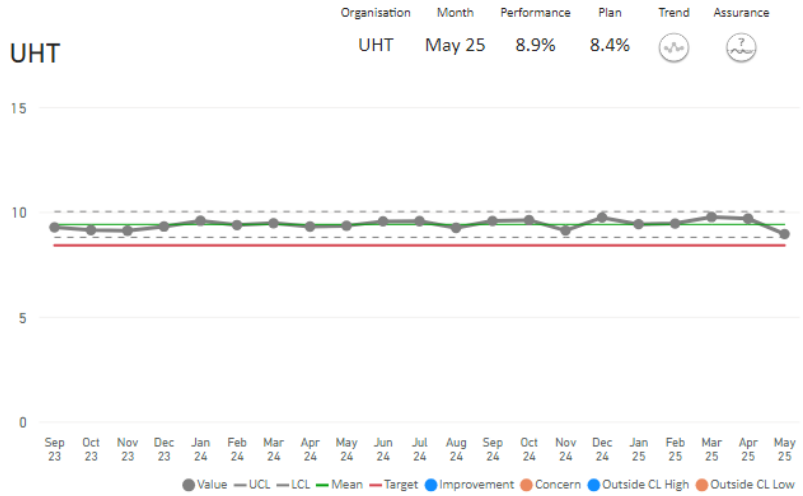


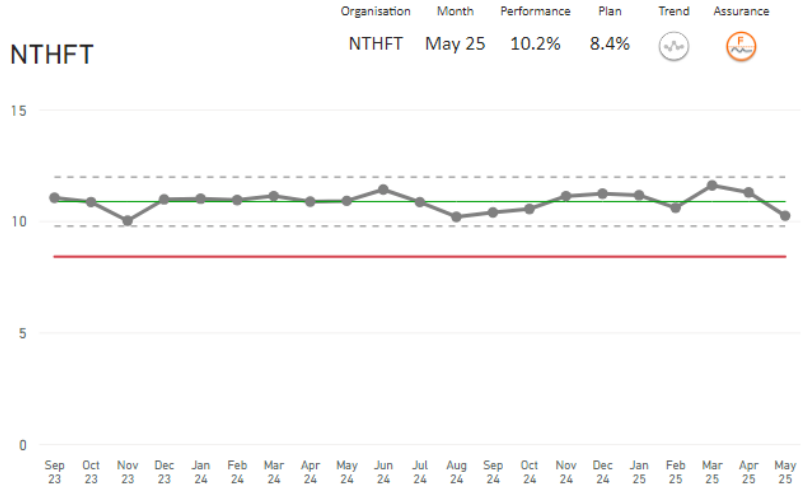


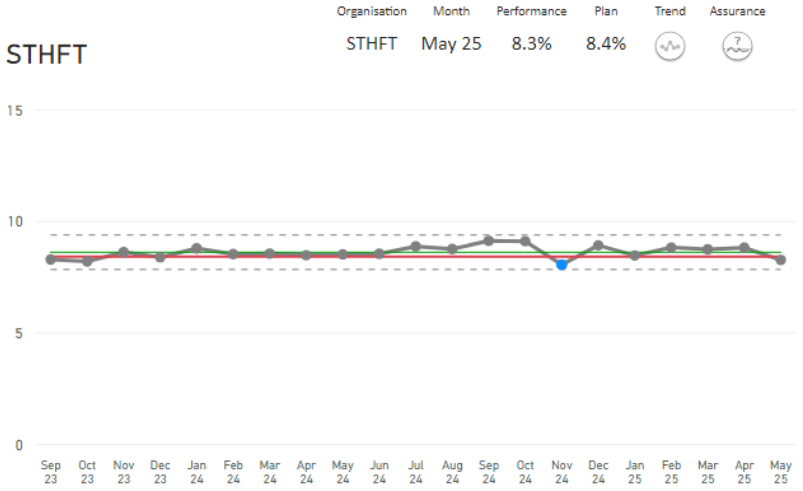


Metric: Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: No Trend. STHFT: Improving, close to national benchmark in August 2025.
Assurance: NTHFT: Assure. Consistently below (better than) the national benchmark. STHFT: Advise. As expected, within national variation.
Action taken: Continued focus on depth of coding at STHFT may lead to further improvement in SHMI. Coding audit work is also underway focusing on diagnoses with higher mortality.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

EFFECTIVE Readmission Rate (%)

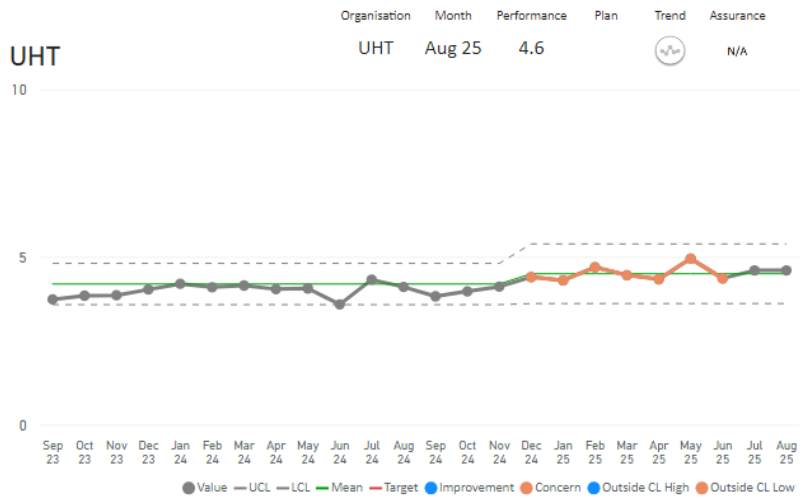


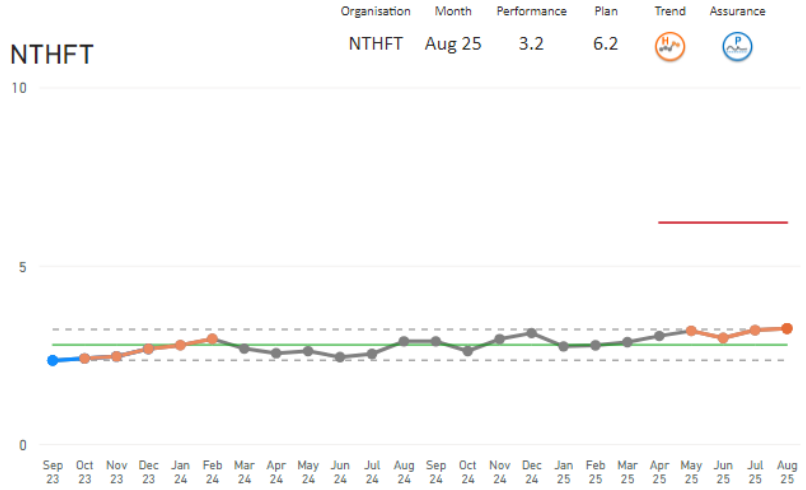


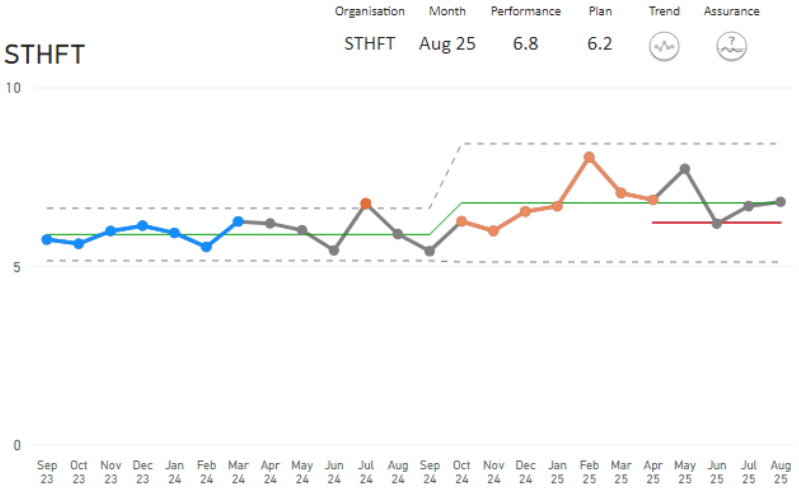


Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Alert. Readmission rates consistently higher than national average. STHFT: Advise. Rates are close to national average.
Action taken: Clinical engagement in audit of samples of respiratory and surgical patient readmissions at both sites, preliminary findings to be available October 2025.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

EFFECTIVE Discharge Delay Average (days)







Metric: Average number of days between discharge ready date and discharge date, excluding zero-day length of stay.
Plan: No published standard, local plan to perform significantly better than national mean rate March 2025.
Rationale: NHS Oversight Framework 25/26 core metric.
Data quality: Minor variation to published metric due to data freeze/publication dates.
Trend: NTHFT: Increasing, at limits of expected variation in August but below (better than) national average. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Renewed focus on ensuring plans and escalations are in place for patients with longer lengths of stay, including patients awaiting repatriation. Utilisation of Home First in cases of delays in access to social care which varies between the local authorities of each Trust.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **Accountable to: Resources Committee**

Urgent and emergency care

Assurance on ambulance handover performance now focuses on handovers completed within 45 minutes, replacing the 60-minute metric. Compliance is assured at >95% at NTHFT, and there is an improvement trend at STHFT.

NTHFT A&E standard performance is below the agreed trajectory, however the national recovery standard of 78% is exceeded throughout for NTHFT as one of the top performing trusts nationally. There is continued focus at STHFT to secure delivery to trajectory, including implementing a rapid assessment and treatment model.

12-hour breaches in ED are stable at both trusts, and significantly lower than the national planning guidance standard of fewer than 10%, but delivery of agreed plans is not assured. This remains an operational focus.

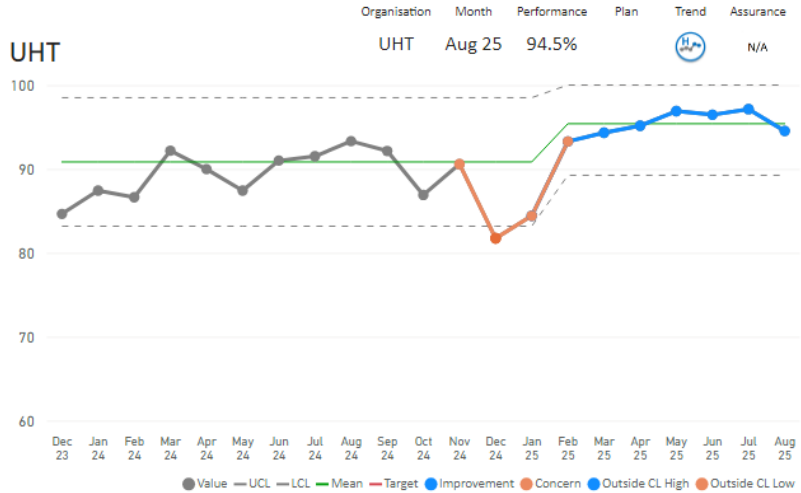
Above-standard performance in the community urgent 2-hour response reflects the continued focus on supporting urgent and emergency care pathways by caring for patients in the most appropriate setting.

Elective operations cancelled on the day not rebooked within 28 days requires improvement, with case-by-case monitoring in place.

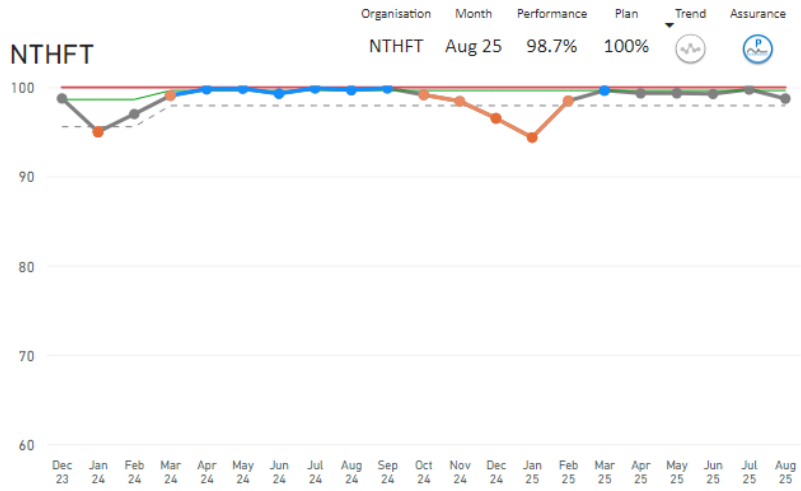
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
NEAS Handovers - Within 45 Mins (%)	100%	99.9%	99.1%	98.4%	96.5%	94.4%	98.5%	99.6%	99.3%	99.3%	99.2%	99.7%	98.7%
4-Hour A&E Standard	89.6%	85.6%	83.8%	81.9%	80.9%	81.3%	85.5%	85.6%	83.7%	86.4%	84.6%	84.9%	84.6%
12-hour ED breaches rate	0.3%	1.4%	2%	3.6%	6.3%	6.4%	1%	1.7%	2.2%	1.4%	3.2%	1.5%	1.4%
Community UCR 2hr Response Rate (%)	70%	76%	79%	77%	73%	79%	72%	74%	70%	75%	75%	77%	
Cancelled Ops - Not Rebooked Within 28 days	0	2	3	3	4	5	10	0	3	4	5	1	0

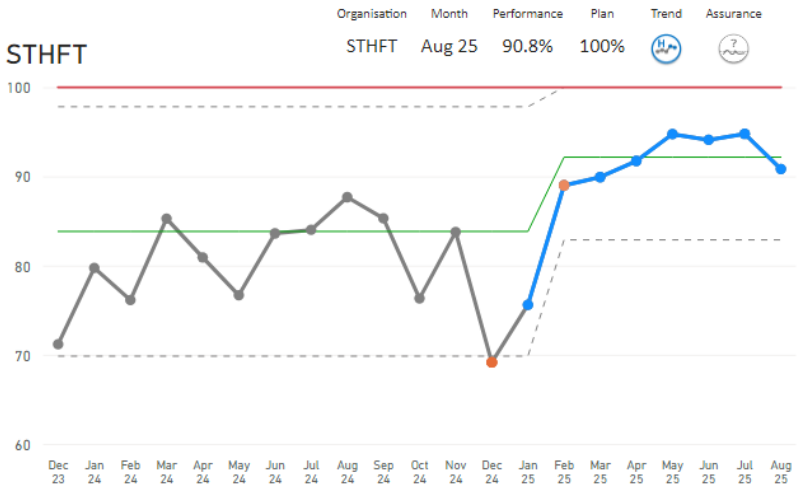
South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
NEAS Handovers - Within 45 Mins (%)	100%	85.3%	76.3%	83.8%	69.1%	75.6%	89%	89.9%	91.7%	94.7%	94.1%	94.8%	90.8%
4-Hour A&E Standard	78%	77.3%	73.5%	75%	72.1%	74.2%	75.4%	75.7%	77%	77%	76.6%	78.5%	77.9%
12-hour ED breaches rate	1.1%	2.3%	7.9%	4.1%	9.8%	11.6%	5.1%	4.1%	4.4%	2.8%	3.2%	2.7%	4.6%
Community UCR 2hr Response Rate (%)	70%	83%	82%	83%	81%	80%	83%	86%	82%	81%	78%	77%	
Cancelled Ops - Not Rebooked Within 28 days	0	13	21	21	18	19	26	16	10	6	11	10	10

RESPONSIVE NEAS Handovers - Within 45 Mins (%)

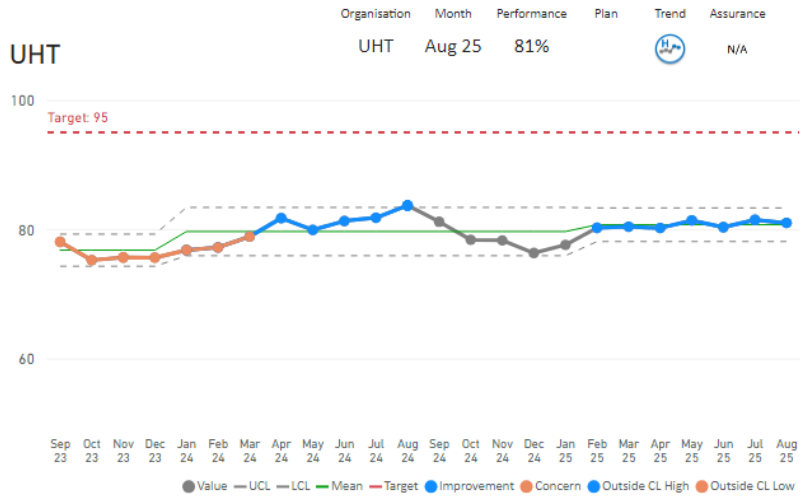


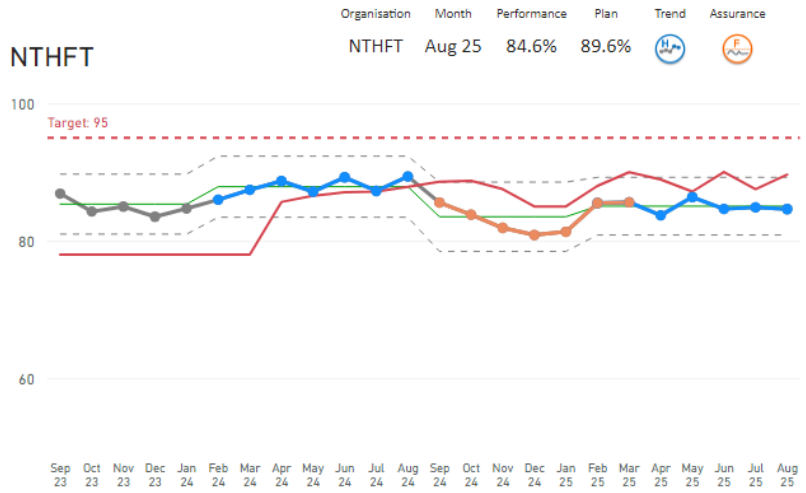
Metric: Percentage of NEAS ambulance handovers completed within 45 minutes of arrival at ED.
Plan: 100% within 45 minutes
Rationale: NHS Contract metric.
Data quality: NEAS data may differ from Trust data.
Trend: NTHFT: No trend. STHFT: Improvement trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: NTHFT continue focus on full compliance. Handover SOP in place and use of corridor in surge to provide timely release of crews. STHFT reinforcing the handover escalation SOP with clinical teams. ED patient flow will become the primary source of escalation to minimise ambulance delays.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

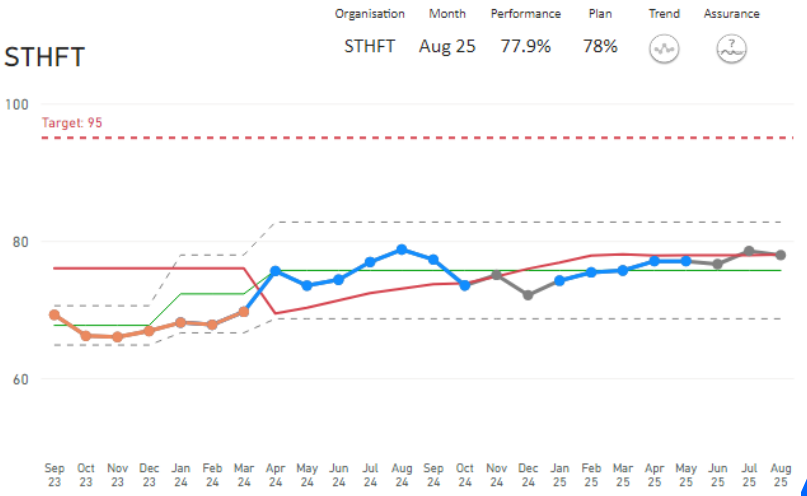




RESPONSIVE 4-Hour A&E Standard

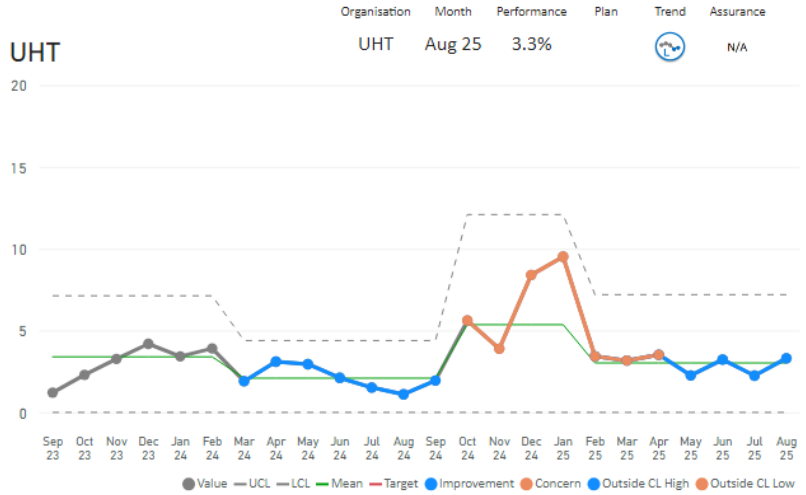


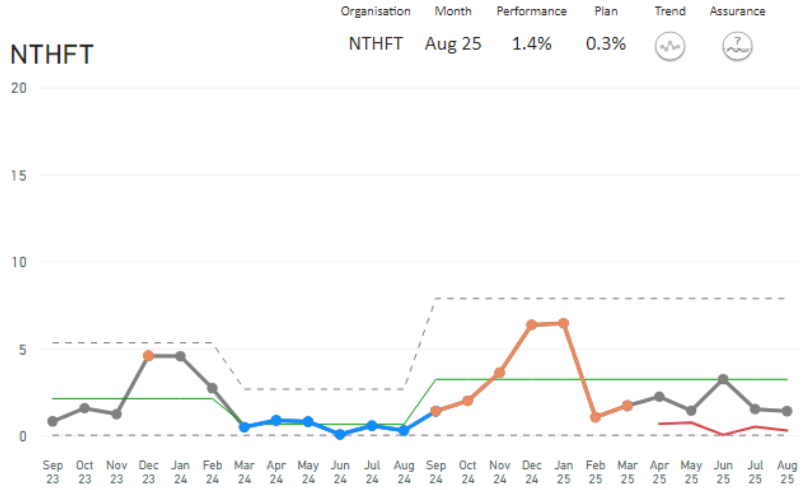




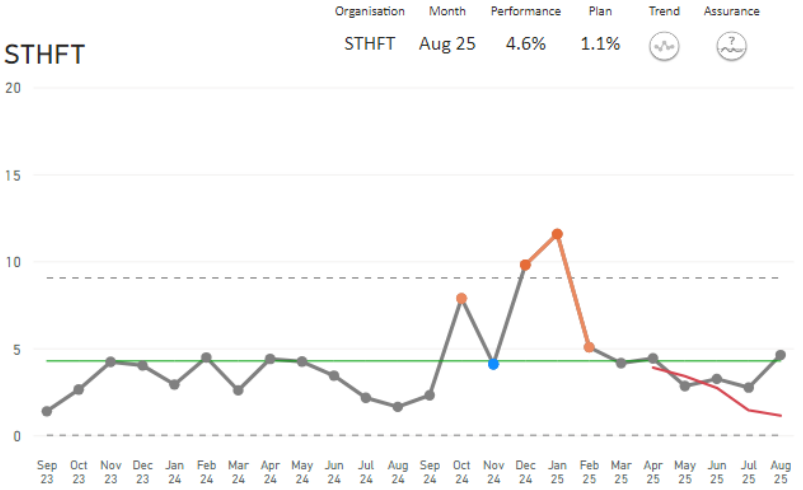
Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, agreed operational plan to achieve 90% NTHFT, 78% STHFT by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Trakcare fix in place.
Trend: NTHFT: Improvement trend. STHFT: No trend.
Assurance: NTHFT: Alert, agreed plan higher than current expected performance variation. STHFT: Advise.
Action taken: NTHFT: Partnership working to improve flow within and out of the Trust, monitored via the 4-hour steering group to meet the higher local plan. STHFT: Rapid assessment and treatment trial was effective and in September, a model was implemented to operate for 20 hours over 5 days.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE 12-hour ED breaches rate

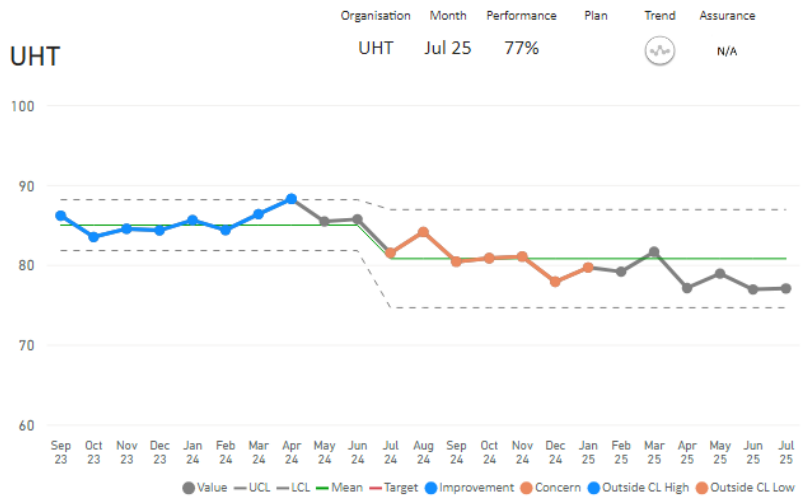


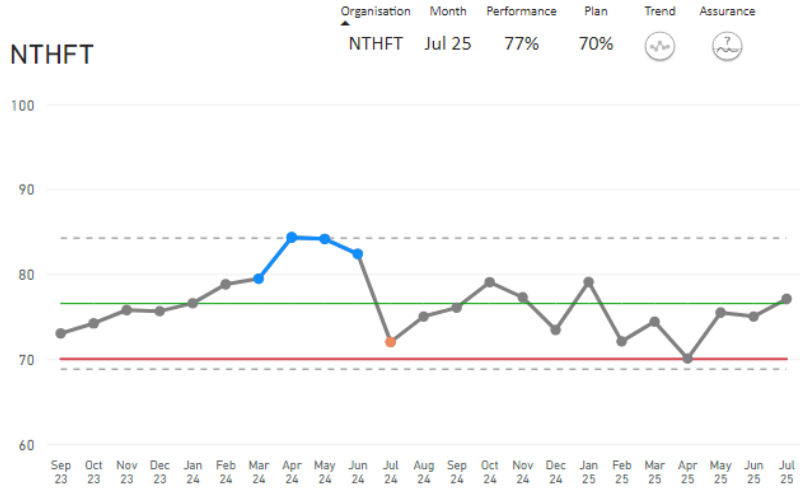


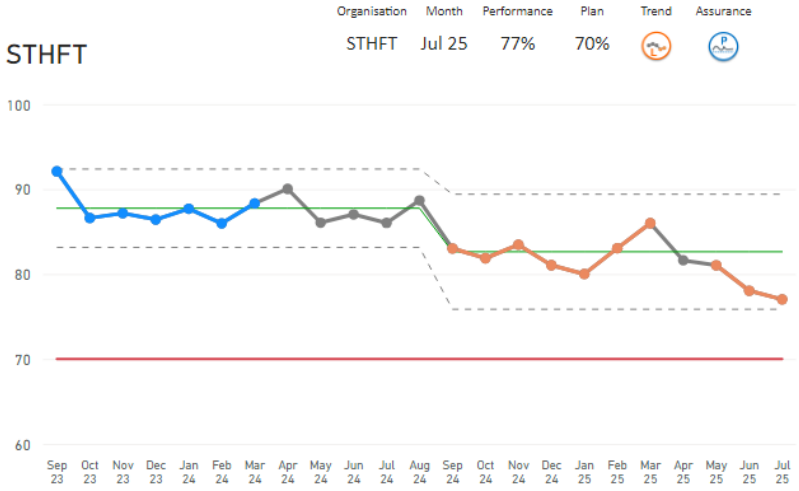
Metric: Percentage of patients admitted or discharged from Type 1 Emergency Department after 12 hours.
Plan: Seasonalised operational plan for 25/26 submitted by each Trust: NTHFT to achieve 1.93% in March 2026; STHFT to achieve 3.22%. National planning guidance standard 10%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: All breaches are audited to identify key themes weekly at NTHFT, with new breach codes live from 20th August to ensure more intelligent analysis. STHFT: Continued focus on interventions made at 10-hours to avoid 12-hour breaches. Implementation of rapid assessment and treatment model in September.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



RESPONSIVE Community UCR 2hr Response Rate (%)

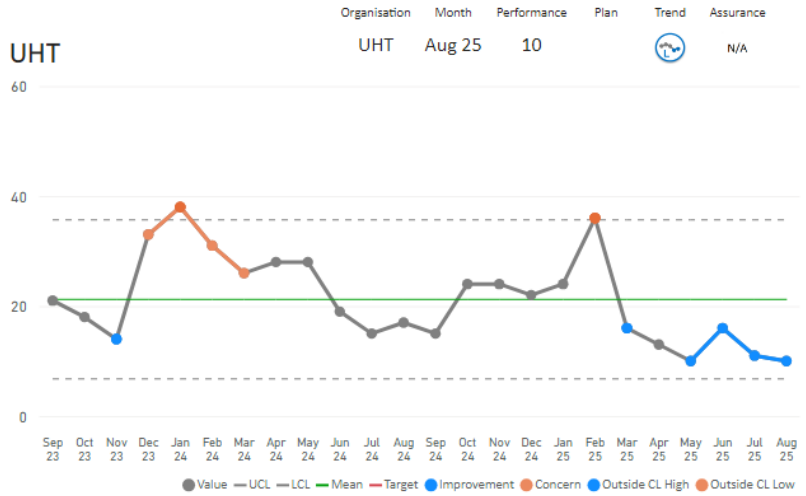




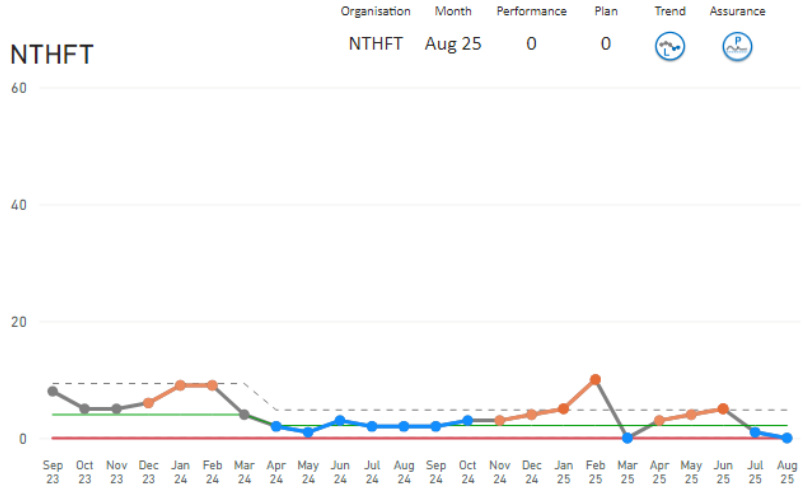


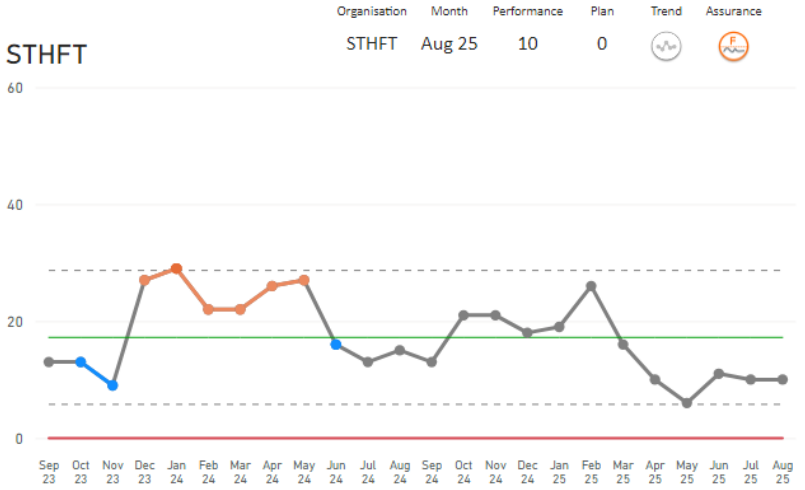
Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, available one month in arrears.
Trend: NTHFT: No trend. STHFT: June and July 2025 performance close to lower limits of expected performance.
Assurance: NTHFT: Advise. STHFT: Advise, national target consistently achieved but lower performance in last 2 months.
Action taken: Community rapid response services remain a key element of caring for patients in the most appropriate setting. An integrated UHT care coordination pilot is planned for November 2025, helping to optimise use of community resources to avoid unnecessary admissions.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days



Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improvement trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Alert.
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 renewed focus on rebooking is monitored via Collaborative performance and Surgical Improvement Group meetings.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **Accountable to: Resources Committee**

Elective, diagnostic and cancer care

Achievement of key access targets continues to be challenging and logged as strategic risks for both trusts.

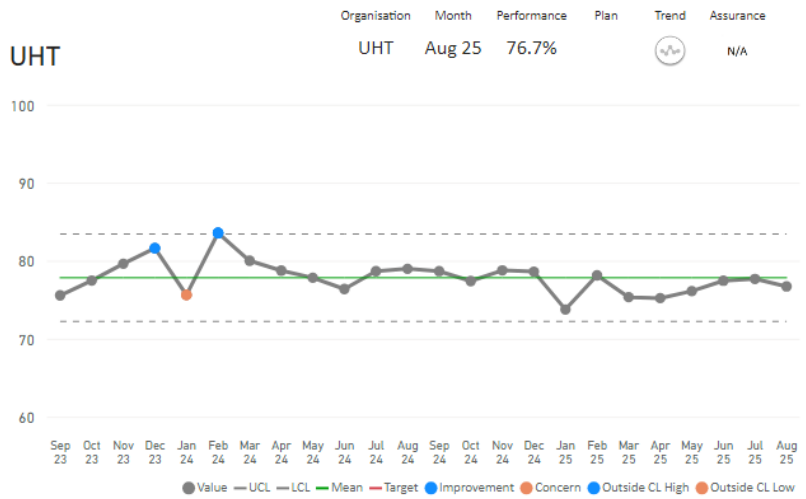
Cancer faster diagnosis standard is not assured for NTHFT or STHFT, and 31-day compliance at STHFT in 2025 is lower than in 2023/24. However, STHFT compliance with 62-day standard now shows a significant improvement trend and is ahead of plan. Tiered support from NHS England continues. NTHFT 31-day and 62-day performance compliance is starting to show impacts of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025 . The team are working closely with CDDFT and the Cancer Care Alliance to support a collaborative approach to service delivery in the short / medium term and longer-term models of delivery across the system. Specific interventions are being put in place to reduce pathway delays and improve the standards going forward. Tumour specific pathway improvements are driven by the clinically-led Cancer Delivery Groups.

Elective recovery trajectories are supported by 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 prioritised, and no patients at NTHFT wait over 65 weeks; however 52-week waits exceed planned trajectories at both Trusts.

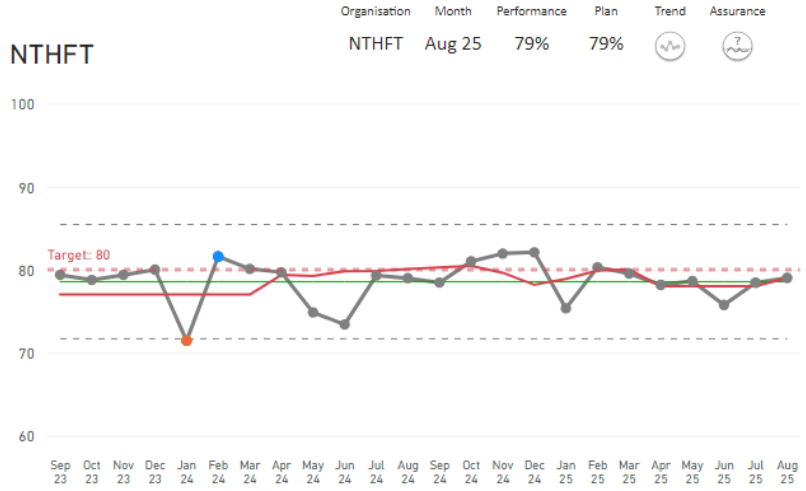
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Cancer Faster Diagnosis Standard (%)	79%	78.4%	81%	81.9%	82.1%	75.3%	80.3%	79.5%	78.2%	78.6%	75.7%	78.4%	79%
Cancer 31 Day Standard (%)	96.2%	91.8%	94.7%	96.2%	96.6%	96.6%	96.4%	93.8%	97.2%	94.8%	97.1%	92.5%	88.8%
Cancer 62 Day Standard (%)	72.5%	60.1%	70.8%	71.6%	76.2%	72.2%	63.4%	67%	64.3%	58%	56.7%	52.3%	51.7%
Diagnostic 6 Weeks Standard (%)	95%	77.7%	82.7%	86.5%	83.9%	91.6%	95.1%	96.7%	95.1%	96.3%	95.8%	96.6%	94.5%
RTT Incomplete Pathways (%)	73.3%	72.1%	72.4%	71.5%	72.5%	73.2%	74.4%	75.5%	74.5%	74.5%	73.9%	74.2%	72.7%
RTT 52 Week Waiters Rate	0.9%	0.8%	0.9%	1.1%	0.9%	0.8%	0.8%	0.8%	1%	1%	1.2%	0.9%	0.8%
Community Over 52 Week Waiters Rate	7.1%	1.3%	4%	3%	3.1%	0.6%	0.3%	0.1%	0.6%	1.5%	2.9%	3%	3.4%
RTT Time to First Appointment (%)	80.4%	77.8%	79.2%	78.6%	79.5%	80.1%	81.8%	82.2%	81.7%	82.3%	81.1%	81%	79.9%

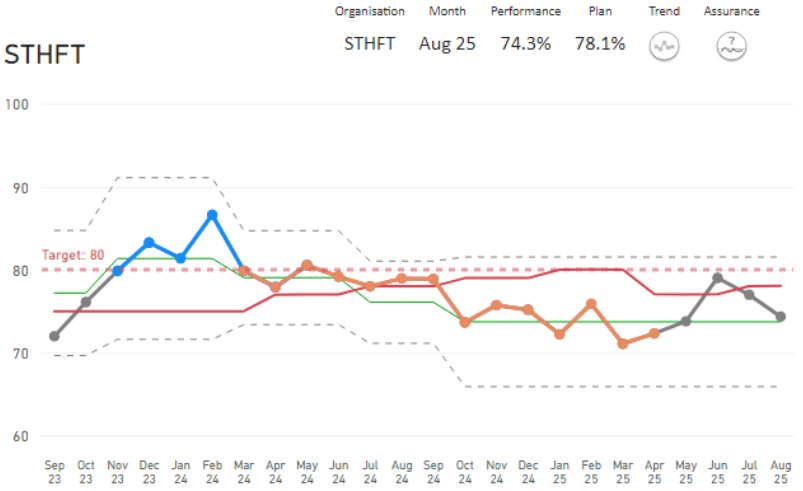
South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Cancer Faster Diagnosis Standard (%)	78.1%	78.9%	73.6%	75.7%	75.2%	72.2%	75.9%	71.1%	72.3%	73.8%	79%	77%	74.3%
Cancer 31 Day Standard (%)	91.1%	91.1%	90.5%	89.1%	88.3%	81.1%	86.8%	82.6%	86.6%	82.2%	87%	86.3%	82.1%
Cancer 62 Day Standard (%)	63.4%	61.9%	56.7%	58.5%	59.9%	63.1%	61%	61.2%	62.3%	60.4%	61.1%	67.2%	65.7%
Diagnostic 6 Weeks Standard (%)	95%	84.9%	85.9%	85.5%	85%	88.7%	88.7%	87.4%	85%	83%	84.4%	86.9%	82.2%
RTT Incomplete Pathways (%)	61.6%	59.1%	60.2%	60%	59.4%	59.5%	59.9%	60.3%	61.1%	62.1%	62.1%	61.9%	61.1%
RTT 52 Week Waiters Rate	2.1%	3.2%	2.6%	2.8%	2.7%	2.9%	2.9%	2.7%	2.8%	2.8%	2.8%	2.7%	2.9%
Community Over 52 Week Waiters Rate	7.1%	2.9%	2.3%	3.2%	3.2%	2.1%	2%	1.7%	1.6%	2.3%	2.2%	2%	1.9%
RTT Time to First Appointment (%)	67.3%	63%	65.1%	65.2%	64.3%	64.3%	64.8%	64.7%	66.2%	66.2%	65.4%	64.3%	64%

RESPONSIVE Cancer Faster Diagnosis Standard (%)



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: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT continued focus on compliance improvement in urology and respiratory pathways, STHFT focus on compliance in urology and gastro-intestinal tumour groups. Recent changes in prostate diagnostic pathway are evident with new changes in bladder pathway will improve performance in coming months.
Executive lead: **Chief Delivery Officer**
Accountable to: Resources Committee

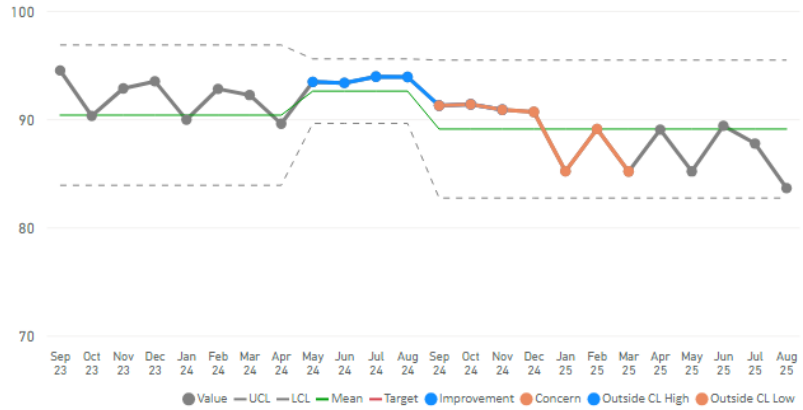




RESPONSIVE Cancer 31 Day Standard (%)

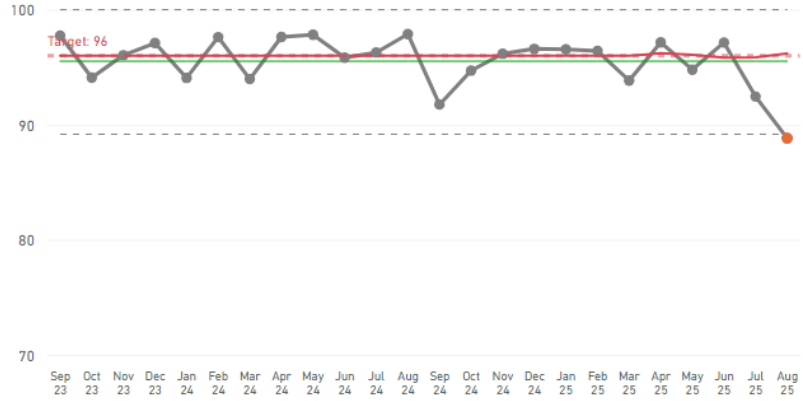
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	83.6%			N/A



NTHFT

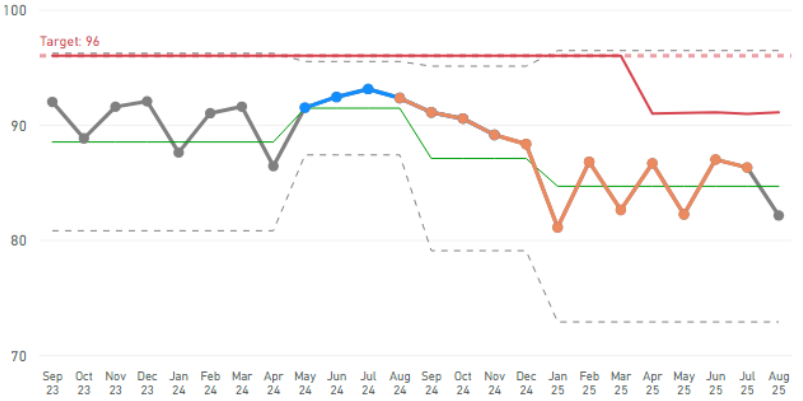
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	88.8%	96.2%		



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: NTHFT: Decline in performance, outside of (worse) expected variation. STHFT: Decline in performance.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: For both NTHFT and STHFT breast pathway demand is challenging to compliance. Ongoing collaboration with CDDFT to support service delivery is taking place. There is wider strategic discussion with the ICB for a longer-term regional response. STHFT focus is the patients waiting longest for treatment.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	82.1%	91.1%		

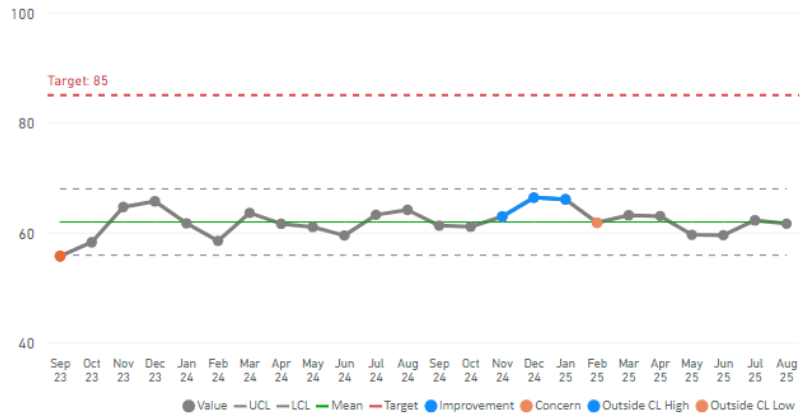


RESPONSIVE **Cancer 62 Day Standard (%)**

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%, STHFT 68.3% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Declining performance trend. STHFT: improving trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT breast pathway demand is challenging to compliance. On going collaboration with CDDFT to support service delivery is taking place. There is wider strategic discussion with the ICB for a longer-term regional response. Respiratory and Urology also report low performance, however recent pathway improvements implemented will support performance improvement over the next few months. STHFT changes in prostate diagnostic pathway now impacting positively on 62-day standard.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

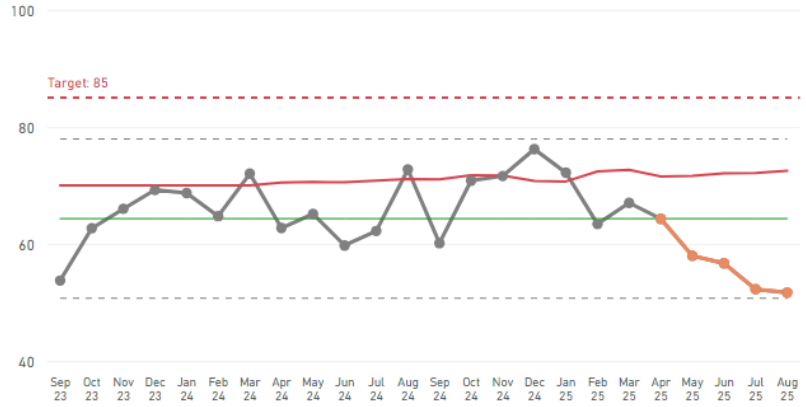
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	61.6%			N/A



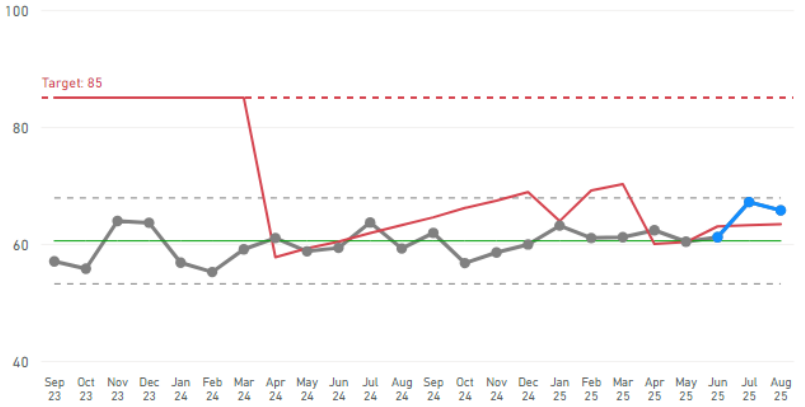
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	51.7%	72.5%		

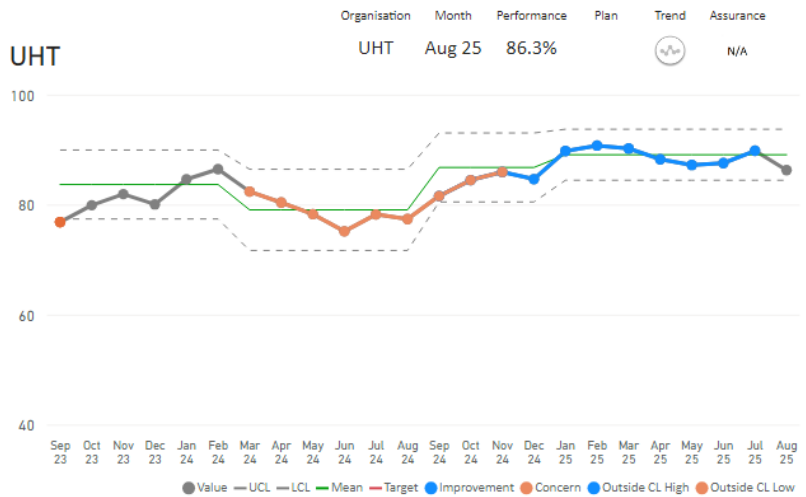


STHFT

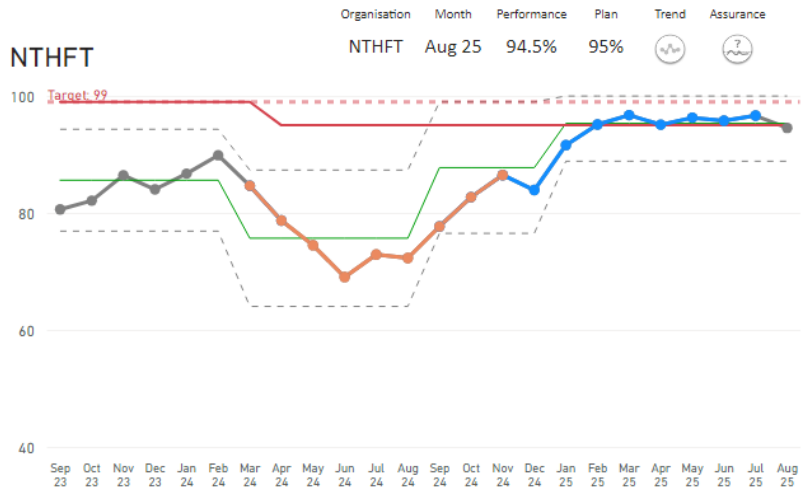
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	65.7%	63.4%		

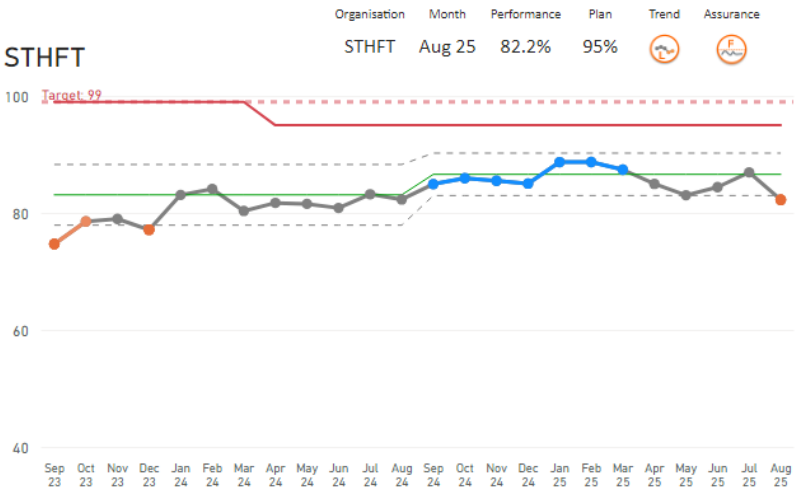


RESPONSIVE Diagnostic 6 Weeks Standard (%)

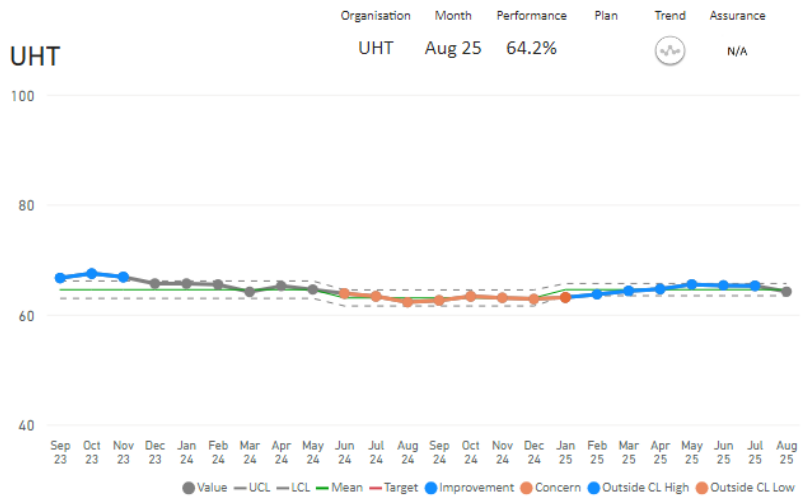


Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Deteriorating trend triggered by August compliance lower than expected variation.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Improvement work underway in STHFT specialist services will show only incremental improvement over several months. Deterioration in Echocardiography staffing capacity has been addressed but performance will take several months to recover.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

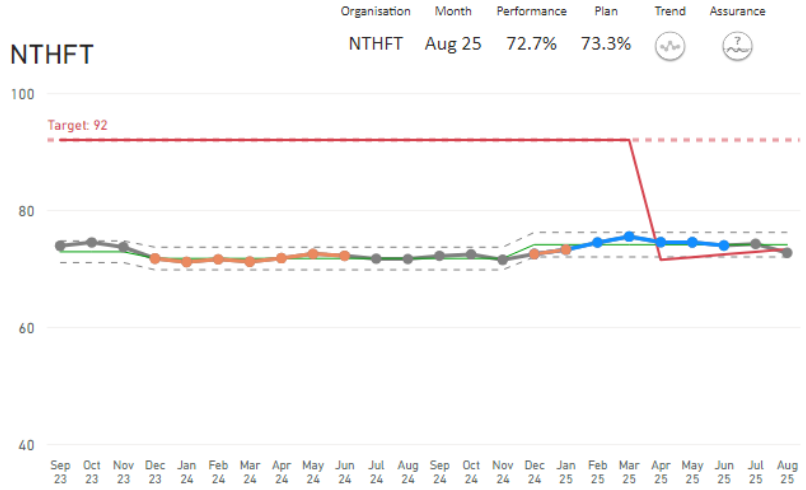


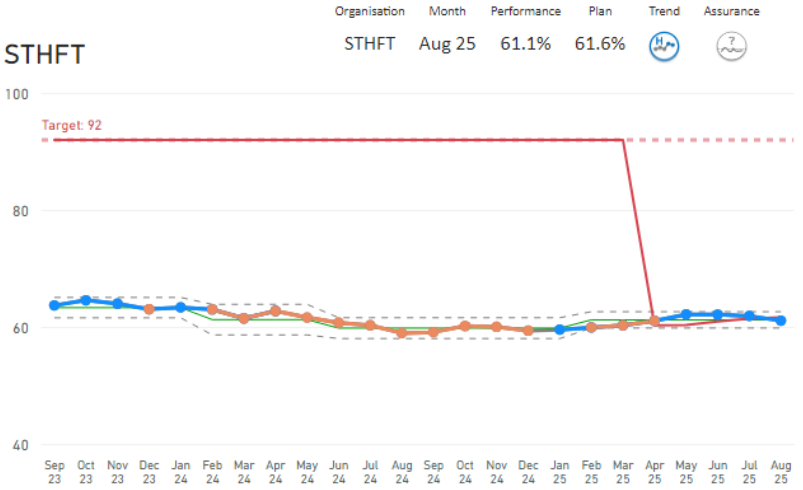


RESPONSIVE RTT Incomplete Pathways (%)

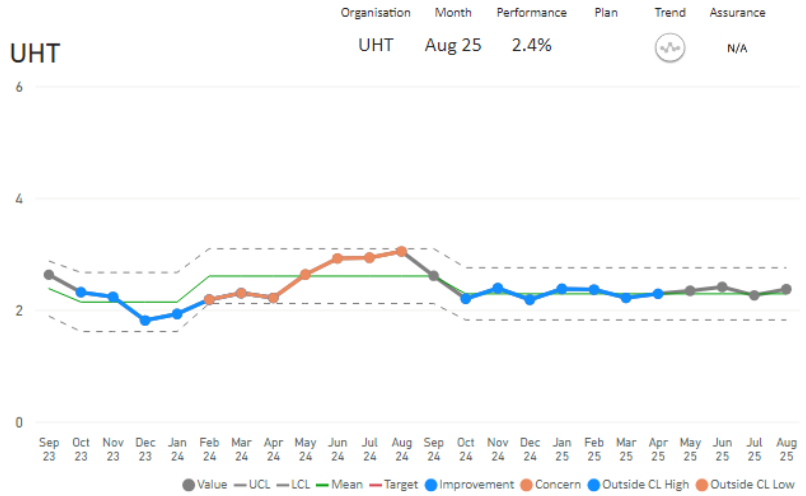


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%. Agreed operational planning trajectories: NTHFT 76.5%, STHFT 65.0% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Improving trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks. Q2 June to September validation sprint is now complete with a Q3 Sprint planned to commence in November 2025.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

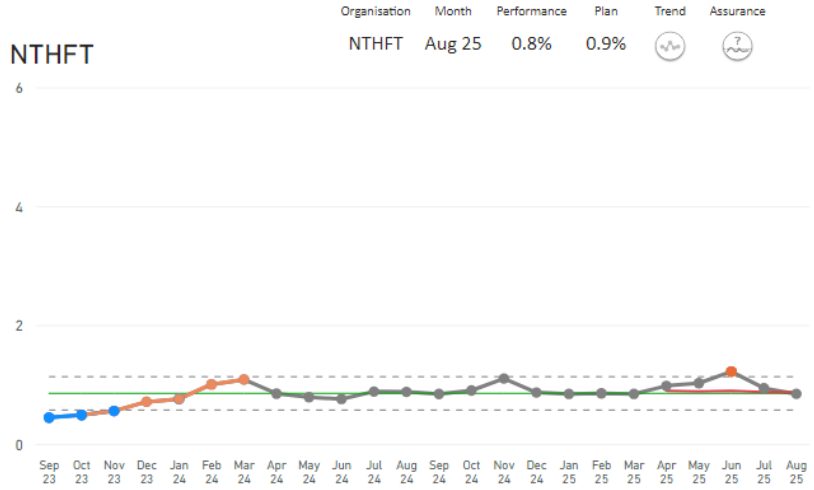


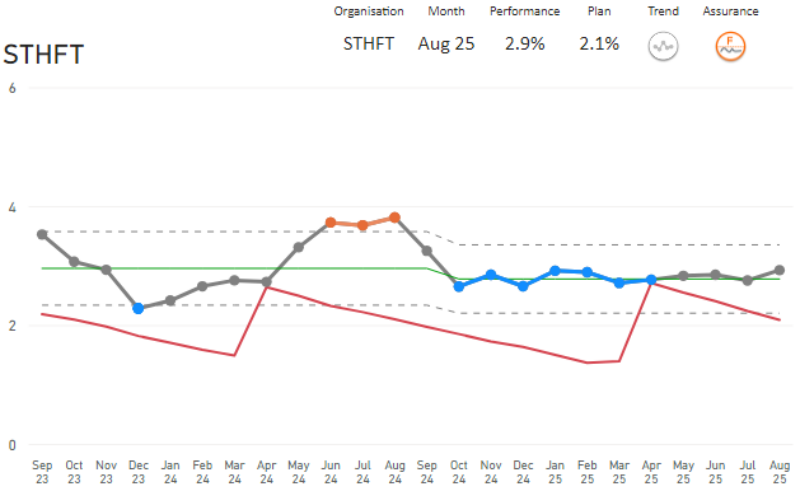


RESPONSIVE RTT 52 Week Waiters Rate



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 to less than 1% of the waiting list by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Both Trusts are focused on return to plan. STHFT have increased capacity in Neurology, ENT and OMFS with other pressured specialties addressing capacity constraints through refreshed recovery plans.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



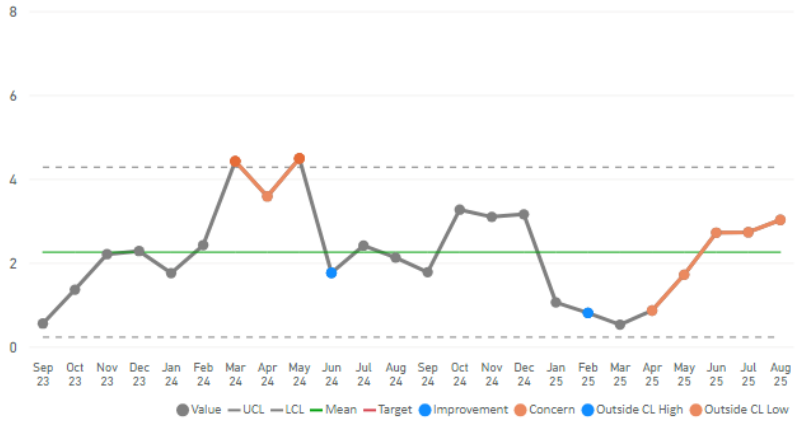


RESPONSIVE Community Over 52 Week Waiters Rate

Metric: Rate of community patients awaiting treatment who have waited more than 52 weeks from referral.
Plan: No published standard, local plan to perform significantly better than national mean rate March 2025.
Rationale: NHS Oversight Framework metric.
Data quality: Advisory, variation in reported position. further validation may be required.
Trend: NTHFT: Deteriorating performance trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: Focus validation of reported position and bringing forward longest waiters, improvement trajectory for next 4 months to return NTHFT position to previous performance.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

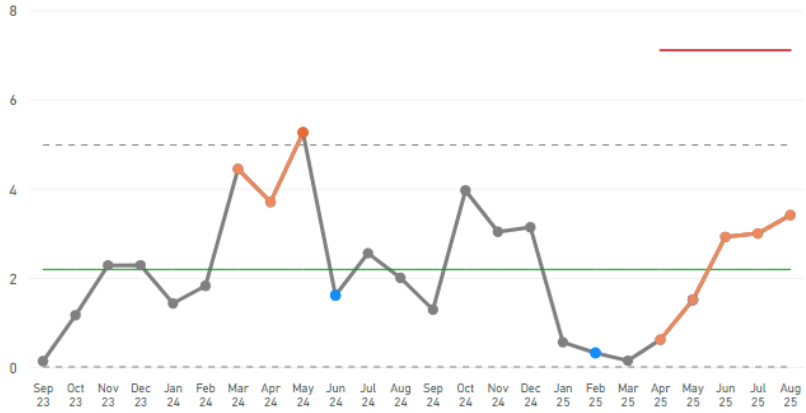
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	3%			N/A



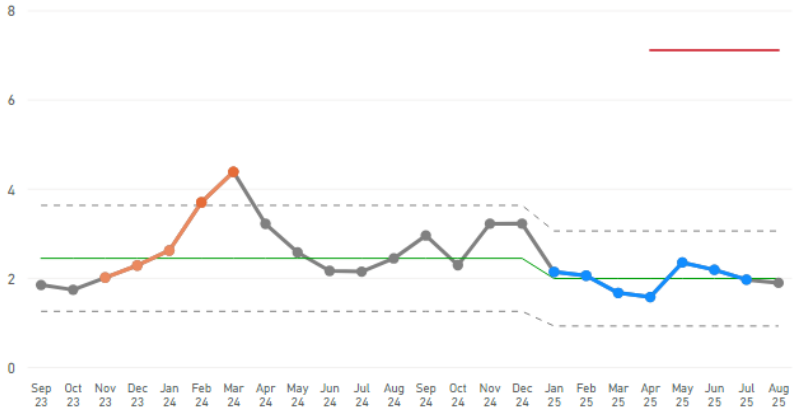
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	3.4%	7.1%		

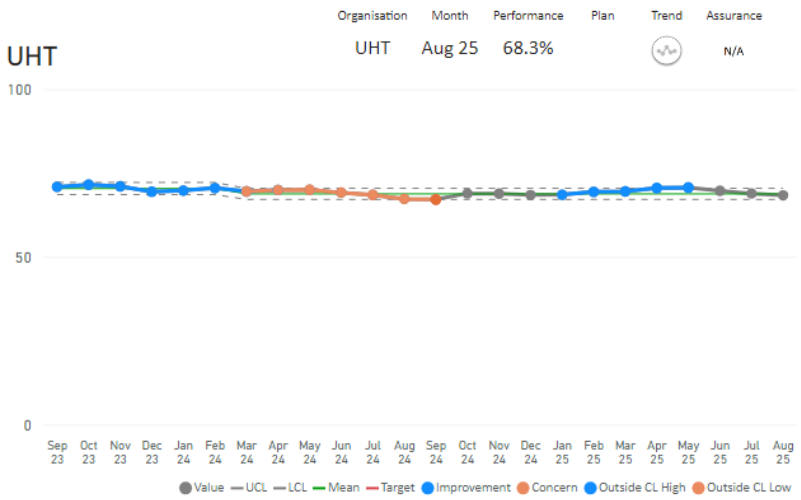


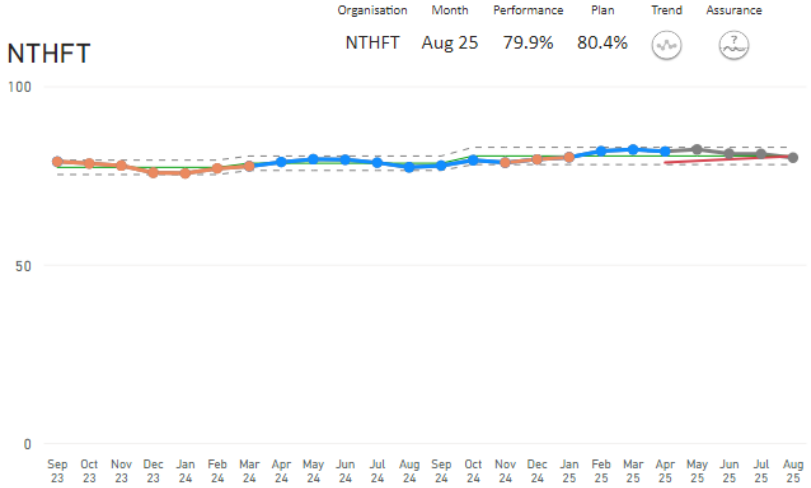
STHFT

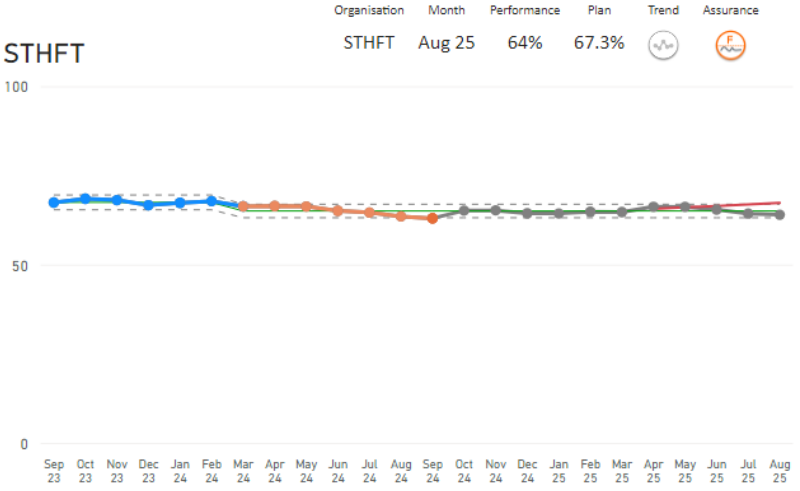
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	1.9%	7.1%		



RESPONSIVE RTT Time to First Appointment (%)







Metric: RTT Referral to First Appointment within 18 weeks.
Plan: Agreed operational planning trajectories: NTHFT 83.57%, STHFT 72.3% by end March 2026.
Rationale: 25/26 NHSE planning guidance priority.
Data quality: assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Q2 June to September validation sprint is now complete with a Q3 Sprint planned to commence in November 2025. Outpatient clinic template reviews and resulting clinic template changes being undertaken across UHT to increase capacity. Revisit *Getting it Right First Time* guidance and benchmarking to identify further improvement priorities.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

CARING DOMAIN SUMMARY

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. Both Trusts were on or above plan in four of the five surveys in the month of August, with statistical assurance for STHFT Outpatient and Community services. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care, supported by digital data collection. STHFT are doing a staged approach from Meridian to InPhase, NTHFT will transition from an external service provider (Formfinity) to Inphase.

Work continues in Q2 25/26 to ensure consistency in timely responses to complaints. 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. Complaints acknowledged in 3 days remains high at 98-100% across UHT.

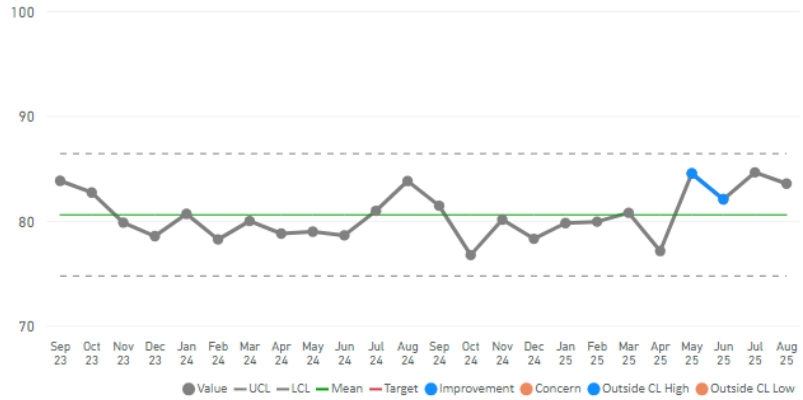
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
A&E Experience (%)	79%	85.8%	85.7%	85%	85.2%	84.3%	85.9%	84.2%	88.2%	87.2%	84.8%	84.9%	85.8%
Inpatient Experience (%)	95%	95.8%	94.7%	94.8%	94.8%	91.2%	92.4%	91.5%	95%	93.5%	95.4%	92.7%	93.4%
Maternity Experience (%)	92%	83.3%	87.5%	100%	87.5%	96.3%	100%	100%	93.3%	94.1%	84.8%	94.3%	96.2%
Outpatient Experience (%)	94%	93.6%	93.8%	94.9%	94%	93.8%	94.4%	93.1%	99.4%	95.5%	94.1%	94.2%	94.4%
Community Experience (%)	94%	96.4%	98.3%	96.9%	97.1%	97.5%	94%	97%	100%	97.7%	96%	94.5%	96%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	54.4%	52.6%	72.1%	55.4%	60.9%	73.1%	67%	71%	78.5%	65.9%	62%	73.6%

South Tees Hospitals NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
A&E Experience (%)	79%	80.5%	75.5%	79.8%	76.7%	78.5%	78.3%	80%	76.9%	84%	80.1%	84.4%	82.3%
Inpatient Experience (%)	95%	97.6%	99.1%	96.8%	96.9%	98.9%	97.8%	98.2%	96.9%	95.1%	97.8%	98.2%	99.3%
Maternity Experience (%)	92%	94.6%	92.3%	91.7%	87.6%	89.6%	94.3%	93.4%	93.3%	93.8%	93.2%	89%	91.2%
Outpatient Experience (%)	94%	97.1%	96.5%	95.5%	96.7%	96.1%	95.8%	95.9%	95.2%	95.9%	96.3%	95.8%	95.7%
Community Experience (%)	94%	97.5%	97.5%	100%	100%	97.3%	100%	100%	100%	100%	100%	100%	100%
Feedback Acknowledged in 3 Days (%)	100%	98.7%	98.6%	100%	100%	100%	100%	96.6%	99%	99.1%	100%	100%	97.9%
Complaints Closed Within Target (%)	80%	58.1%	35.6%	38%	40.4%	46.6%	59.5%	47.8%	76%	68.2%	48%	37%	33.3%

CARING A&E Experience (%)

UHT

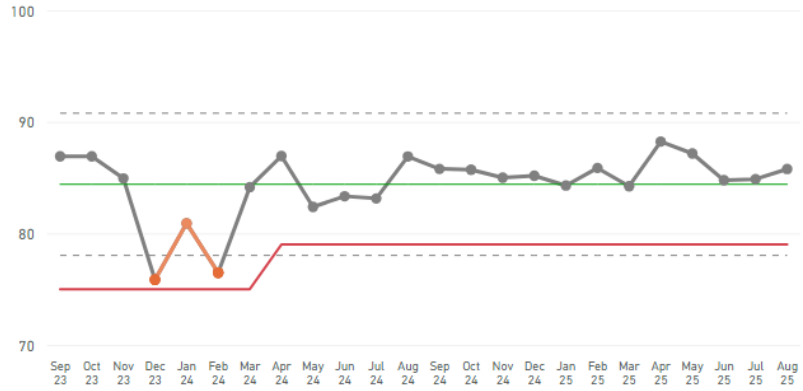
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	83.5%			N/A



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 and May for FFT returns, resolved in June.
Response rates: NTHFT 4%, STHFT 9%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise, assurance hampered by past variation in performance. STHFT: Advise.
Action taken: Patient feedback appears to correlate inversely with A&E waiting times metrics, so focused improvement of waits is expected to improve experience.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

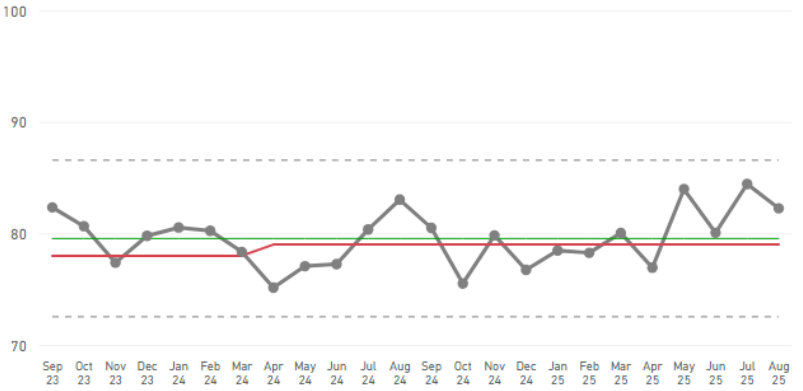
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	85.8%	79%		



STHFT

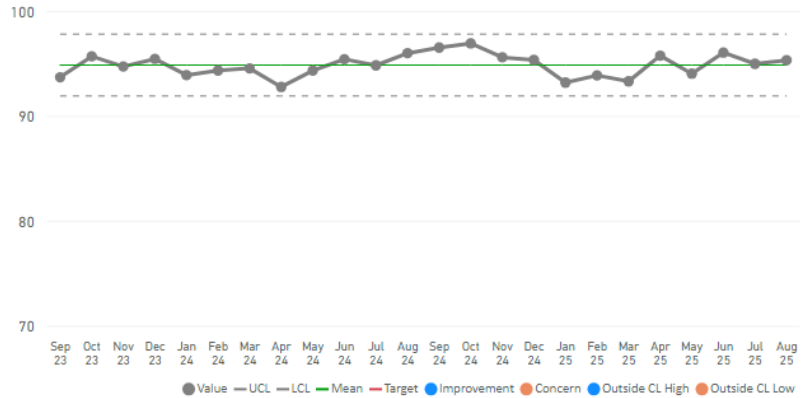
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	82.3%	79%		



CARING Inpatient Experience (%)

UHT

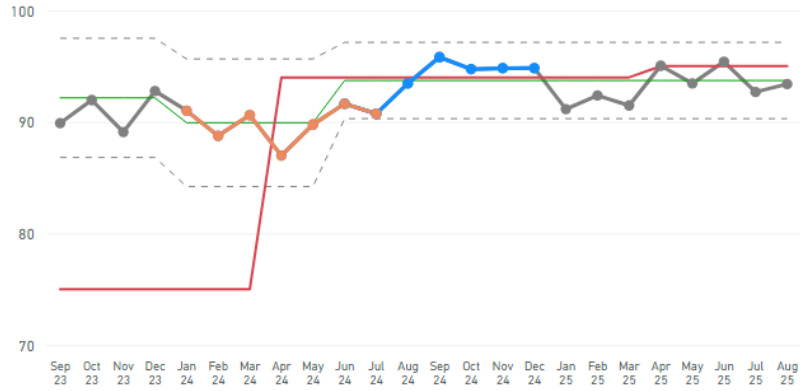
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	95.3%			N/A



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 4%, STHFT 15%.
Trend: NTHFT: Outside of (worse) expected variance in August. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: STHFT transitioning from Meridian to InPhase, NTHFT transitioning from external service provider to InPhase. This will standardise patient feedback collection processes and analysis across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

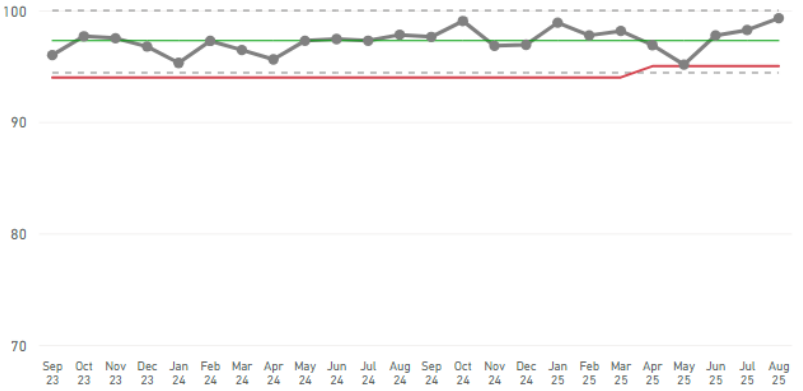
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	93.4%	95%		

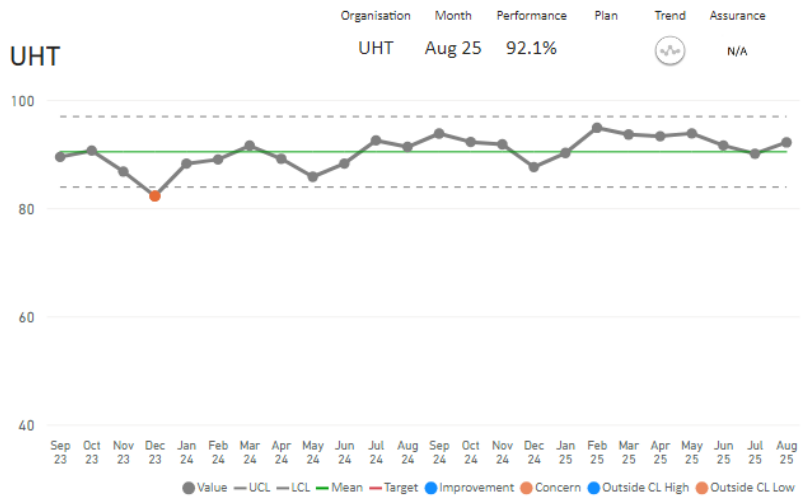


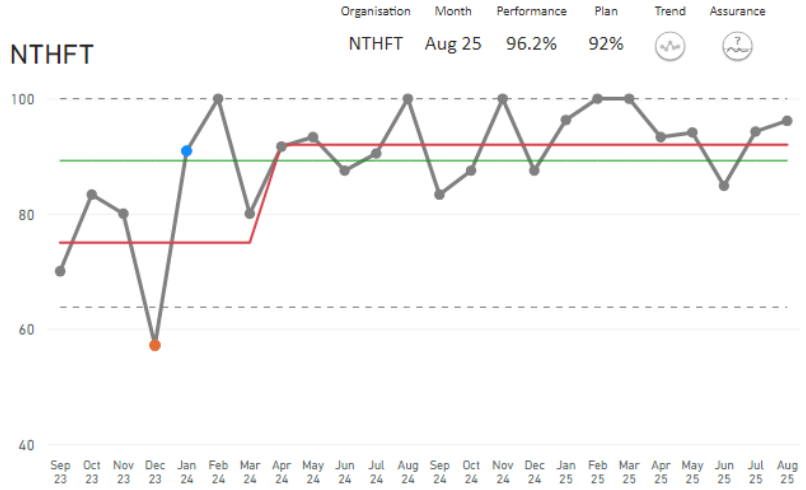
STHFT

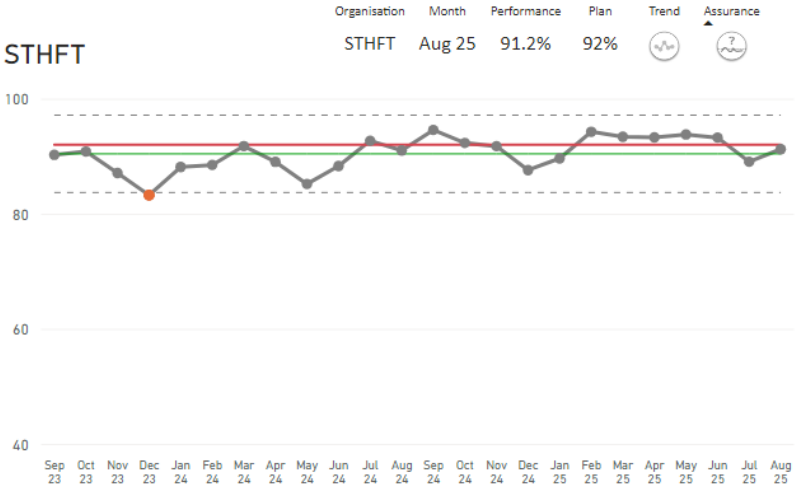
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	99.3%	95%		



CARING Maternity Experience (%)

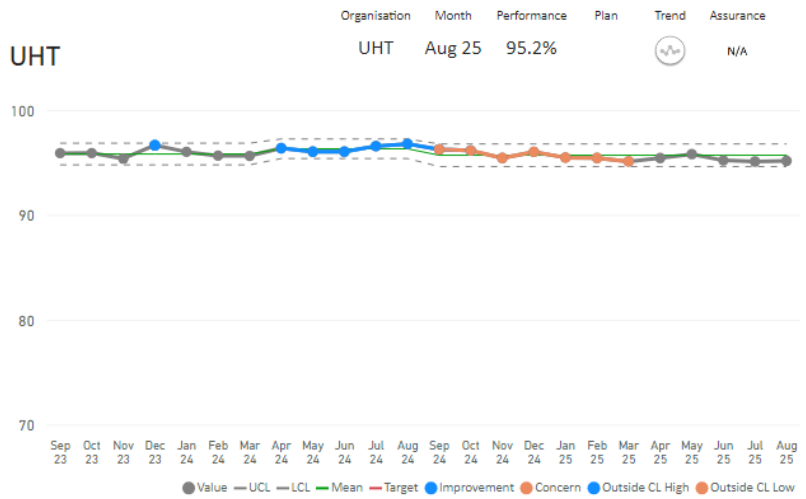


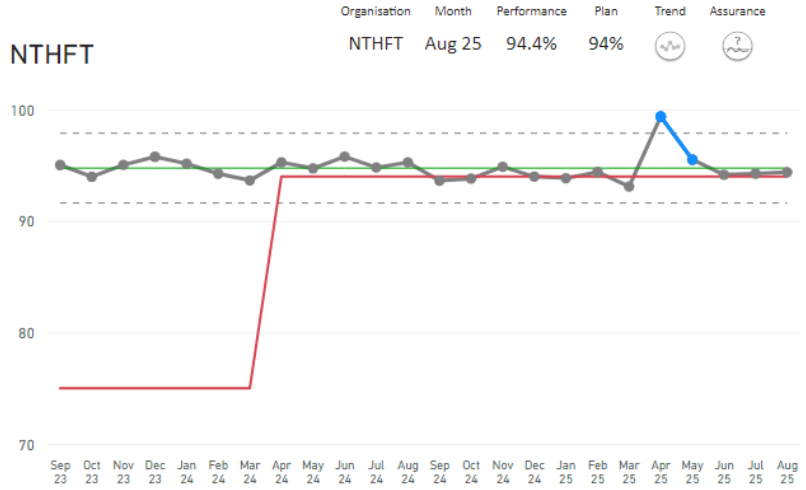


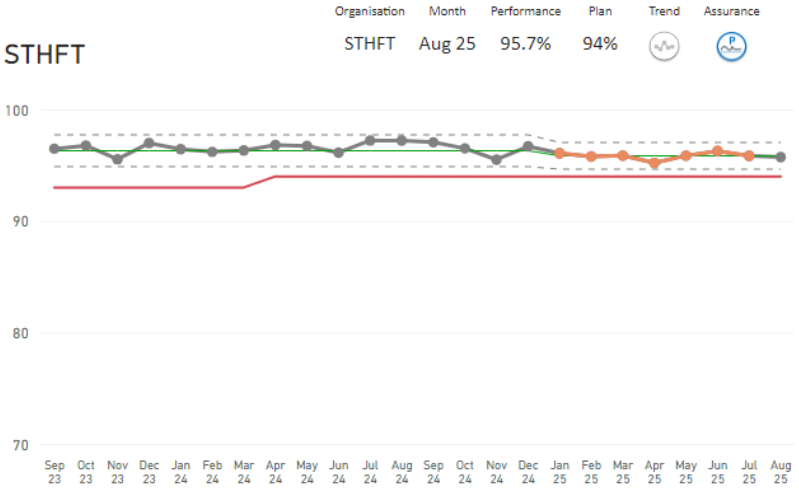


Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, reported figure is Birth only.
Response rates: NTHFT 10%, STHFT 13%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: To continue to promote engagement with Friends and Family Test. STHFT transitioning from Meridian to InPhase.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Outpatient Experience (%)

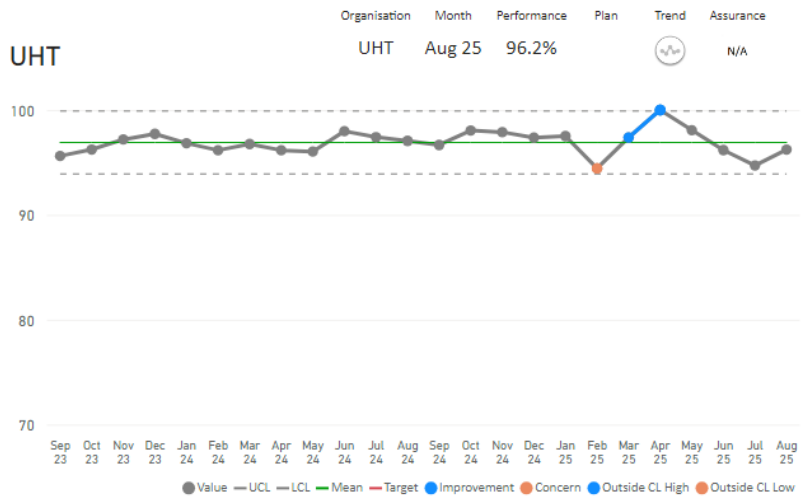


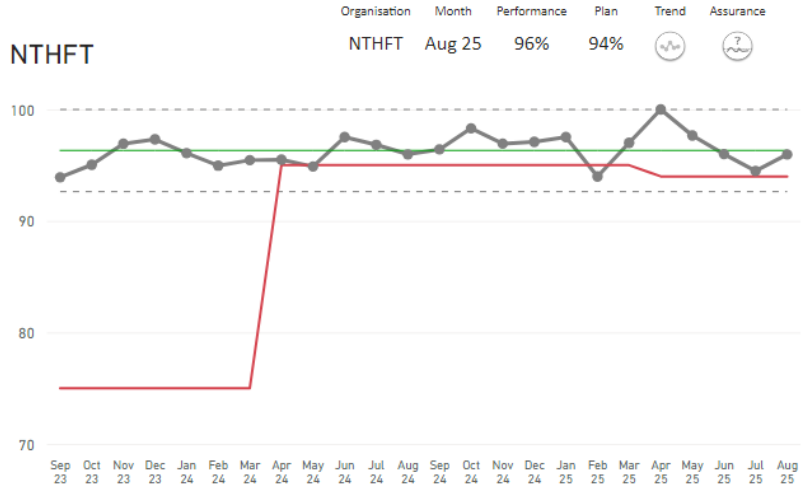


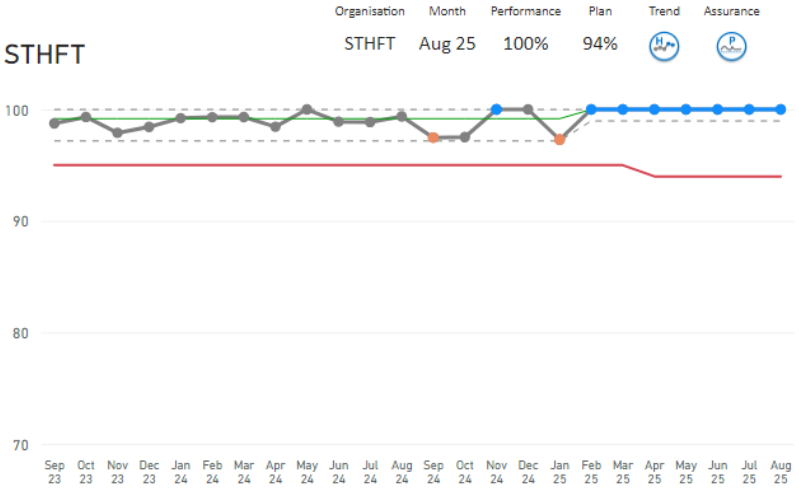


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 16%, STHFT 15%.
Trend: NTHFT: No trend. STHFT: Previous negative trend now stabilised.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: NTHFT transitioned to a new digital platform in June 2025 to improve response rates.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Community Experience (%)

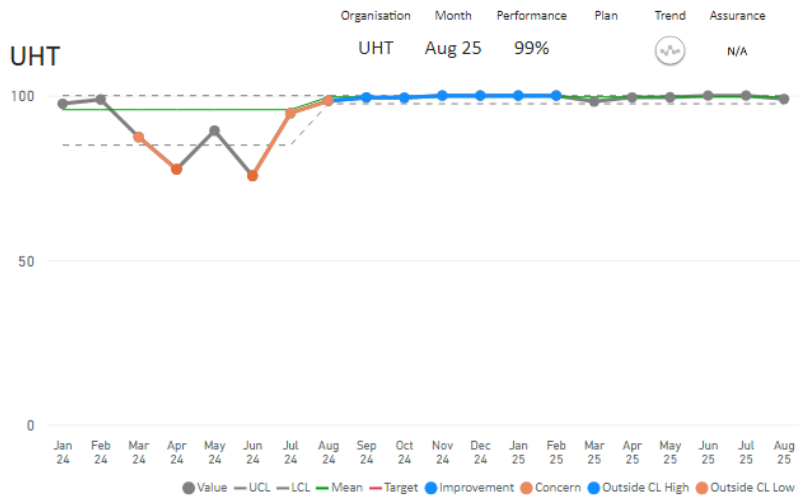




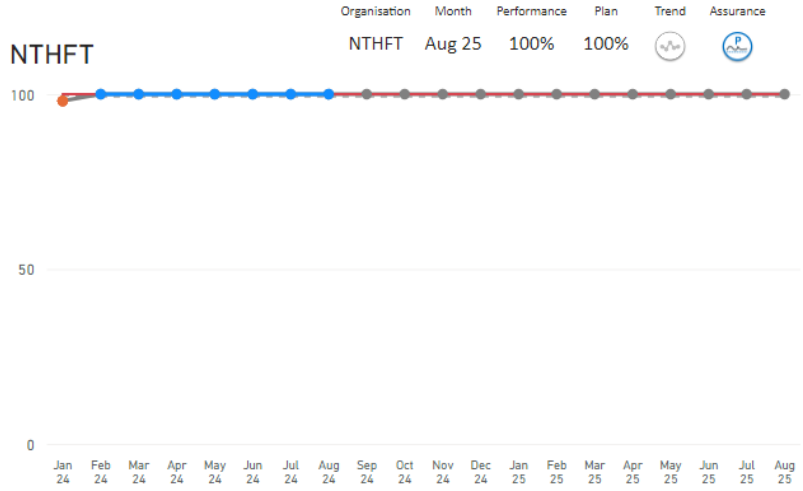


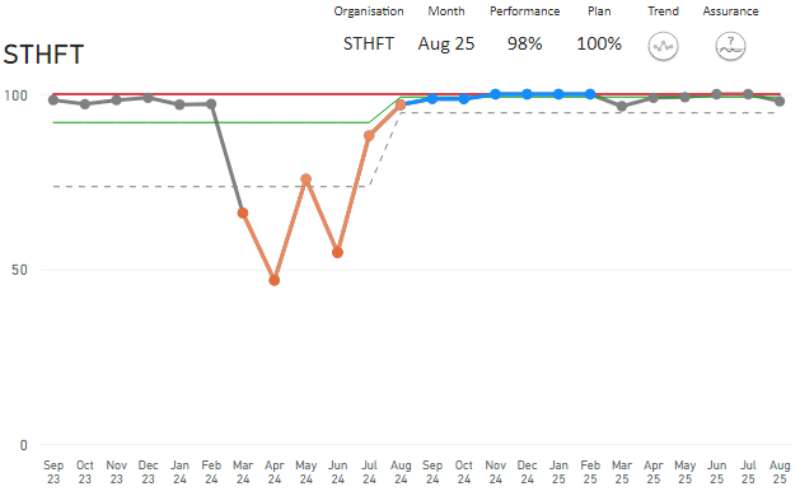
Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: 5% NTHFT, STHFT 9%.
Trend: NTHFT: No trend. STHFT: Improved trend of 7 consecutive months of 100% positive feedback.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: Further work is required at NTHFT community services 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: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: STHFT: new process for acknowledging complaints implemented in July 2024 led to improved performance which has been sustained. This is not yet statistically assured due to lower compliance March to August 2024.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



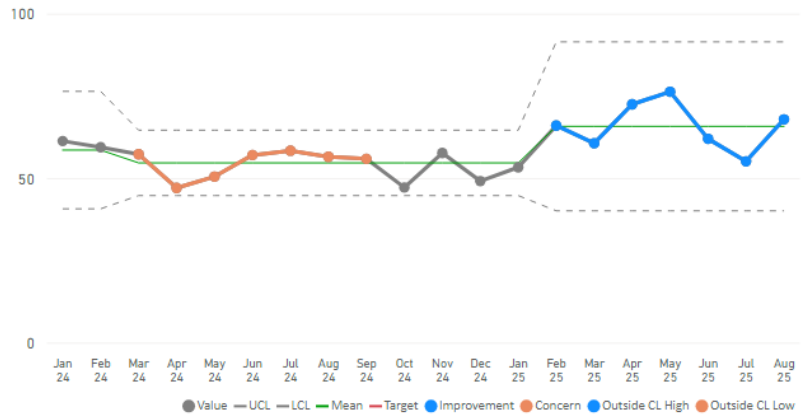


Caring Better Together

CARING Complaints Closed Within Target (%)

UHT

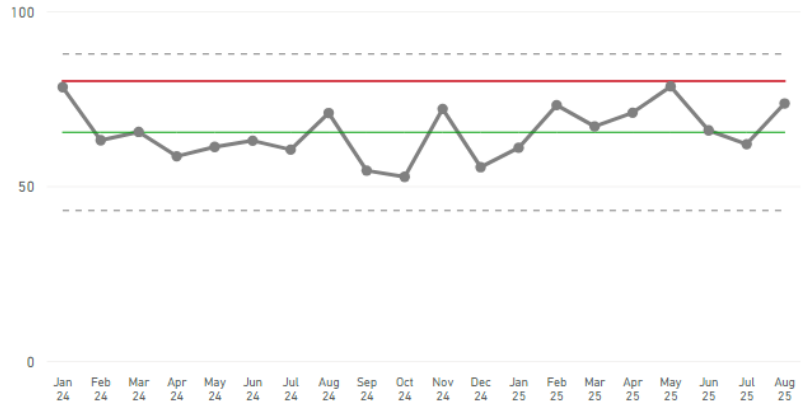
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Aug 25	67.9%			N/A



Metric: Percentage of complaints closed in agreed timeframe.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend, wide variation.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT: InPhase reporting functionality to be improved to allow increased performance monitoring within Care Groups. STHFT: off-target complaint responses continue to be reported weekly for senior focus and accountability for completing responses by Collaboratives.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

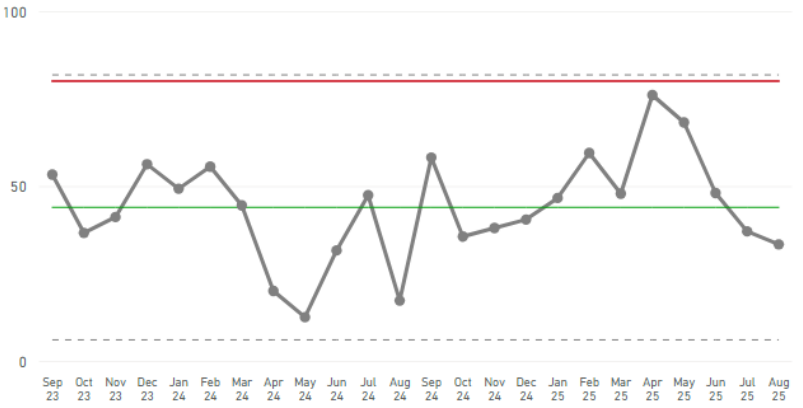
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Aug 25	73.6%	80%		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Aug 25	33.3%	80%		



WELL LED DOMAIN SUMMARY

Executive leads: Rachael Metcalf, Chief People Officer
Chris Hand, Chief Finance Officer

Accountable to: People Committee
Resources Committee

In preparation for the introduction of CSU's focus is upon producing consistent data reports to support teams to manage workforce effectively. System hierarchies across UHT will need to be reviewed and updated to reflect organisational changes and provide accurate information.

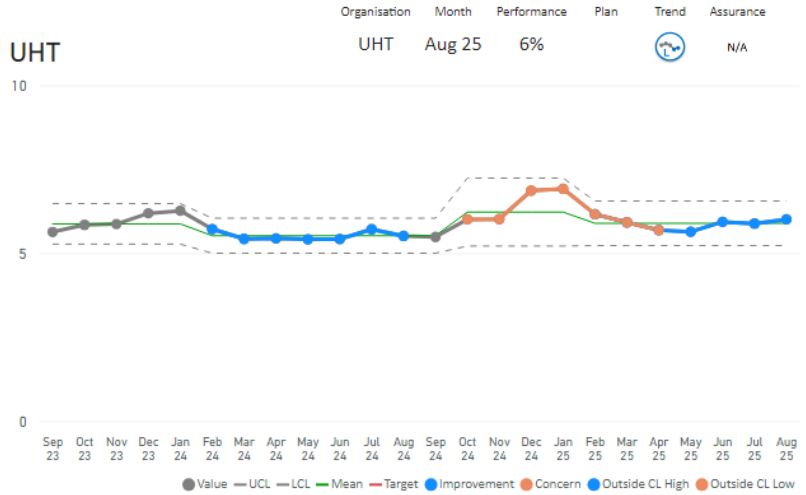
Focussed work on ensuring accurate reporting and data analysis of trends and patterns has been undertaken with additional training and development provided for managers on identifying and addressing sickness absence. Work continues to implement a standardised reporting dashboard for mandatory training across UHT.

The Board is advised that financial position shows a small positive variance to plan at the end of Month 5 (August) for both NTHFT and STHFT. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

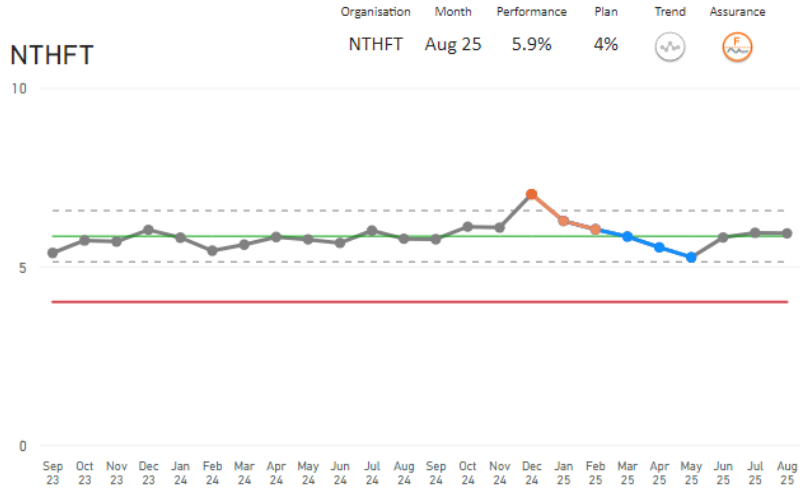
North Tees & Hartlepool NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Sickness Absence (%)	4%	5.8%	6.1%	6.1%	7%	6.3%	6%	5.8%	5.5%	5.3%	5.8%	5.9%	5.9%
Staff Turnover (%)	10%	7.3%	7.3%	7.2%	6.9%	7.1%	7%	7.2%	7.5%	7.6%	7.4%	7.4%	7.6%
Annual Appraisal (%)	85%	87.2%	86.9%	86.9%	87%	87.2%	86.6%	85.9%	86.3%	88.5%	88.5%	88.6%	87.9%
Mandatory Training (%)	90%	89.5%	89.8%	89.4%	88.9%	88.9%	88.1%	88.9%	88.7%	88.9%	89.4%	89.8%	90.2%
Cumulative YTD Financial Position (£'millions)	£0.823	-£0.861	-£1.114	-£1.289	-£1.404	-£0.994	-£0.473	£0.002	£0.117	£0.28	£0.644	£0.416	£0.833

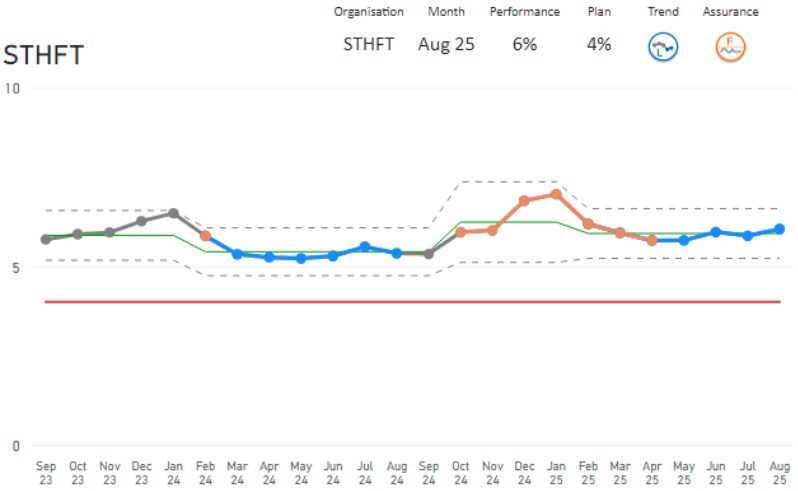
South Tees NHS FT	Plan	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Sickness Absence (%)	4%	5.3%	6%	6%	6.8%	7%	6.2%	5.9%	5.7%	5.7%	6%	5.9%	6%
Staff Turnover (%)	10%	9.8%	9.3%	6.6%	6.5%	6.6%	6.5%	6.6%	6.7%	6.6%	6.5%	6.5%	6.8%
Annual Appraisal (%)	85%	80%	78.8%	78.7%	78.8%	78.8%	80.2%	82.2%	82%	83.1%	84%	83.1%	83.5%
Mandatory Training (%)	90%	89.7%	89.2%	87.8%	87.3%	86.8%	86.7%	85.6%	85.6%	85.7%	85.7%	86.2%	85.9%
Cumulative YTD Financial Position (£'millions)	-£5.77	-£12.715	-£14.342	-£16.684	-£18.873	-£7.583	-£7.489	-£7.796	-£2.065	-£3.467	-£7.009	-£4.503	-£5.725

WELL LED Sickness Absence (%)

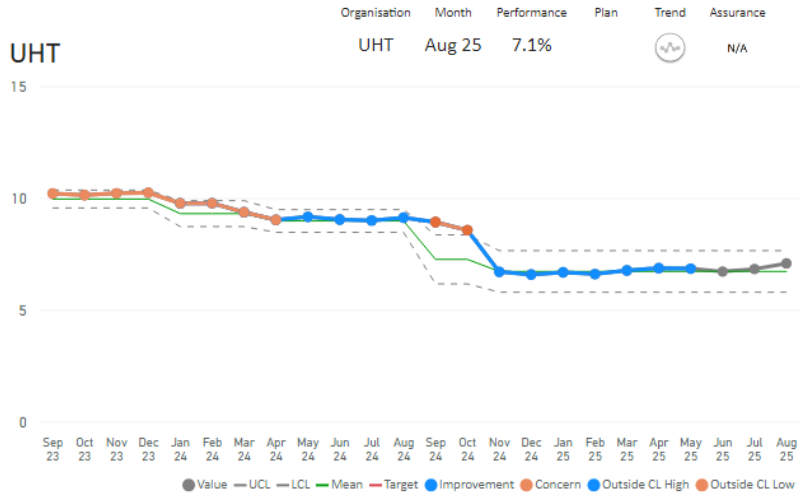


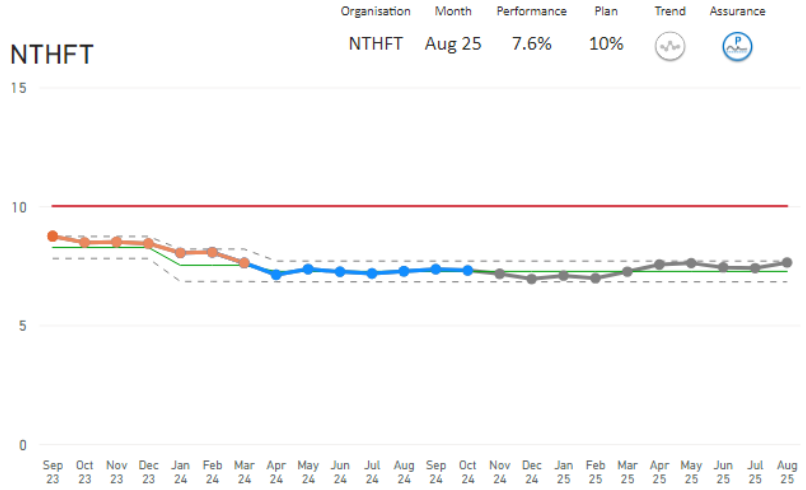
Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Improved from May 2025.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Focus on absence data to track patterns and early intervention before absence escalates. Flag high-risk absence trends and identify departments or roles with recurring short term absences and provide targeted support.
Executive lead: Chief People Officer
Accountable to: People Committee



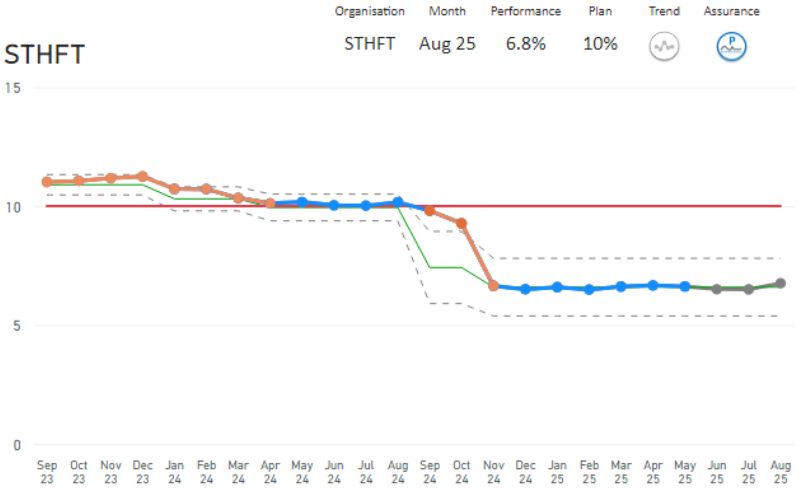


WELL LED Staff Turnover (%)

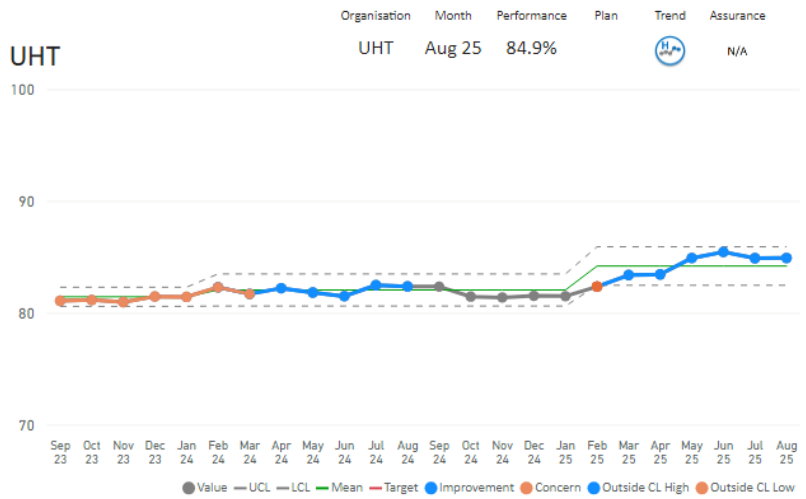




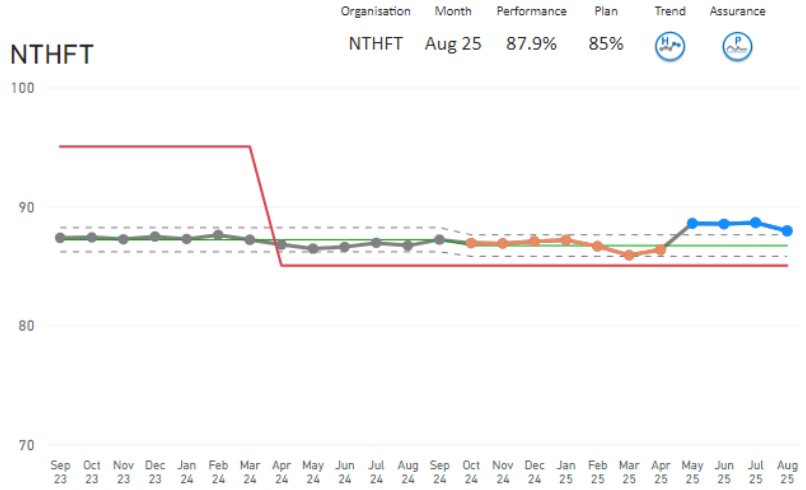
Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: NTHFT: No trend. STHFT: no trend.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Overall turnover is consistently low in both Trusts with none of the eight staffing groups being outliers. Focussed analysis of data to be undertake to identify outliers across UHT. Additional analysis will be provided to People Committee as part of the annual cycle of business in November 2025.
Executive lead: Chief People Officer
Accountable to: People Committee

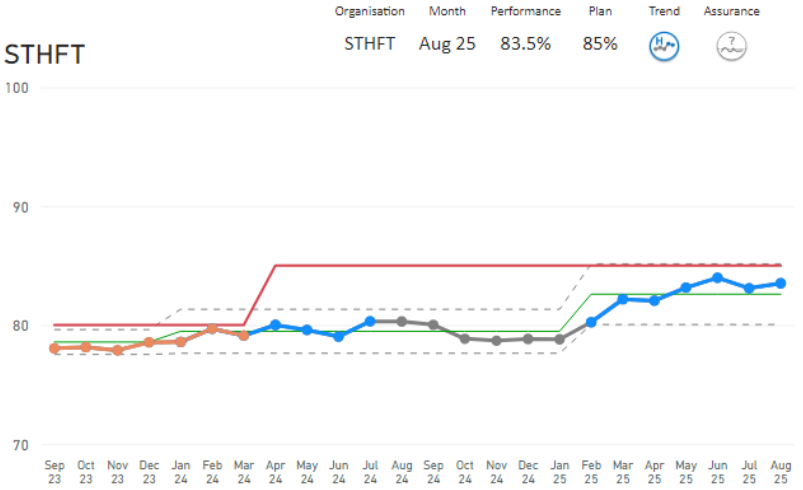


WELL LED Annual Appraisal (%)

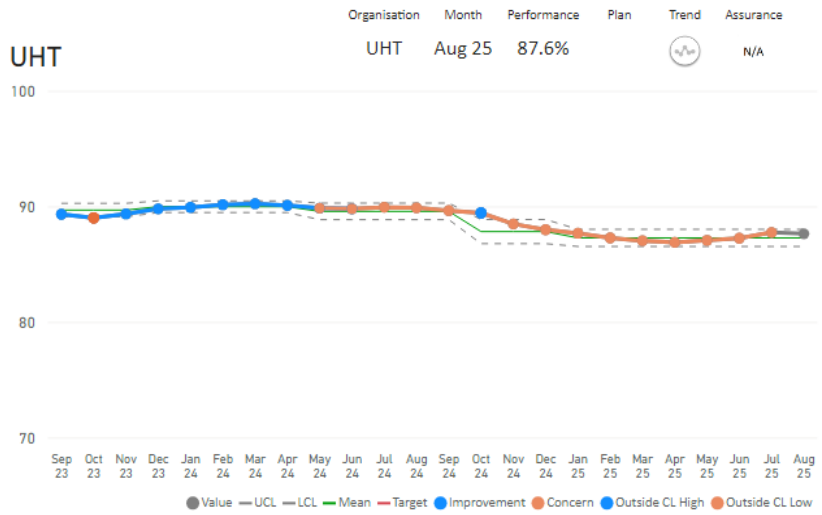


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improving, with high outliers from May 2025. STHFT: Improving since February 2025.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: The cohort of staff who are more than 6 months overdue has reduced, with additional focus in those areas that are not demonstrating improvement.
Executive lead: Chief People Officer
Accountable to: People Committee

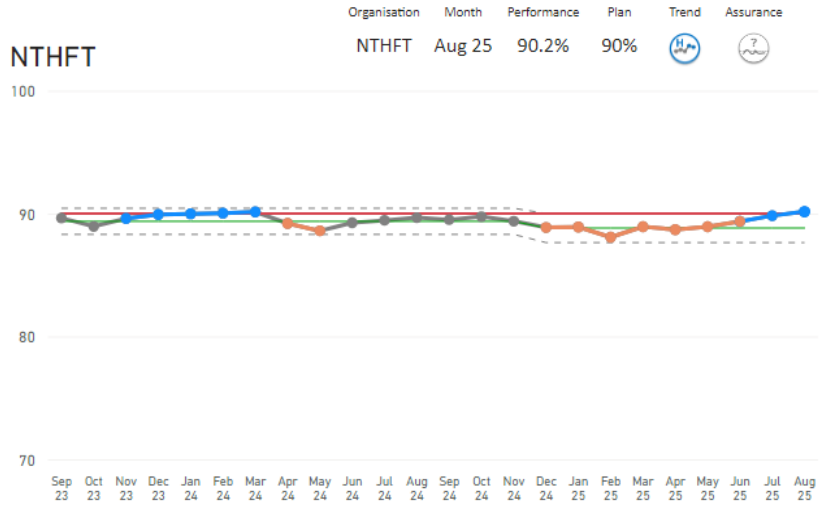


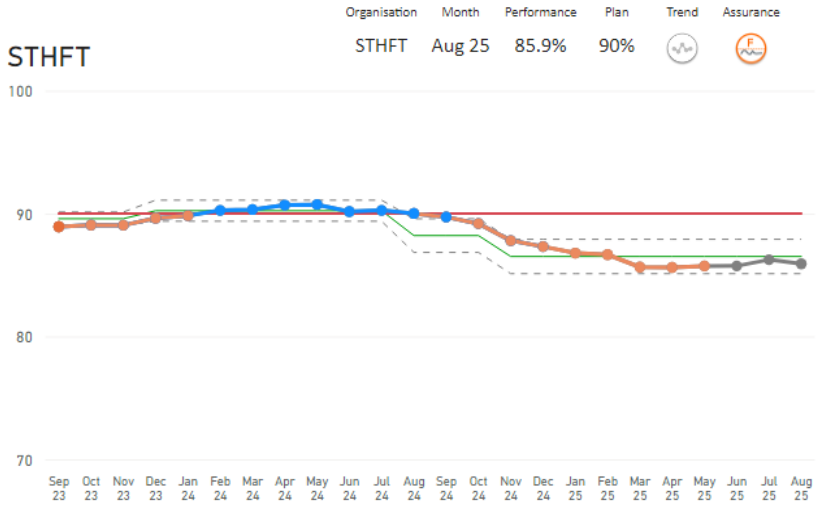


WELL LED Mandatory Training (%)

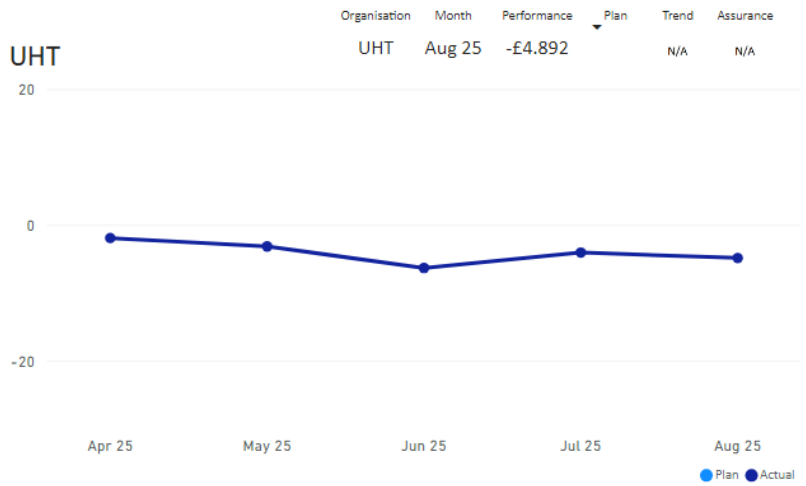


Metric: Percentage of mandatory training elements within date, across all staff groups at month end.
Plan: Trust internal plans: 90%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improving. STHFT: No trend, compliance stabilised.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Standardised reporting across UHT via new UHT dashboard developed with plans in place to align to Clinical Service Units. Work to improve Training Need Analysis allocation across topics with focus core topics. Focussed work underway across different professional groups with initial focus on medical staff. Plans underway to implement national policy in the Autumn.
Executive lead: Chief People Officer
Accountable to: People Committee

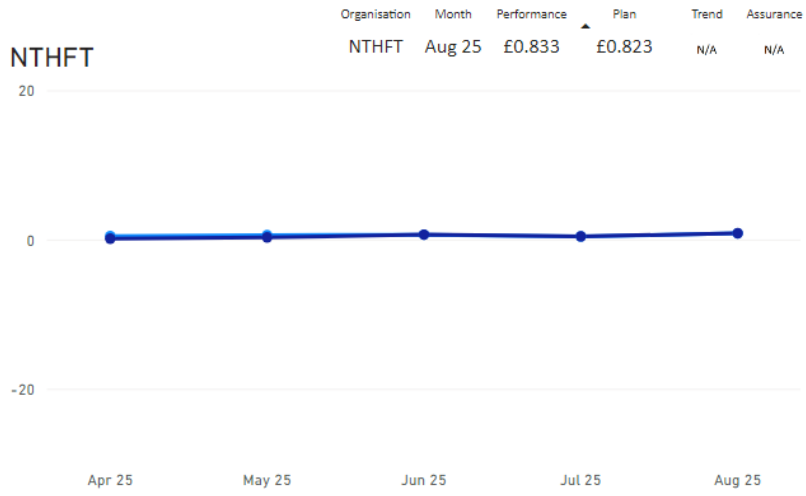


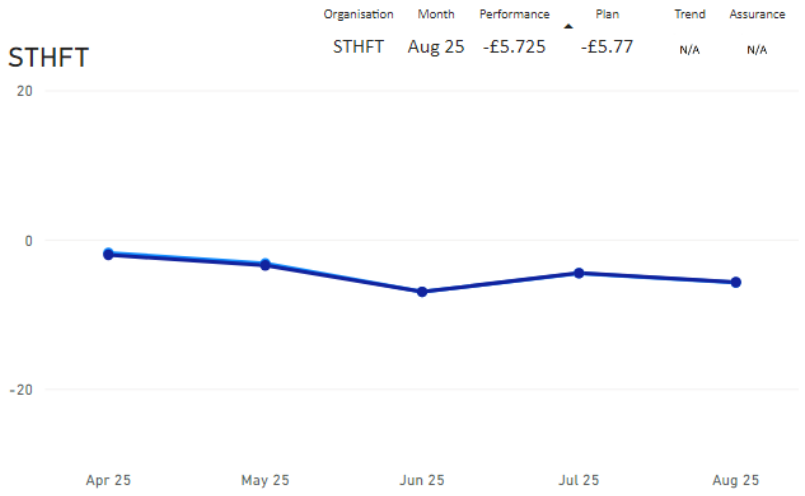


WELL LED Cumulative YTD Financial Position (£'millions)



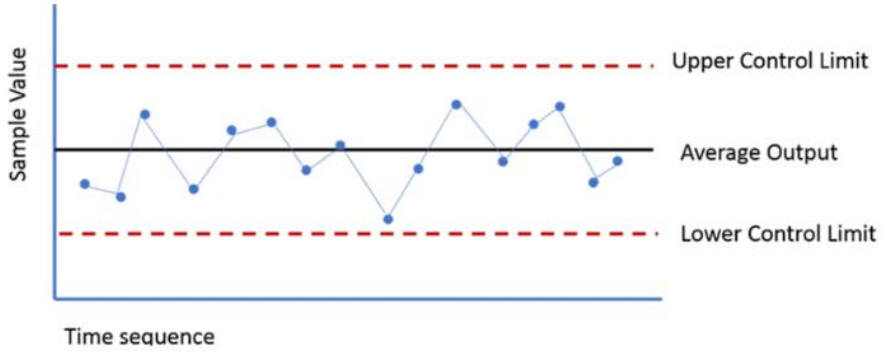
Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2025/26. The STHFT control total for 2025/26 is a £9.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: Both NTHFT and STHFT reported small positive variances to plan at Month 5.
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





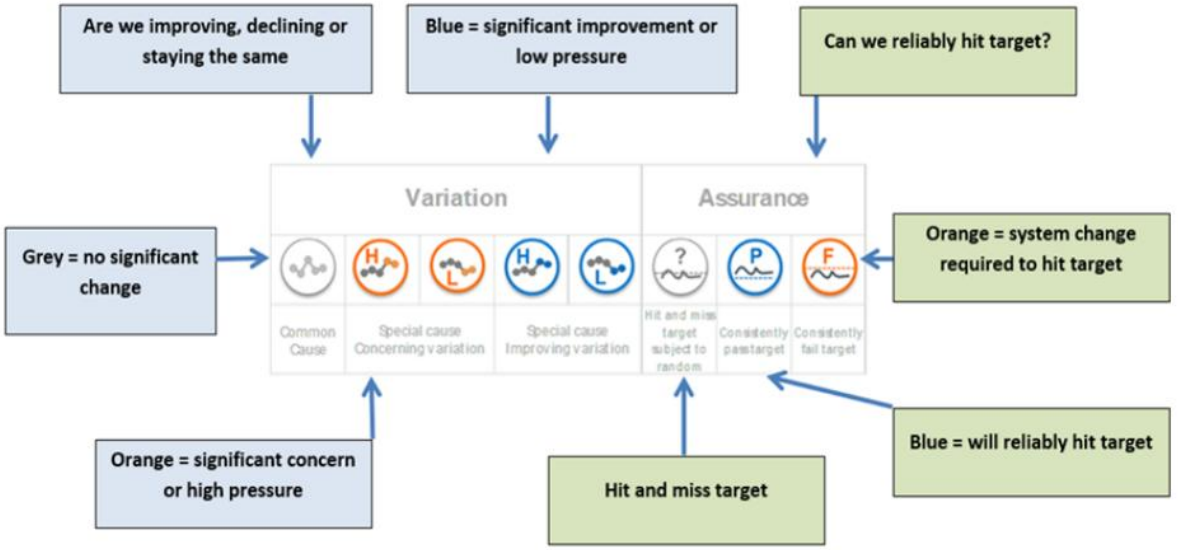
OVERVIEW SPC CHARTS

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

Academic Committee

18 September 2025

Connecting to: Group Board of Directors

Key topics discussed in the meeting:

Key agenda items discussed in the meeting included (not exhaustive);

- Board Assurance Framework (Research & Innovation)
- Research Strategy
- Innovation Strategy
- Education Plan Update
- Academic Strategy
- Annual Quality Report
- Academic Research Unit – Cardiovascular (presentation)
- GMC Survey
- University Hospitals Status
- TVRA Autumn Research Conference (Friday 19th September 2025)
- Briefing Paper – Teesside University Application (Medical School)

Actions:

- **Board Assurance Framework** (Research & Innovation) to be reviewed in light of the discussion at a recent Board meeting to reflect upon the red strategic risks and the context of the operating environment. This will be completed and presented to the next Academic Committee meeting. The likelihood is a reduction in the number of red strategic risks relating to research & Innovation (specifically the non-recurrent income).
- **Academic Strategy** was discussed along with enabling strategies for research, innovation and education. The Academic Strategy was agreed to be attached to the Escalation Report (along with the enabling strategies for research, innovation and

education to inform the overarching Academic Committee) and the Terms of Reference for Board oversight and approval.

- A University Hospitals Tees **Intellectual Property Policy** to be developed, compared with the Code of Conduct and shared with Counter Fraud colleagues prior to being finalised and approved.
- An **action plan** to evidence improvement will be developed, to address the findings in the **GMC survey** to be reviewed and action plan developed with a formal review at the Academic Committee in March 2026.
- Meeting to take place to confirm the **content of Finance reports** for future meetings, aligned to the Terms of Reference of the Academic Committee.
- Maintain ongoing evidence of the compliance across UHT with the **University Hospitals Status** (which includes the criteria for complying with Teaching Hospitals Status).
- **Annual cycle of business** to be updated and consideration of the agenda items 'for information' across other committees to ensure there is continues to be effective triangulation between committees of the Board.

Escalated items:

- Terms of Reference to be formally ratified at Board of Directors meeting.
- Academic Strategy (and enabling strategies for Research, Innovation & Education) to be formally signed off at Board of Directors meeting.

Risks (Include ID if currently on risk register):

- No new risks identified.