NHS
University Hospitals Tees

Board of Directors Meeting

Thursday, 2 July 2026, 9:45

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

Caring
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University Hospitals Tees

MEETING OF THE BOARD OF DIRECTORS
TO BE HELD IN PUBLIC
ON THURSDAY, 2 JULY 2026 AT 9:45AM
BOARDROOM, 2ND FLOOR, MURRAY BUILDING
JAMES COOK UNIVERSITY HOSPITAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
1. CHAIR'S BUSINESS					
1.1	Welcome and Introductions	Information	Chair	Verbal	9:45
1.2	Apologies for Absence	Information	Chair	Verbal	9:45
1.3	Quorum and Declarations of Interest	Information	Chair	ENC	9:45
1.4	Minutes of the last meeting held on 7 May 2026	Approval	Chair	ENC	9:45
1.5	Matters Arising and Action Log	Information	Chair	ENC	9:50
1.6	Chair's Report	Information	Chair	ENC	9:55
1.7	Chief Executive's Report	Information	Chief Executive	ENC	10:05
1.8	UHT Management Team Chairs Log: 21 May and 18 June 2026	Information	Chief Executive	ENC	10:20
1.9	Board Assurance Framework to 30 April 2026 inc: Risk Appetite 2026/27	Assurance Approval	Director of Assurance & Deputy MD	ENC	10:25
2. QUALITY AND SAFETY					
2.1	Quality Committee Chairs Log: 22 June 2026	Assurance	Chair of Committee	ENC	10:35
3. PEOPLE					

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
3.1	People Committee Chairs Log: 26 May and 23 June 2026	Assurance	Chair of Committee	ENC	10:45
3.2	Academic Committee Chairs Log: 11 June 2026	Assurance	Chair of Committee	ENC	10:55
3.3	UHT People Plan Update	Assurance	Chief People Officer	ENC	11:05
3.4	Nurse Safer Staffing Report	Assurance	Chief Nursing Officer	ENC	11:15
COMFORT BREAK 11:25 – 11:35					
4. FINANCE & PERFORMANCE					
4.1	Resources & Performance Committee Chairs Log: 27 May and 25 June 2026	Assurance	Chair of Committee	ENC	11:35
4.2	Finance Report Month 2: 2026/27	Assurance	Chief Finance Officer	ENC	11:45
4.3	Integrated Performance Report - to 30 April 2026	Assurance	Chief Delivery Officer	ENC	11:55
4.4	Annual Review of Board Committee Terms of Reference	Approval	Director of Corporate Affairs / Company Secretary	ENC	12:05
5. SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
5.1	Modern Slavery Statement 2026/27	Approval	Director of Corporate Affairs / Company Secretary	ENC	12:15
5.2	Use of Seal	Information	Director of Corporate Affairs / Company Secretary	ENC	12:20

	ITEM	PURPOSE	LEAD	FORMAT	TIME
5.3	Audit Committee Chairs Log: 21 May 2026 and EO meeting 19 June 2026	Assurance	Chair of Committee	ENC	12:25
6. NORTH TEES AND HARTLEPOOL NHS TRUST UNITARY BOARD					
6.1	Modern Slavery Statement 2026/27	Approval	Director of Corporate Affairs / Company Secretary	ENC	12:30
6.2	Use of Seal	Information	Director of Corporate Affairs / Company Secretary	ENC	12:35
6.3	Audit Committee Chairs Log: 21 May 2026 and EO meetings 19 & 25 June 2026	Assurance	Chair of Committee	ENC	12:40
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Board of Directors will take place on Thursday 3 September 2026 in the Health and Social Care Academy, University Hospital Hartlepool				

University Hospitals Tees

Register of members interests

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 1.3

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 UHT 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.

Board of Directors Register of Interests 2026/27

Board Member	Position	Relevant Dates From	to	Declaration Details
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
Celia Weldon	Non-Executive Director	February 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Non-Executive Director, Leazes Homes
			Ongoing	Member of the Karbon Group Audit and Risk Committee, Karbon Homes
Chris Day	Non-Executive Director		Ongoing	Vice Chancellor and President at Newcastle University
			Ongoing	Institutional Member at Universities UK (UUK)
			Ongoing	Board Member at The Russell Group
			Ongoing	Board Member at Sir Bobby Robson Foundation
			Ongoing	Member of N8 Research Partnership
			Ongoing	Trustee at Foundation for Liver Research
			Ongoing	Trustee at Newcastle University Development Trust
		1 July 2025	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
		April 2024	Ongoing	Representation on behalf of South Tees Hospitals NHS Trust on NTH Solutions LLP – Company Number OC419412
		June 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
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.

Board Member	Position	Relevant Dates From	to	Declaration Details
		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 Trust and Director of South Tees Hospitals NHS Trust Board
		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 OC41912
		31 March 2026	Ongoing	Director of Seaton Delaval Sports Property Limited – Company Number 17129251
Emma Nunez	Chief Nursing Officer	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	October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
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
		March 2023	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			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 Foundation Trust and Director of South Tees Hospitals NHS Foundation 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
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)

Board Member	Position	Relevant Dates From	to	Declaration Details
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 Formation (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
Michael Stewart	Chief Medical Officer	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	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops
Neil Atkinson	Managing Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		June 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
		October 2025	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
		1 November 2025	Ongoing	Trustee, Age UK
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

Board Member	Position	Relevant Dates From	to	Declaration Details
Stacey Hunter	Chief Executive	March 2024	Ongoing	Director, Health Innovation North East North Cumbria Limited
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work within organisations of the NHS
		April 2025	Ongoing	Member of UHA Executive Steering Committee (hosted by NHS Providers)
		May 2025	Ongoing	Member of NHS Confederation Acute Advisory Panel
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
		Aug 2025	Ongoing	Lead, Leadership of Planned Care, Provider Leadership Board
Steven Taylor	Director of Estates	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		1 July 2024	Ongoing	Honorary Contract as Director of Estates and Facilities for NTH Solutions LLP - Company Number OC419412
			Ongoing	Son employed by NTH Solutions LLP – ICT Project Officer/Digital Performance Coordinator
			Ongoing	Wife employed by NTH Solutions LLP – Catering Assistant
Stuart Irvine	Director of Assurance/Deputy Managing Director	2023	Ongoing	Chair – Hartlepool College of Further Education
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Trustee of Hospitals Trust of the Hartlepool
			Ongoing	Sons (x2) are employees at Hartlepool College of Further Education
			Ongoing	Wife employed by University Hospitals Tees
Russell Nightingale	Chief Delivery Officer	May 2026	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

University Hospitals Tees

DRAFT Minutes of a meeting of the University Hospitals Tees Board held in Public at 1:30pm on Thursday, 7 May 2026 in Boardroom, 4th Floor, North Wing, University Hospital North Tees

Present:
Professor Derek Bell, Chair (Chair)
Ali Wilson, Vice Chair/Non-Executive Director
Fay Scullion, Non-Executive Director
Miriam Davidson, Non-Executive Director & Maternity Champion
Celia Weldon, Non-Executive Director
David Redpath, Non-Executive Director
Ken Readshaw, Non-Executive Director / Senior Independent 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, Managing Director
Mike Stewart, Chief Medical Officer
Emma Nunez, Chief Nursing Officer & Maternity Champion
Gary Wright, Deputy Director Education & Learning on behalf of Rachael Metcalf, Chief People Officer

Directors – non-voting:
Steve Taylor, Director of Estates
Ken Anderson, Chief Information & Technology Officer
Ruth Dalton, Director of Communications
Stuart Irvine, Director of Assurance & Deputy Managing Director
Russell Nightingale, Chief Delivery Officer

In Attendance:
Sarah Hutt, Assistant Company Secretary (note taker)
Steph Worn, Director of Midwifery for items 2.2 & 2.3 only
Jules Huggan and Samantha Sinclair, FTSU Guardians for item 3.4 only
Jennie Winnard, (Shadow Board observer)
Laura Lucas-Hartley (Shadow Board observer)

GB26/021 Welcome and Introductions

The Chair welcomed members to the meeting including Russell Nightingale, newly appointed Chief Delivery Officer and the two participants of the Shadow Board programme who were attending the meeting as observers.

GB26/022 Apologies for Absence

Apologies for absence were reported from Professor Chris Day, Rachael Metcalf, Chief People Officer and Jackie White, Director of Corporate Affairs & Company Secretary.

Resolved: that, the verbal update be noted.

GB26/023 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

No perceived conflicts of interest

The Chair of the meeting referred to the Trust's declaration of interest register for board members. 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.

GB26/024 Minutes of the last meeting held on, 5 March 2026

The minutes of the last meeting held on, 5 March 2026 were accepted as a true and accurate record.

Resolved: that, the minutes of the meeting held on, 5 March 2026 be confirmed as a true and accurate record.

GB26/025 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.

GB26/026 Chair's Report

The Chair presented the Chair's Report that included national, regional and local matters and took the information as read.

- Discussions remained ongoing regarding the establishment of a Medical School at Teesside University.
- Foundation Trust Chairs Meeting on 21 April 2026 included update regarding Aubrey Report learning, well led reviews and Alliance nested collaborative.
- University Hospitals Tees (UHT) would undertake a Well Led Review in Autumn 2026.
- Extra Ordinary Council of Governors Meeting in Common on 30 April 2026 discussed the Medium-Term Plan (MTP) submission, Non-Executive Director recruitment and Lead Governor appointment process for North Tees & Hartlepool NHS Foundation Trust (NTHFT). A session on 20 May 2026 led by Christopher Akers-Belcher, Healthwatch was scheduled to discuss the national position regarding Governors and role of engagement.
- Charities of both trusts were working more closely together with a view to greater integration over time – £150k of projects had been funded to support patients and staff across UHT.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, it be noted that a UHT Well-Led review be undertaken in Autumn 2026.

GB26/027 Chief Executive's Report

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

- The organisation successfully achieved its planned financial position for 2025/26, which was a positive result. Thank you to Chris Hand, Chief Finance Officer and others involved.
- The organisation's MTP submission was approved on 17 March 2026.
- Attended regional learning event regarding the Aubrey Report with the Chair and other Directors. A Board session was scheduled on 4 June 2026 to discuss the outcome of the UHT internal True for Us Review and wider learning with invitations extended to Lead Governors, Freedom to Speak Up Guardians (FTSU) and Clinical Service Units (CSU) triumvirates to attend.

- Return to Constitutional Standards (RTCS) Capital bids (2026-2029) successfully submitted. Larger multi-year bids approved to progress to the next stage.
- Industrial Action 7 – 13 April 2026 staff worked at pace to put safe arrangements for cover in place with no patient safety concerns raised during the period. All cancer and urgent surgery activity maintained, unfortunately some elective surgery and outpatient appointments were postponed and would be rescheduled as quickly as possible.
- Work progressing with Stockton Neighbourhood Health Pilot, part of 43 national neighbourhood health pilot sites.
- NHS Leadership Event on 28 April 2026 shared priorities for 2026/27 including transforming outpatients, developing neighbourhood health and delivering convenient urgent care services for patients. Updates were also provided regarding the NHS Leadership and Management Academy and National Quality Strategy.
- Bill McCarthy appointed as Regional Chair for North East and Yorkshire.
- North East North Cumbria (NENC) Chief Executive System Leaders Meeting on 17 April 2026 set out requirement for providers and commissioners to consider developing narrative to support strategic commissioning with 4 key areas of focus. Details to be submitted to NHSE by 15 May 2026.
- Provider Capability Ratings published, both trusts rated amber-green.
- Exercise to assess compliance across UHT against recommendations in the Fuller Report parts 1 and 2 was complete including development of an action plan to achieve full compliance. The outcome of the exercise was being progressed through internal governance and assurance processes and would be presented to a future board meeting.
- University Hospital Hartlepool (UHH) hosted an Aspiring Health Care Worker event for the children and families of UHT staff, the event was well received.

Ali Wilson, Vice Chair/Non-Executive Director sought to understand whether the key elements of the National Quality Strategy had been released and was the organisation prepared. Emma Nunez, Chief Nursing Officer explained that only headline messages had been released to date. It was anticipated it would be published imminently.

Mark Dias, Non-Executive Director commended the Aspiring Health Care Workers event at Hartlepool and queried whether there were any plans to host similar events in other locations including Middlesbrough. Stacey Hunter, Chief Executive confirmed that there was wide engagement and strong links in place with schools, with the Chair adding that as an anchor organisation there were lots of initiatives that involved schools and colleges and it would be good to consider how best to capture the strands of activity being undertaken.

Resolved:

(i) that, the content of the report be noted; and

(ii) that, it be noted that a Board Development session on the learning from the Aubrey Report was taking place on 4 June 2026 with invites extended to CSUs, FTSU Guardians and Lead Governors; and

(iii) that, consideration be given how best to capture the strands of activity as an anchor organisation with external stakeholders; and

(iv) that, it be noted that the outcome of the review to assess compliance against the Fuller Reports part 1 & 2 would be presented to a future meeting.

GB26/028 Chair's Log – UHT Management Team Meeting 19 March and 23 April 2026

Stacey Hunter, Chief Executive presented the UHT Management Team Meeting Chairs Logs from meetings held on 19 March and 23 April 2026.

Ken Readshaw, Non-Executive sought assurance regarding progress to strengthen corporate data particularly workforce and performance information to inform CSU delivery. The Chief Executive noted that whilst there was some data available to the CSUs, there were issues with an aged patient administration system (PAS). Solutions were being explored and an update would be provided as part

of the wider Digital update at the Board Development session on 6 August 2026.

Resolved: (i) that, the content of the Chair's Log be noted; and
(ii) that, a progress update be provided regarding the single EPR system as part of the Digital update at the Board Development session on 6 August 2026.

GB26/029 Board Assurance Framework

Stuart Irvine, Director of Assurance & Deputy Managing Director presented the Board Assurance Framework (BAF) to the period 28 February 2026 and highlighted the key points.

For NTHFT:

- 30 strategic risks
- 9 strategic risks outside the approved risk appetite, with 6 red/high risks
- No change to risk appetite
- 86 planned mitigating actions
- 1 timescale extension request
- Planned action timescale range: December 2025 to April 2035 including eradicating RAAC by 2035.

For STHFT:

- 31 strategic risks
- 10 strategic risks outside the approved risk appetite, 7 red/high risks
- No change to risk appetite
- 88 planned mitigating actions
- 1 timescale extension request
- Planned action timescale range: December 2025 to April 2035 including PFI exit strategy by 2033 and eradicating RAAC by 2035.

As part of the BAF annual refresh, a review would be undertaken regarding the effectiveness of mitigating actions and a clear distinction between strategic and operational actions. Prior to the refresh, a session was planned as part of board development on 4 June 2026 to review and agree the risk appetite for 2026/27. The internal audit of the BAF and Risk Management processes was now complete with an expectation of positive assurance.

Ken Readshaw, Non-Executive Director highlighted the importance of agreeing the risk appetite as the organisation was operating in a high- risk environment and at present there were a number of strategic risks outside of the agreed risk appetite, this being the case for all the Quality and Safety strategic risks. It was confirmed that a BAF and risk appetite discussion was scheduled for the Board Development session on 4 June 2026 in line with the action log.

The Chief Executive agreed there was unwarranted variation and inconsistency being applied to risk scores acknowledging the influence of organisational culture and highlighted that work was ongoing with management teams to educate and ensure consistent application of the Risk Management Policy.

Ali Wilson, Non-Executive Director shared feedback from the Shadow Board's review of the BAF Report, with a number of questions posed which Stuart Irvine responded to and were noted. Many of the comments were aligned with the Board discussion.

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

GB26/030 Quality Committee Chairs Logs 23 March and 27 April 2026

Miriam Davidson, Non-Executive Director presented the Quality Committee (QAC) Chairs Log for the meeting held on 23 March 2026 and Ali Wilson, Non-Executive Director presented the Chairs Log for the meeting on 27 April 2026 highlighting the key points.

- Infection Prevention Control (IPC) BAF and Integrated Performance Report (IPR) were reviewed as a source of internal assurance, assessing against the National IPC Control Manual (NIPCM). Actions were in progress to address gaps in compliance. IPC remained a concern and was a regular agenda item for discussion, noting a Board development session was scheduled for 4 June 2026 in line with the action log.
- The Quarter 4: 2025/26 Maternity Reports were presented, which were on the Board agenda for the meeting today both in public and in committee.
- Readmissions Rate Report set out benchmarking data for emergency readmissions within 30 days was considered with NTHFT improving and STHFT relatively static.
- As part of the Annual Effectiveness Review of the Committee, the Terms of Reference (ToR) had been met and the Cycle of Business appropriate. Consideration would be given to the sub-Committee structure.

Following a query by Celia Weldon, Non-Executive Director regarding the relationship between readmissions and length of stay, it was noted that targeted work was underway to address outliers and potential patient harm. A readmission outliers report was being reviewed by the CSUs and would feed into the Clinical Effectiveness Group. It was recognised that not all readmissions were inappropriate.

- National alert had been issued regarding system C (Badgernet), which was being proactively managed internally.
- The PSII system continued to be embedded across the organisation, however, timescales for completion were impacting on patient experience and the implementation of learning. Work was underway to expedite the completion of the most long-standing incident reports.
- Four never events were reported during the Quarter, with assurance provided that work continues to embed learning from the incidents.
- Required actions in relation to the UKAS accreditation in Pathology were complete. It was noted that sickness absence had improved significantly, which was positive. The re-accreditation for STHFT was anticipated to be in September 2026.
- Following the development of a UHT Complaints Policy, significant training and development was taking place with an initial improvement in the quality and timeliness of complaint responses being seen.
- Despite increased focus, a number of Healthcare Acquired Infections (HCAIs) were reporting above trajectory including an outbreak of MRSA in the Neonatal Unit at JCUH with a number of cots initially closed, noting that the cots had subsequently re-opened. Although antimicrobial stewardship remained a high priority, attempts to recruit a medical lead had been unsuccessful. It was noted that UHT was working with independent global consultants from the World Health Organisation (WHO) regarding IPC improvement, facilitated by the NENC ICB.
- Implementation of the Healthcare Guardian system in STHFT had temporarily negatively impacted on reporting, however this had now improved.
- The first combined UHT draft Quality Accounts were presented, with some excellent examples of achievements during 2025/26. It was noted that a more accessible summary document would be produced.
- The Maternity Incentive Scheme (MIS) Year 8 scheme would focus on six core safety actions. It was noted that for the Year 7 scheme, NTHFT had achieved full compliance and STHFT had achieved 9 out of the 10 safety action, which potentially carried a financial penalty, however, an application for discretionary funds has been submitted to NHS Resolution.

Emma Nunez, Chief Nursing Officer highlighted that as part of the IPC session with the Board on 4 June 2026 national context would be applied, sharing some useful information following a call the previous evening with Professor Sir Chris Whitty, Chief Medical Officer for England.

The Chair observed that from a complaints perspective, the IPR data did not provide assurance regarding progress, however, accepting there was a time-lag in reporting so no step change was evident. The Chief Nursing Officer confirmed work was ongoing and moving to the new system would improve processes, although recognising it would take time to embed.

The Chief Executive reported that some of the complaints' responses were very delayed, with the issue often being ownership from the service areas and not the Patient Experience team who in some cases were chasing leadership teams multiple times. It was recognised that there was a patient at the end of the process and timeliness at all stages of the process was important.

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

GB26/031 Perinatal Quality and Safety Report Quarter 4: 2025/26

Steph Worn, Director of Midwifery presented the Perinatal Quality and Safety Report Quarter 4: 2025/26 and highlighted the key points.

The results of the MIS Year 7 had been published with NTHFT achieving all ten safety actions and STHFT achieving nine, an action plan was put in place and completed. Monthly progress including training compliance was provided monthly to Quality Committee, with no escalation of concerns reported. The MIS Year 8 scheme would include six key safety actions with a stronger focus on outcomes for women, babies and the workforce with Trust Board oversight and accountability. Monthly progress reports were facilitated via the governance route of the MIS compliance meeting, Perinatal Leadership Team meeting, Maternity and Neonatal Safety Champions meeting, Perinatal Oversight Group, CSU 1 Board, Quality Committee and Board of Directors.

External assurance by NHSE was positive in relation to STHFT's progress against the Maternity and Neonatal Improvement Support Team (MNIST) framework with no escalations raised. The Perinatal Leadership Team had benchmarked against the national roles and descriptors, and expectations; meeting the requirements as approved by the MNIST improvement advisors. Strong engagement continued with the board safety champions at bi-monthly meetings and engagement sessions.

Community Services across UHT were implementing workforce remodelling to support future service delivery, with staff consultation forming a key component of the approach. The services at each trust were working through mitigations and actions in place following notification that primary care would cease prescribing all maternity related requirements. The estates constraints and increase in demand for caesarean births were being actively reviewed as part of future service delivery.

Miriam Davidson, Non-Executive Director, highlighted that theatre capacity was under pressure due to increased demand for caesarean births and queried the timescale of community remodelling. The Director of Midwifery confirmed that the case for change was expected as part of staff side process and population engagement. It was agreed to provide an update at the next meeting.

Following a query by Stacey Hunter, Chief Executive regarding the revised business case for elective caesareans, it was agreed to provide an update regarding the timelines and addressing the clinical concerns and theatre capacity issues. This would be managed through the CSUs and presented to the UHT Management Team.

Emma Nunez, Chief Nursing Officer highlighted the national alert in respect of System C (Badgernet), which was an auto-population error and had required significant manual reviews of records.

Mike Stewart, Chief Medical Officer reported on a national call, in respect of service models for home births where learning from the tragic events in Manchester had been shared. The Director of Midwifery reported that the number of home births in the organisation were low and there were a number of factors to consider regarding workforce sustainability and geographical footprint. A lengthy discussion ensued regarding the model for a homebirth service noting the national focus and importance to adopt guidance and apply learning.

It was agreed that the sustainability and safety of the home birth service model be reviewed in light of the national learning, considering whether to move to a single service or alternative staffing model for UHT.

The Chair queried whether the improvement projects in relation to Avoiding Term Admissions into Neonatal Unit (ATAIN) Rates undertaken were nationally prescribed or locally derived. It was confirmed they were chosen locally based on themes where a difference could be made. The Chair noted that progress appeared limited for at least one of the projects.

Emma Nunez, Chief Nursing Officer highlighted that neonatal and maternity capital bids had not been part of the bid successes reported earlier but highlighted that the reported issues in relation to HCAI within Neonatal services were impacted by the restraints of the Estate, which was an ongoing problem and the service was not currently meeting national guidance. It was agreed to undertake a rapid risk assessment of the neonatal estate, focusing on cot numbers and spacing to identify any changes that can be made, pending further progression of the larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session. Arrangements to be progressed through the CSUs and UHT Management Team.

The Chief Executive shared some recognition from the national team regarding the leadership of the Director of Midwifery, which good to note and thanked her.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the sustainability and safety of the home birth service model be reviewed in light of the national learning, considering whether to move to a single service or alternative staffing model for UHT; and
(iii) that, an update regarding the revised business case for elective caesareans with timelines and addressing the clinical concerns and theatre capacity issues be managed through the CSUs and presented to the UHT Management Team and an update to be provided at the next Board meeting; and
(iv) that, a rapid risk assessment be undertaken of the neonatal estate to identify any changes that can be made, pending larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session.

GB26/032 Perinatal Staffing Report Quarter 4: 2025/26

Steph Worn, Director of Midwifery presented the Perinatal Staffing Report Quarter 4: 2025/26 and highlighted the key points.

The midwifery staffing establishment was compliant with BirthRate+ across the organisation, and a new assessment had been completed. This would be brought for Board consideration and approval of the recommendations. Midwifery red flags were monitored monthly and reported to the Quality Committee via the PQOM report, with no concerns or escalations for the reported quarter. For Obstetric staffing, the full required establishment at Consultant level was being met in the Service with any rota gaps being escalated and actively managed and it was expected to recruit to the Obstetric gap at NTHFT. Obstetric medical lead posts had been advertised adopting a UHT approach where appropriate.

Obstetric Anaesthetic 24/7hr cover was provided, evidenced through rotas. Neonatal staffing continued to be monitored in line with BAPM guidance, and a refreshed workforce review would be provided in Quarter 1: 2026/27.

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

GB26/033 People Committee Chairs Logs 24 March and 28 April 2026

Mark Dias, Non-Executive Director presented the People Committee Chairs Logs for the meetings held on 24 March and 28 April 2026 and took the report as read.

Alert items

- A 12-week vacancy freeze had commenced, with the exception of safety-critical posts. Triangulation work remained ongoing with Resources Committee regarding managing whole-time equivalents (WTE).
- Assurance continued to be sought regarding the pace and order of workforce reduction plans, noting the earlier discussion in private board.
- Sickness absence remained above plan at 6.5% across the organisation, further assurance was required regarding reducing sickness absence by 1% reduction which had not been achieved in 2025/26, noting the impact on achievement of the financial plan and sustainability. However, progress in managing long-term sickness absence through capability processes was noted.
- Appraisal compliance remained below the 85% target and a deep dive was undertaken by the Committee in April. It was noted that the momentum gained the previous year had not continued. An update had been requested for 3 months' time to gain assurance around actions undertaken and the continued support of the Board was requested.
- UHT had been awarded Ambassador Status for health and wellbeing at work services and was recognised as an Employer of Choice for Menopause Support, which reflected strong organisational commitment.

The Chair referenced it had been reported earlier that sickness absence had improved in Pathology and sought to understand whether there was any learning that could be applied across the wider organisation. It was noted that progress had been in relation to isolated underlying challenges, with investment in specific areas, however, concern remained about overall progress within the Service.

A wider discussion ensued regarding the management of sickness absence acknowledging the amount of work undertaken and a focus going forward to ensure consistent application of the new single Attendance Management Policy which was being implemented. People Business Partners would support line managers to manage processes. As part of the policy to manage long-term sickness absence assessment of capability were being undertaken through final review meetings with staff exiting the organisation on ground of ill-health dismissal. The People Committee would continue to have oversight and escalate to Board as appropriate through the Chairs Logs.

In respect of appraisals, it was recognised sustained improvement was required and the embedding of appraisal as standard practice.

Resolved: that, the content of the report be noted; and

GB26/034 Academic Committee Chairs Log 19 March 2026

Mike Stewart, Chief Medical Officer presented the Academic Committee Chairs Log for the meeting held on 19 March 2026 and highlighted the key points.

- Recruitment of an Innovation Manager was supported by the Committee, however, approval by the Vacancy Control Panel remained pending, impacting on the implementation of the Innovation Strategy. It was expected that a new manager would drive progress and support the function to become self-sustaining through funding and income streams.
- A new senior clinical leadership and research structure had been established across UHT and in order to create clear distinction between internal work and that of the wider work undertaken by the Tees Valley Research Alliance (TVRA), approval was sought for 'UHT Research' to be the name for all internal research activity, which was supported by the Committee and agreed by the Board.
- Education and Learning Annual Report 2025/26 provided assurance around educational workforce planning and governance, with ongoing work to clarify the use of educational tariffs and apprenticeship levy funds aligned to clinical priorities.
- Clinical Effectiveness Review of the Committee in shadow form highlighted the terms of reference had been met and most objectives had been achieved, recommending the Committee be established as a permanent committee of the Board, with a future focus on research and education metrics including finance and strategy progress. Information was being collated regarding the overall income and expenditure for research, innovation and education activities, which would be reported at a future meeting.

It was agreed to establish the Academic Committee as a permanent Committee of the Board.

Resolved: that, the content of the Chair's Log be noted;
that, the name 'UHT Research' to support all internal research activity be agreed; and
that, the Academic Committee was confirmed as a permanent committee of the Board, supporting national guidance.

GB26/035 NHS Staff Survey Overview 2025

Gary Wright, Deputy Education and Learning presented the NHS Staff Survey Overview 2025 highlighting the key points and taking the report as read.

The results of the survey provided critical insight into staff experience in the reporting period due to significant organisational change and sustained operational pressure. The overall combined response rate for UHT was 33%, noting a 3% decline for NTHFT aligning with the national trend and a sustained response rate of 29% for STHFT, which was one of the lowest scores nationally. There was an overall downward trend across the themes, including a reduction in the levels of morale, staff engagement and recommending the organisation as a place to work, which was disappointing. However, there were some cultural strengths highlighted including diversity and equality, scoring above the national average which could be built upon.

The next steps were outlined including developing targeted action plans with CSUs and department managers. Focused team engagement surveys would also be undertaken with the lowest scoring departments.

A substantial discussion ensued regarding the stark survey results with the Board expressing significant concern and highlighting perceived complacency around the declining trend. There was a shared view around the requirement for urgent, focused action including wider cultural interventions and linking the survey to other cultural indicators such as appraisals, sickness and mandatory training using continuous improvement (CI) methods and more frequent pulse surveys to monitor progress.

It was agreed that a comprehensive update regarding actions being taken be presented to People Committee in June and then reported to Board in July.

Ali Wilson, Non-Executive Director shared feedback from the Shadow Board with a number of interesting observations made regarding the report and survey results.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a comprehensive update regarding actions being taken to address the poor results of the 2025 staff survey and issues raised be presented to People Committee in June and then to Board in July.

GB26/036 Freedom to Speak Up End of Year Report: 2025/26

Jules Huggan and Samantha Sinclair, Freedom to Speak Up Guardians presented the Freedom to Speak Up End of Year Report 2025/26 and highlighted the key points.

- There was a 12.9% increase in number of concerns reported, with in appropriate attitudes and behaviours the most reported theme, although a decrease in reporting during Quarters 3 & 4 anticipated due to establishment of CSUs and operational pressures;
- Anonymous reporting had decreased, attributed to improved systems and promotional work;
- Largest reporting staff group nurses and midwives;
- Reporting of concerns would be aligned to Healthcare Guardian in future;
- National Guardians Office (NGO) set to close 30 June 2026. NHSE England published revised responsibilities, planned engagement sessions with Executives in May;
- Sexual Harassment became a protected disclosure from 6 April 2026;

- FTSU Champion Networks aligned as UHT and FTSU office now established at FHN.

Work was ongoing to improve follow-up and feedback to staff who raise concerns, with collaboration between patient safety and FTSU teams. The importance of triangulating staff survey data and integrating learning into organisational support was emphasised.

The Board were asked to support the completion of the FTSU Reflection and Planning Tool, to help set the strategic and operational direction of the FTSU Service across the organisation.

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

GB26/037 Nurse Safer Staffing Report

Emma Nunez, Chief Nursing Officer presented the Monthly Nurse Safer Staffing Report for the period February 2026 and highlighted the key points, taking the report as read.

Work continued to align reporting methods and processes across the organisation in relation to safe staffing. The report would continue to develop to be able to provide continued assurance that the right skills were in the right place to provide safe, sustainable and productive staffing.

Registered sickness at STHFT had increased marginally by 0.1% to 7.10%. The areas with the largest variation between actual and required CHPPD were outlined, showing potential misalignment between staffing and patient acuity. The Band 3 HCSW vacancy position at NTHFT remained a concern, increasing from 46.24 WTE in January to 52.5 WTE in February, with a forecast position of 56.3 WTE for March 2026. The Band 2-3 pipeline programme remained in place at NTHFT supporting trainee HCSWs to achieve the required competencies through a 12-month fixed term post, however, the programme could not sustain the rising vacancy position each month. Following a Band 3 HCSW advert, 45 people had been shortlisted and were pending interview.

Ali Wilson, Non-Executive Director shared feedback and a number of questions from the Shadow Board regarding the report, which the Chief Nursing Officer responded to.

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

GB26/038 Resources Committee Chairs Logs 25 March and 29 April 2026

Celia Weldon, Non-Executive Director presented the Chairs Log for the meetings held on 25 March and 29 April 2026 and highlighted the key points, noting some of the items had already been discussed earlier in the agenda:

- Plans for deep dives around performance metrics and improvement actions in the Alert category.
- Productivity Report – lower quartile performance in a number of operational productivity measures was reported, noting further improvement in productivity along with new approaches to demand management and waiting list management would be essential to support achievement of agreed performance plans within the resources available.
- Finance - achievement of the financial plan for 2025/26 was commended, however, noting the challenging plan for 2026/27.
- The CIP programme achieved target for 2025/26.
- Effectiveness Review of Committee – met the Terms of Reference and Cycle of Business, consistency of sub-Committee reporting would be reviewed and deep dives into Productivity and Estates were identified as priorities, requesting to take place at the May or June meeting.
- Proposed name change of the Committee to Resources and Performance, which was approved by the Board.
- Positive update regarding the Northern and Yorkshire Apprentice Assessment Centre (NYAC) progressing its main provider application, supporting the ‘grown your own’ philosophy to develop young local talent for Estates.
- Touched on cyber risk rating following the development session in April.

Russ Nightingale, Chief Operating Officer highlighted the disparity in performance against the cancer metrics, with the 28-day faster diagnosis standard reporting strong performance but the 62-day standard reporting non-compliance, which was an unusual position. Stacey Hunter, Chief Executive explained that the Alert, Assure & Advise reporting was improving however, the supporting 'so what' element was lacking and cited a complacency in respect of improving performance, which prompted broader discussion including use of data and actionable outcomes.

Resolved: (i) that, the content of the Chairs' Logs be noted; and
(ii) that, the proposed name change to Resources and Performance Committee be approved.

GB26/039 Finance Report: Month 12, 2025/26

Chris Hand, Chief Finance Officer presented the Finance Report for Month 12: 2025/26 and highlighted the key issues.

The organisation achieved the control total of a deficit control total of £9.1m for 2025/26 reporting a year-to-date favourable variance of £8.2m. This largely related to the decision by NHSE to redistribute Deficit Support Funding (DSF). A workforce reduction of 1.77% was achieved.

Reductions in premium pay expenditure continued, with Agency spend £2.2m (24%) and Bank spend £3.5m (10% less) than the same period the previous year. WTEs worked increased in Month 12 compared to Month 11, however, compared to the same period the previous year was lower by 274.61 WTE.

Across the organisation, the full allocation of Capital was utilised, which was positive reporting expenditure at Month 12 of £98.9m.

The cash balance at Month 12 was £144.4m, which was positive and demonstrated good compliance with the Better Payment Practice Code.

Ali Wilson, Non-Executive Director shared feedback and a number of questions from the Shadow Board regarding the report, which the Chief Executive responded to.

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

GB26/040 Integrated Performance Report

Neil Atkinson, Managing Director presented the Integrated Performance Report (IPR) for the reporting period to 28 February 2026 and highlighted the key points, noting there had been discussion earlier in the meeting regarding future format of the IPR and some of the metrics.

In respect of items in the Alert category

- Nine metrics remained for NTHFT including E. coli infections, MSSA infections, Klebsiella infections, Readmission rate, 12-Hour ED Breaches, Cancer 62 Day Standard, RTT Incomplete Pathways, RTT time to first appointment and Sickness Absence.
- In addition, the following metrics were regraded from Advise to Alert:
  - Breast feeding at first feed. Collaboration between NTHFT and STHFT continues to support an increase in breast feeding.
  - Cancer Faster Diagnosis
  - RTT 52 Week Waiters
  - Ambulance Handovers within 45 Minutes
  - 4-hour A&E Standard

- Eleven metrics remained for STHFT including Never Events, Klebsiella infections, Pseudomonas infections, Breast feeding at first feed, Still birth rate rolling 12 months per 1,000 births, Diagnostic 6-week standard, RTT time to first appointment, Cancer 31 Day Standard, Sickness Absence,

Mandatory Training and Annual Appraisal.

- In addition, the following metrics were regraded from Advise to Alert:
  - MRSA infections
  - Neonatal Mortality Rate
  - Inpatient Experience
  - Community UCR 2 Hour Response

Positive feedback was noted regarding the latest Quality Performance Review (QPR) meetings with the CSUs.

The Chair referenced performance against the HAI and Cancer metrics, noting that the planned Board Development session on 4 June would cover IPC and suggested an update be brought to the July meeting in respect of the variation in Cancer metrics performance. The Chair sought to understand what impact the increased referrals to the breast pathway were having. It was noted there was an ongoing significant impact and CSUs had been asked to develop a business regarding capacity on a substantive basis. There was work on-going to increase radiology capacity, including breast services.

Resolved: (i) that, the content of the report be noted; and
(ii) that, an update be brought to the next meeting regarding a review of performance against 28 days and 62 days cancer targets.

GB26/041 Fit and Proper Person Framework Report 2025/26

Stuart Irvine, Director of Assurance & Deputy Managing Director presented the Fit and Proper Person (FPP) Framework Report 2025/26 reporting there were no issues to alert the Board to.

The annual review confirmed all Board members met the fit and proper person requirements, with oversight of the exercise by the Nominations and Remuneration Committee, with an independent validation of outcomes.

The Chair would formally sign off the return to NHSE to confirm the outcome of the 2025/26 annual FPP exercise within the agreed timescales, which was agreed.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Chair formally sign off the return to NHSE to confirm the outcome of the 2025/26 annual FPP exercise within the agreed timescales.

South Tees Hospital NHS Trust Unitary Board

GB26/042 Going Concern Annual Accounts 2025/26

Chris Hand, Chief Finance Officer presented the Going Concern Annual Accounts 2025/26 Report, highlighting it was a requirement for the Board to agree to declare that the annual accounts were prepared on a going concern basis, which was agreed.

Resolved: (i) that, the content of the report be noted; and
(ii) that, it was agreed that the Annual Accounts 2025/26 be prepared on a Going Concern basis for STHFT.

GB26/043 Audit & Risk Committee Chairs Log: 19 March 2026

Ken Readshaw, Non-Executive Director presented the Audit and Risk Committee Chairs Log for the meeting held on 19 March 2026, highlighting there were no alerts or issues to report, with a number of items already discussed earlier in the meeting, demonstrating good triangulation.

Resolved: that, the content of the Chairs Log be noted.

GB26/044 Audit & Risk Committee and Audit Committee in Common Chairs Logs: 19 March and 24 March 2026

No additional alerts or issues to report.

Resolved: that, the content of the Chairs' Logs be noted; and

North Tees and Hartlepool NHS Trust Unitary Board

GB26/045 Going Concern Annual Accounts 2025/26

Chris Hand, Chief Finance Officer presented the Going Concern Annual Accounts 2025/26 Report, highlighting it was a requirement for the Board to agree to declare that the annual accounts were prepared on a going concern basis, which was agreed.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, it was agreed that the Annual Accounts 2025/26 be prepared on a Going Concern basis for NTHFT.

GB26/046 Audit Committee Chairs Log: 19 March 2026

Ken Readshaw, Non-Executive Director presented the Audit Committee Chairs Log from the meeting held on 19 March 2026 and highlighted there were no additional alerts or issues to report.

Resolved: that, the content of the Chairs Log be noted.

GB26/047 Audit & Risk Committee and Audit Committee in Common Chairs Logs: 19 March and 24 March 2026

No additional alerts or issues to report.

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

GB26/048 Any Other Business

The Chair sought the views of members to confirm whether the challenges being faced around the financial plan, estates and clinical services had been adequately explored and triangulated during the meeting requesting any specific comments to be made directly.

Stacey Hunter, Chief Executive highlighted that it had been agreed to schedule a future Board Development session regarding significant transactions and contract strategies, in line with improvement plans linked to the Aubrey Report. Matt Neligan, Deputy Chief Executive & Chief Strategy Officer would lead.

The Chair reported that a recruitment exercise had commenced to fill the vacant Non-Executive Director posts.

Reflections regarding the Shadow Board outlined that a smaller number of papers be considered for future meetings and the mechanism for feedback at the Board.

Resolved:
(i) that, a smaller number of papers be chosen to be reviewed as part of future Shadow Board meetings and the mechanism for feedback at the Board; and
(ii) that, it be noted a Board Development session to be scheduled regarding significant transactions and contract strategies led by the Deputy Chief Executive & Chief Strategy Officer; and
(iii) that, it be noted a recruitment exercise had commenced to fill the vacant Non-Executive Director posts.

GB26/049 Date of Next Meeting

The next meeting of the Board of Directors will take place on Thursday 2 July 2026 in the Boardroom, University Hospital North Tees.

Meeting closed: 4.30pm

Signed: Date:

Board of Directors Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes	Action delegated to Committee
08 January 2026	GB25/206	***Integrated Performance Report*** Consider aligning the IPR to the UHT strategic objectives rather than the CCQ domains for 2026/27	Neil Atkinson Stuart Irvine	07 May 2026	Open	Following discussion it was agreed to consider aligning both the BAF and IPR to the UHT strategic objectives as part of the refresh exercise in advance of 2026/27. it would be reviewed as part of the annual exercise and agreed that a proposal be brought to a future meeting. An update was provided at the meeting on 7 May, it was planned to bring an update to the June Board Devpt session. The Chief Executive referenced it would be a light touch piece of work at this stage. The Chair highlighted how the Board could receive more timely data to enable more real-time discussion and inform the improvement agenda. A proposal would be taken to UHT Management Team and then presented to Board with a discussion regarding timeliness of data. Agreement of the risk appetite would take place at the session on 4 June.	
05 March 2026	GB25/242	***Quality Committee Chairs Logs 26 January and 23 February 2026*** A board development deep dive session to be arranged regarding IPC	Emma Nunez	04 June 2026	Close	Following challenge regarding the month-on-month alert in respect of IPC and whether the Quality Assurance Committee were assured that sufficient actions were being taken a discussion ensued. A board development session deep dive into IPC was on the schedule for 2026/27 and it was confirmed it would take place on 4 June 2026.	
05 March 2026	GB25/245	***People Committee Chairs Logs 27 January and 24 February 2026*** The plan being developed for Financial Recovery Oversight Group (FROG) to support a different approach to tackling sickness absence to be shared with Committee and Board once agreed.	Rachael Metcalf	07 May 2026	Close	In response to the Board being asked to consider a more cultural and performance-based assessment in respect of the underlying causes of sickness absence, the Chief Executive highlighted that the FROG had requested for a plan to be developed to support a different approach to tackling sickness absence and once agreed the plan could be shared with Committee and Board. An update was provided at the 7 May meeting, confirming that it was a regular item on People Committee agenda with a number of deep dives undertaken including how to move resources to manage the workstreams. This remains an area of concern and it was agreed that this would be escalated to Board through the People Committee Chairs Logs.	People Committee
05 March 2026	GB25/245	***People Committee Chairs Logs 27 January and 24 February 2026*** A development session be arranged to consider in more detail the instances where regulatory and process-driven reporting requirements were creating structural imbalances in how performance was presented and could result in one site or statutory body appearing to be comparatively underperforming.	Jackie White	06 August 2026	Open	In response to the Board being asked to think about Group decisions and the potential disparity in reporting for each trust as part of a broader risk due to the group structure maybe resulting in one site or statutory body appearing to be comparatively underperforming, it was agreed to discuss as part of a development session regarding options going forward for the organisation.	
07 May 2026	GB26/026	***Chair's Report*** A Well-Led Review for UHT would take place in Autumn 2026.	Jackie White	01 October 2026	Open	It was confirmed that a Well-Led Review for the organisation would be planned to take place in the Autumn of 2026 and a procurement process would be undertaken.	
07 May 2026	GB26/027	***Chief Executive's Report*** Consideration to be given how best to capture the various strands of activity undertaken with schools and other external stakeholders as an anchor organisation.	Ruth Dalton	03 September 2026	Open	It was noted that there was wide engagement and strong links in place with local schools and colleagues as an anchor organisation and it would be good to consider how best to capture the strands of activity being undertaken.	
07 May 2026	GB26/028	***Chair's Log – UHT Management Team Meeting 19 March and 23 April 2026*** An update regarding single EPR system to be provided as part of Digital Update at Board Development session on 6 August 2026.	Ken Anderson	06 August 2026	Open	Connecting to discussion and action from Private Board regarding a Digital Update to be provided at a Board Development session to include Digital Strategy, digital initatives/work streams amd timescales.	

07 May 2026	GB26/031	***Perinatal Quality and Safety Report Quarter 4: 2025/26*** The sustainability and safety of the home birth service model to be reviewed in light of the national learning, considering whether to move to a single service or alternative staffing model for UHT.	Emma Nunez	03 September 2026	Open	Following discussion regarding home birth service provision and national focus, it was was agreed to review the sustainability and safety of the current home birth service model for consideration whether to move to a single service or alternative staffing model for UHT. To be taken through Quality Committee and escalated to Board.	Quality Committee
07 May 2026	GB26/031	***Perinatal Quality and Safety Report Quarter 4: 2025/26*** An update regarding the revised business case for elective caesareans with timelines and addressing the clinical concerns and theatre capacity issues be managed through the CSUs and presented to the UHT Management Team	Emma Nunez / Mike Stewart	02 July 2026	Open	Following discussion regarding the estates constraints and increase in demand for caesarean births were being actively reviewed as part of future service delivery, it was agreed to provide an updated regarding the revised business case with clarity around timelines and addressing the clinical concerns and theatre capacity issues to be managed through the CSUs and presented to the UHT Management Team with an update to Board via the Management Team Chairs Log.	
07 May 2026	GB26/031	***Perinatal Quality and Safety Report Quarter 4: 2025/26*** A rapid risk assessment to be undertaken of the neonatal estate to identify any changes that can be made, pending further progression of the larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session.	Emma Nunez / Steve Taylor	04 June 2026	Open	Following discussion regarding the estates constraints and not currently meeting national guidance for neonatal care, it was agreed to undertake a rapid risk assessment including cot numbers and spacing to identify any changes that can be made, pending further progression of the larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session. Arrangements to be progressed through the CSUs and UHT Management Team.	
07 May 2026	GB26/035	**NHS Staff Survey Overview 2025** It was agreed to bring an update regarding the action plan to address the staff survey results encompassing all elements to ensure the concerns raised were addressed.	Rachael Metcalf	02 July 2026	Open	A lengthy discussion ensued regarding the poor results of the staff survey and the concerns raised. It was agreed that a more rigorous response and action plan encompassing all elements would be presented to People Committee in June and to Board in July.	People Committee
07 May 2026	GB26/040	***Integrated Performance Report*** An update to be brought to the next meeting regarding a review of performance against 28 days and 62 days cancer targets.	Russ Nightingale	02 July 2026	Open	Following discussion regarding performance and the variation in compliance against 28 days and 62 days cancer targets, it was agreed to bring an update to the next meeting.	
07 May 2026	GB26/048	***Any Other Business*** A future Board Development session would be scheduled to discuss significant transactions and a review of contract strategies.	Matt Neligan	01 October 2026	Open	A Board Development session would be led by the Chief Strategy Officer regarding significant transactions and contract strategies in line with improvement plans linked to the Aubrey Report.	
07 May 2026							

NHS
University Hospitals Tees

Chair's Report

Meeting date: Thursday, 2 July 2026

Reporting to: Board of Directors

Agenda item No: 1.6

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.

Chair'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 National and Regional meetings

At the Chairs meeting it was emphasised that the North East must look at increased collaboration for patient benefit. This includes 'not only' back office functions but also optimising clinical pathways for access and outcomes across the region. The region recognises this will be a challenging year for the NHS and it is important that we continue to build strong foundations for the future.

I attended NHS Charities together and National Arts in Hospital Event in London. It re-emphasised the importance of art, in its broadest form, contributing to health and wellbeing for patients, carers and staff in the health and care setting. It was useful to know that while we still have work to do that the progress, we have made in establishing the UHT Arts Council is in the right direction and compared to some organisations we are further ahead. Important areas include a robust infrastructure, Board (trustees) line of sight, coordination an importantly sustainability.

3.2 Governors

Thanks are extended to Christopher Akers-Belcher and colleagues from Healthwatch for facilitating a recent discussion with the Council of Governors in Common on the future role of Governors, particularly in light of the changes outlined in the White Paper. The session provided a valuable opportunity for Governors to reflect on how their roles may evolve and to consider, in practical terms, what high-quality patient and carer experience should look like going forward within this changing policy landscape.

Thank you to colleagues who have expressed an interest in the lead governor role for North Tees & Hartlepool NHS Trust Council of Governors. Three candidates have expressed an interest and in light of this a ballot will take place at the Council of Governors meeting on 25 June 2026.

3.3 Board development / seminar

Board seminars have been held covering the expiry of the PFI contract, the Trust's continuous improvement journey, healthcare-associated infections, and learning arising from the Aubrey Report. Lead Governors, Freedom to Speak Up Guardians, and the CSU Leadership Teams also joined the Board for a discussion on the *True for Us* report. This

work, undertaken by the Trust, considered the recommendations of the Aubrey Report and reflected on their relevance to the organisation. The session provided an opportunity to explore whether similar issues could arise within UHT and to identify key actions and personal reflections to support ongoing improvement.

3.4 UHT charities

The Charites of North Tees and Hartlepool and South Tees have been working together have funded over £150K of staff generated ideas to support health and wellbeing, education and research. Thanks to the charity teams who are already working on this year's competitive bidding round

3.5 NEDs

The Chairman and Vice Chair have met with all Non-Executive Directors and completed their appraisals for 2025/26. A summary report will be provided to the Nominations Committee in common at their next meeting.

Work is ongoing to recruit new Non-Executive Directors, with a particular focus on strengthening expertise in clinical, commercial capability, and neighbourhood and third sector engagement. A shortlist of candidates has been agreed, and interviews are scheduled to take place on 29 and 30 June 2026. The interview panel will comprise Lead Governors, selected members of the Nomination Committee in Common, together with the Vice Chair and myself.

Derek Bell
Chairman

University Hospitals Tees

Chief Executive Officer Report

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 1.7

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 Trust Board will be aware that there has been damage to theatres at the North Tees site following a significant flood that occurred after it rained on the 2nd June. This has resulted in over 400 people having to have their surgery rearranged for which we apologise. It has also had a material impact on capital given the repairs and revenue to provide additional capacity to rearrange people's operations. This has been escalated to the region. Thank you to all of our staff who responded to the floods exceptionally well and have managed our response via a prolonged business continuity incident.

The resident doctor industrial action planned for June was called off 36 hours prior to the start of the strikes following a revised offer from government which the BMA have agreed to put to their members. Details of the revised offer are available in the reading room. The output of the BMA vote is expected towards the end of June 2026

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.

Following Board approval, the voluntary redundancy scheme has been offered to colleagues. There was a significant response which the Executive Team is working through with our Clinical Service Unit and Directorate leadership teams. I will ask the Chief People Officer to provide an update in our private session.

The financial plan for month 2 has been delivered the details of which the Board can review via the finance report and the IPR. Work to close the gaps in the financial plan and firm up delivery of the cost improvement schemes is as expected ongoing and being overseen by the Financial Recovery Oversight Group and the Resources committee.

There are gaps against RTT and Cancer performance at month 2 which the Chief Delivery Officer and our teams are aware and working towards resolution. Part of this is due to the impact of the theatres flood for NTH.

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

Due to the improvements in the emergency care standards at South Tees largely driven by the James Cook site we were eligible for additional capital and have recently had confirmation that we will receive an additional two million. This is excellent news and our thanks to the teams and our leaders for securing this improvement for patients and families.

Recommendations:

The 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 7 May 2026.

2. National Priorities

2.1. NHS Modernisation Bill

The NHS Modernisation Bill is progressing through Parliament and is currently at Committee stage. The Bill aims to put power and resources in the hands of NHS organisations providing direct patient care by abolishing NHS England and stripping back national bureaucracy. It further aims to improve patient safety and experience through a new single patient record (SPR) that will enable joined-up, proactive care and will empower patients. Specific measures outlined in the Bill include:

- abolition of NHS England and transfer of its functions into the Department of Health and Social Care (DHSC);
- associated expansion of the Secretary of State's powers over commissioning, performance, and resource allocation;
- changes to the statutory duties and role of integrated care boards (ICBs), strengthening their role as strategic commissioners within local systems, including taking on greater responsibility for primary care commissioning and long-term planning;
- creation of a single patient record (SPR) and changes to data governance, that will bring together patients' health and social care records in one place and make these available to patients and clinicians;
- transfer of Healthwatch England functions into a newly-established patient voice function in DHSC, and local Healthwatch functions into ICBs (in relation to health) and local authorities (in relation to social care);
- removing the requirement for foundation trusts to have Councils of Governors; and
- merging of the Health Services Safety Investigations Body (HSSIB), which investigated patient safety issues, into the Care Quality Commission (CQC) regulator.

The legislative timeline aims for rapid progress; the King's Speech and draft Bill were published in May 2026, with the current Committee stage starting in June to be followed by further parliamentary stages through summer and autumn, and potential implementation from early 2027. NHS England is planned to be formally abolished by 1 April 2027.

We will continue to keep this in sight and update the Board re anything material.

2.2. Newly Appointed Health Secretary

The new Health Secretary, James Murray, took up post in May and was welcomed at the recent NHS ConfedExpo Conference. In this role, he assumes responsibility for oversight of the NHS and wider health and social care policy across the UK.

Early indications suggest his priorities will focus on strengthening primary care, enhancing integration of community services, and ensuring continuity of key national programmes, including the 10-Year Health Plan.
He met with NHS CEOs alongside Jim Mackey in June and reiterated appreciation to colleagues for efforts to land key priorities for the end of 25/26 and confirmed that there would be continuity in the focus for the 3-year plans.

2.3. Mann Report

The Lord Mann Review is an independent government-commissioned assessment of antisemitism and other forms of racism within the NHS. The report sets out a series of recommendations to support NHS organisations in ensuring services are safe and inclusive for all patients, communities and colleagues. It emphasises the critical importance of compassionate, inclusive and accountable leadership in creating cultures where staff feel safe, valued and able to speak up. The review reinforces those sustainable improvements in quality, safety and performance rely on addressing behaviours, power imbalances and organisational culture, supported by robust governance and clear leadership accountability. There are a number of specific actions for the Board which I have asked the Chief People Officer to oversee on behalf of the Board.

2.4. Cyber Security

NHS England has reinforced in a letter to Trusts, the expectation that cyber security is an organisation wide risk requiring robust governance, clear executive accountability, and sustained improvement programmes. Compliance with the Data Security and Protection Toolkit (DSPT), aligned to the National Cyber Security Centre Cyber Assessment Framework, remains a core assurance mechanism. Boards are expected to receive clear assurance on preparedness, resilience, and recovery planning, including tested incident response and business continuity arrangements, to ensure the ongoing safe delivery of services which will be provided through the Resources Committee and Chief Digital and Technology Officer.

2.5. Fuller Compliance Update

University Hospitals Tees has undertaken a comprehensive compliance review of the Fuller Phase 1 and Phase 2 reports. A multi-disciplinary team approach was adopted for this review and all relevant recommendations were considered, an evidence based current position was confirmed and required actions that needed to be completed were identified to ensure full compliance. The report has confirmed partial compliance with the reports and agreed actions are planned to be completed by 30 September 2026. The report has been presented to the Executive Team, Quality Assurance Committee and to Board via the Chief Executive Report. The Designated Individual will report ongoing

compliance with Fuller to the Quality Assurance Committee on a 6 monthly basis and any escalations will be received to Board via the Chair Escalation Report.

An external review of Fuller Compliance has been included in the Internal Audit Plan for 2026/27 which will provide independent and objective assurance on the reported compliance position.

3. Regional Update

3.1. New Monthly CEO Meetings

New monthly CEO meetings have now been scheduled, with a clear focus on delivery against the 2026–27 plan. These sessions also provide a valuable platform for sharing good practice across ICBs within the region, strengthening collaboration and collective improvement.

4. Local update

4.1. Theatres at North Tees – Update

Highlighted in the BAF, there is a significant estates risk associated with North Tees hospital which the Board are well sighted on. This recently resulted in significant flooding in the main theatres following rain on the 2nd June. It impacted 7 out of the available 8 theatres which has had a significant impact on available capacity resulting in circa 400 people needing their operations rearranged. Our apologies to patients and families for this inconvenience. Our teams are working hard to plan additional capacity and get patients rebooked as soon as possible.

There is also a significant impact on capital, revenue and RTT performance which I have escalated to the region.

I have requested a more detailed report from the Chief Delivery Officer, which will be shared with Board members. The incident was managed through internal business continuity processes, with both the ICB and the region kept fully informed throughout. My thanks go to all staff involved for their effective management of the situation.

4.2. Voluntary Redundancy Scheme Update

A Voluntary Redundancy (VR) scheme ran from 14 May to 1 June 2026 with a significant number of colleagues wanting to be considered for this at this stage.

This forms part of the organisation's planning submission, which requires an overall workforce reduction of circa 600 WTE. Our clear preference is to achieve this through mutually agreed solutions wherever possible.

Staff groups critical to frontline delivery, including Nurses, Midwives, HCAs, Doctors in training, were excluded to protect service continuity.

Applications are currently being reviewed by the Executive Team with Clinical Service Unit leadership teams. Patient safety remains the overriding priority, and no application will be

supported where it would compromise the safe delivery of care.

Outcomes will begin to be communicated by the end of July 2026, with earliest departures expected from September 2026, subject to safe implementation. As the Board will be aware we are working closely with the regional team who will want to understand the final details of this plan over the coming weeks.

4.3. Finance – Month 2

At Month 2, the Trust is reporting a year-to-date deficit of £3.1m, in line with the plan, supported by £2.1m of non-recurrent mitigations to offset emerging pressures. Delivery of the 2026/27 financial plan remains highly challenging, requiring achievement of an £81.7m cost improvement programme (CIP) and significant workforce reductions of circa 600 WTE, alongside continued reductions in premium pay in line with NHSE expectations. CIP delivery is broadly on track at £7.0m year-to-date (95% of target), with a small adverse variance of £0.2m. Workforce levels have reduced to 15,081 WTE in Month 2, with notable reductions in bank and agency expenditure compared to the prior year, indicating early progress on cost control measures.

4.4. Emergency Care Standard – South Tees

South Tees has delivered a significant improvement in performance against the Emergency Care Standard over the past year, reflecting the impact of sustained operational focus, strengthened clinical leadership, and targeted improvements in patient flow across the urgent and emergency care pathway.

This progress has resulted in shorter waits for patients, improved timeliness of care, and greater resilience during periods of high demand. In recognition of this achievement and the organisation's clear commitment to further transformation, South Tees has been awarded £2 million of capital funding.

This investment will support the next phase of service improvement, enabling enhancements to infrastructure and capacity that will help sustain performance gains, improve patient experience, and strengthen the delivery of urgent and emergency care services for the local population.

4.5. Board Development Day – 4 June 2026

A Board seminar was held covering healthcare associated infections, PFI contract hand back, and the organisation's continuous improvement journey. In the afternoon the Board was joined by the Freedom to Speak Up Guardians, CSU leadership, and Lead Governors, to reflect on the True for Us review undertaken by UHT reflecting on the Aubrey Report recommendations. The seminar was highly interactive and provided valuable organisational and personal learning, supporting shared understanding, reflection, and continued improvement in leadership, culture, and governance.

4.6. Continuous Improvement

The executives and Board have received the outputs of the recent readiness assessment undertaken by our strategic partner. This aligned well with the Boards view of our

readiness and provides a helpful benchmark to monitor over the coming months as we progress our Improving Better Together approach.
The Executive Team continues its development programme to ensure senior leaders have the knowledge and capabilities required to provide effective leadership aligned to the behaviours in the Catalysis model over the coming years. This included agreement of 14 strategic metrics aligned to the UHT strategic objectives given the evidence base is clear that having a smaller number of priorities for improvement supports teams to deliver.

The CMO, CNO and CDO are now identifying a small number of priorities (four to six) that will form the breakthrough objectives for focused improvement over the next 12–18 months. This work is data-driven to ensure the right priorities are selected and that improvements can be maximised and measured effectively.

4.7. Pride Month

June marks Pride Month, and UHT is proud to recognise and celebrate our LGBTQ+ colleagues, patients and communities. Pride month provides an important opportunity to reaffirm our commitment to inclusion, dignity and respect, ensuring that everyone feels safe, valued and able to be themselves at work. Across the Trust, teams have been engaging in awareness-raising activity and promoting the importance of allyship, reflecting our ongoing focus on creating a compassionate and inclusive culture aligned to our People Promise.

4.8. Armed Forces Week

Plans for armed forces week commenced on 22 June and saw Executive and Non-Executive colleagues participate in flag raising events across all four hospital sites. Armed Forces day was celebrated on the last Saturday in June. All events were successfully delivered with coordinated activity across all four main sites. Strong governance arrangements supported the programme, underpinned by an active working group of around 150 members.

Recognition was also given to the excellent work of Anna Robinson, Help for Heroes nurse, in supporting veteran colleagues.

Quarterly Armed Forces coffee sessions across the Trust continue.

5. In other news!

5.1. Care Bags

Care bags have been introduced for patients with a learning disability in the urgent and emergency departments at The James Cook University Hospital and the University Hospital of North Tees. Designed to reduce anxiety and distress, each bag includes comfort items such as fidget tools, noise-cancelling earphones, sensory aids, visual supports and information resources.

5.2. Academic Cardiovascular Unit

Researchers in the Academic Cardiovascular Unit at James Cook have launched the NIHR-funded AFFECT trial, which aims to identify the safest and most effective blood-thinning treatment for patients who have undergone heart valve surgery and also have a heart rhythm condition.

5.3. Liver Service

Congratulations to the liver service at the University Hospital of North Tees, which has achieved Level 1 'Improving Quality in Liver Services' (IQILS) accreditation. The team's strong clinical practice, clear pathways and well-established governance placed them in an excellent position as they progressed through the accreditation process.

5.4. Nurse Led Biopsy Service

Patients with suspected prostate cancer are now being seen and diagnosed more quickly thanks to a new nurse-led biopsy service at the University Hospital of North Tees. Specialist urology nurses are performing trans-perineal prostate biopsies, improving diagnostic effectiveness, reducing waiting times and enhancing patient experience.

5.5. Vitreo-retinal Surgery

Patients are benefitting from specialist eye care closer to home following the introduction of vitreo-retinal surgery at the Friarage Hospital in Northallerton. Supported by more than £200,000 in charitable donations from Friends of the Friarage, the new service means patients no longer need to travel to James Cook for treatment, significantly improving access for communities in North Yorkshire.

5.6. Inspirational Staff Story

A particularly inspiring story comes from Amir Vosooghi, who began volunteering at the University Hospital of North Tees during the pandemic. As an asylum seeker and trained vet, Amir used his volunteering experience to build confidence, gain support and ultimately progress into further study and employment opportunities within his profession.

6. Conclusion

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

University Hospitals Tees

Chair's Log of UHT Management Team Assurance Meeting

Meeting date: 21 May 2026

Reporting to: Board of Directors

Agenda item No: 1.8

Report author: Matt Neligan, Deputy CEO / Chief Strategy Officer and Abi Smith, Executive Assistant to the CEO

Executive director sponsor: Stacey Hunter, CEO

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:

Select:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

IT LIMS Update

LIMS programme activity was discussed, including a proposal to defer South Tees' UKAS accreditation in September so that limited specialist capacity can be focused on securing North Tees accreditation in June and delivering the WIN project. With both programmes reliant on the same 20 staff and operational pressures expected in September–October, the group acknowledged the operational, reputational and patient-safety implications of any delay, particularly for research and MHRA-regulated trials. A briefing paper will be prepared ahead of an Executive Team decision.

Ward Closure and Service Redesign

Proposals to redesign elderly people's medicine ward capacity at James Cook as part of a wider service redesign, with a phased approach intended to protect patient flow and ED performance. The plan includes establishing a rapid access Frailty Unit, strengthening Hospital@Home capacity across Middlesbrough and Redcar, and shifting the workforce model to better reflect patient needs. While the redesign aligns with strategic objectives, the team acknowledged significant operational risks associated with bed reductions, particularly around outliers, surgical flow and community capacity. A stepwise approach, targeting full implementation by September, will be supported by further financial and workforce modelling, with a detailed proposal and business case to return for approval.

Neighbourhood Health Centres and Outpatient Transformation

An update was given on the growing programme of work around neighbourhood health centres, including capital bids, emerging PLACE-level partnerships and the central role of CSUs in driving outpatient transformation and reducing health inequalities. The discussion emphasised applying population health principles and strengthening integration across primary care, social care, mental health and voluntary partners, with outpatient redesign to be shaped jointly by clinical directors and primary care colleagues. A joint paper on Neighbourhood Health and Outpatient Transformation will be brought to the Executive meeting in four weeks as pathway development and transformation opportunities continue to be refined.

Quality Performance Review Escalation Report

The Management Team received an update on the Quality Performance Review escalation process, with NA and SI outlining progress in strengthening governance, including the use of AI-driven thematic analysis to identify improvement trends from QPR outcome letters and enhance future reviews. The team noted increasing formality in meetings, clearer action tracking, and the intention to extend the QPR framework into corporate services in line with the wider accountability model. RN will chair future QPRs as these developments are embedded.

Outpatient Waiting List and Dummy Clinics

Significant issues identified within outpatient waiting list management, including a substantial emerging risk in structured weight management services and in respiratory dummy clinics. Validation work is underway and assurance was provided that no patient safety concerns have been identified to date. The discussion highlighted a mismatch between commissioned capacity and demand, the need for renewed engagement with the ICB, and the financial risks posed by outdated community contracts. A task and finish group will be established to review and reprice these contracts within six months, while primary care colleagues will be engaged to support waiting list management and explore additional capacity.

Klebsiella Outbreak

The Management Team was briefed on a Klebsiella outbreak on the Neonatal Unit at JCUH, the third incident in recent months. A dedicated Working Group has been convened, with all actions underway and full engagement from relevant clinical, operational and infection-prevention stakeholders to ensure robust management and oversight of the situation.

Continuous Improvement

The Management Team received an update on the Improving Better Together programme to implement a continuous improvement operating model across UHT, following a recent Executive workshop to refine the overarching objectives and success measures for the programme. An initial longlist of 21 metrics has been streamlined to 16 that best reflect long-term strategic impact, with MN to circulate the proposed set for comment. Design materials will be shared progressively as development and implementation continue.

Fuller Compliance Report

The Management Team received an update on Fuller compliance, with SI outlining progress against the Phase 1 and Phase 2 recommendations and the transition of ongoing oversight to the Designated Individual. The review identified the majority of actions as partially compliant, with clear plans and leads now in place to achieve full compliance by September 2026. Six-monthly reporting and evidence collection will be coordinated by the DI, who will also lead work to standardise mortuary roles and responsibilities across the organisation. No risks relating to deceased patients were identified, and an internal audit is scheduled for Q4 to provide independent assurance ahead of the planned Board review.

Place Committee/HOSC/H&WB Update

The Management Team received an update on Place Committee, HOSC and Health & Wellbeing Board engagement, with JW outlining strengthened partnership arrangements through the assignment of executive leads, clearer representation at local authority meetings and more consistent messaging across place footprints. Quarterly updates will support ongoing coordination, and the discussion emphasised the evolving accountability of health and wellbeing boards and joint committees, alongside the importance of targeted, relationship-building engagement to advance neighbourhood health priorities.

Business Case Updates

The Management Team discussed progress on business case development, including the complex operational and financial considerations surrounding stroke pathway consolidation and the need for commissioner engagement.

The team also explored establishing a business case clinic to strengthen decision-making discipline, accelerate problem-solving and ensure only viable proposals progress, supported by clearer benefits-realisation tracking.

Updates were provided on the Print Smart campaign, which aims to reduce paper usage and deliver £1 million in annual savings through digital solutions, alongside plans to move to digital consent. Process guidelines and pipeline management were reviewed, with a longlist of cases to be socialised and clearer expectations set for agenda items requiring either early sight or formal approval.

Policies Update

Work is ongoing to consolidate the organisation's 400 existing policies into a streamlined suite of around 60 regulatory and legal policies. This will include a new framework to eliminate duplication, clarify ownership and distinguish policies from procedures and guidelines. A task and finish group will support authors in converting documents ahead of an August deadline, ensuring a simplified, risk-based policy landscape for the forthcoming well-led review. The approach and process were approved, with recognition that nationally developed People policies should be adopted without unnecessary rework.

Health Inequalities Steering Group Update

The Management Team received an update from the Health Inequalities Steering Group, with PW highlighting a clinical governance gap in the oversight of public health programmes and proposing the creation of a public health directorate within CSU 10 to strengthen management, intelligence support and coordination. While centralising these functions would address fragmented oversight and limited administrative capacity, CSU 10 expressed concern about taking on additional responsibilities without further resource. The group recommended developing a business case, including options for joint resourcing with local authorities, to ensure sustainable delivery and improved governance.

Recommendations:

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

University Hospitals Tees

Chair's Log of UHT Management Team Assurance Meeting

Meeting date: 18 June 2026

Reporting to: Board

Agenda item No: 1.8.1

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

Executive director sponsor: Stacey Hunter, CEO

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:

Select:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

Respiratory Dummy Clinic List Validation

A review of the Respiratory dummy clinic list has identified significant administrative and pathway issues, with 40% of the list validated to date. While most patients have now been redirected appropriately with no harm identified, a small number of cases of potential harm have emerged, prompting further investigation. This work has highlighted the need for strengthened administrative processes and assurance that no other pseudo waiting lists exist across the organisation. A wider review is being initiated to ensure robust, consistent practices are embedded across all services.

Quality Performance Reviews

RN confirmed that monthly Quality Performance Review meetings are continuing, with colleagues now assigned to specific roles within the process. Approximately 100 actions have been identified, distributed evenly across the six strategic objectives. Governance and any required escalations will be channelled through the Resource and Performance Committee to ensure appropriate oversight and assurance.

Neuro-Ophthalmology

The Management Team were informed that work is underway to streamline processes within the Neuro-Ophthalmology service following concerns raised by Specialised Commissioning about the Trust not currently delivering this element of care. Around 145 patients are not on an active pathway and are being re-triaged, many of whom are already under neurology. The service has been closed to new referrals since 2024 after the consultant's departure, with activity informally diverted to Sunderland, though no formal decommissioning has taken place. With no trained consultant currently in post, the Team discussed whether to recruit and re-establish the service or proceed with formal closure, noting the wider recruitment challenges in ophthalmology. There was broad agreement that a sustainable regional model should be explored, and concerns were raised about the limitations of a reactive mutual aid approach. Further discussions will take place outside the meeting, with the issue also to be raised with Specialised Commissioning to determine a viable long-term solution.

WIN3 Upgrade Update

The Management Team were informed that the Tees Valley pathway for WIN3 will now go live in February next year, rather than the previously planned date of October 2026. Potential financial risk associated with this delay is currently being assessed by the Finance team.

Fertility Services

Following a recent review, the CSU provided initial verbal feedback highlighted the timeliness of audits, estates-related issues, and the UKAS accreditation challenges the team are reviewing the findings in more detail and will engage with the Human Fertilisation and

Embryology Authority (HFEA) to explore this in more detail which will help inform our response.

Voluntary Redundancy

The Management Team were informed that work on the Voluntary Redundancy (VR) process is progressing, with CSUs now reviewing and finalising their proposed numbers and undertaking further challenge where required. Communication to staff will begin shortly via CSUs, with “yes” and “no” outcome letters to be issued. A “yes” outcome will allow progression to stage one, with subsequent the next stage. It was noted that some CSUs approvals also required aligned to our policy. There is further work to do with the CSU and corporate teams to understand the details of proposed changes before the VR can complete.

Maternity New Build

The Management Team were provided with an overview of the Maternity New Build project. The scheme is currently in Stage 3 of the construction process, with detailed design work progressing well and the SOC nearing completion ahead of formal approval. The programme is structured in two phases: Phase 1 is expected to begin on site in Q3 2027 and run for approximately 20 months, with Phase 2 commencing in Q3 2029 and completing in 2030. A range of design decisions are being finalised, including temporary power supply arrangements, with the preferred options—while impacting funding—being the most compliant and operationally appropriate.

Green Plan Progress Report

The Management Team were informed of progress against the 2025–26 Green Plan objectives, with a reminder of the organisation’s obligations in working towards the 2040 carbon-neutral target. Carbon emissions have continued to reduce year on year, with a 3% reduction at ST and a 2.8% reduction at NTHFT over the past year. Significant estates work is underway across the Friarage, Hartlepool and James Cook sites, supported by £46m of government investment aimed at delivering substantial carbon reduction. Future priorities will focus on cultural change to maximise opportunities for further improvement, supported by increased engagement activity, including a joint sustainability day held at JCUH this week and plans to expand the network of Green Champions across the organisation.

Health and Safety Annual Performance

The Management Team were informed of the Health and Safety performance across UHT for the full year. NT reported 12 RIDDOR events, with 42 reported at ST. Sharps injuries remain the most frequent recurring issue, and all areas have been asked to move to safe-sharps devices to reduce risk.

PFI App ‘Go Live’

The Management Team were informed that a campaign is underway to promote the new App linked to the James Cook site, which will enable staff to report building faults using a QR code and upload supporting photos. CSU colleagues were asked to encourage their teams to engage with the process and download the App.

Recommendations:

The Board is asked to receive the report and acknowledge the monthly meetings of the UHT Management Team Assurance Meeting, noting the oversight and assurance these provide to the Executive Team for each Trust.

University Hospitals Tees

Board Assurance Framework Report 2026/27 (reporting to 30th April 2026) – NTHFT/STHFT

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 1.9

Report author: Stuart Irvine, Director of Assurance/Deputy Managing Director

Executive director sponsor: Neil Atkinson, Managing Director

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.
- 10 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 65 planned mitigating actions within the BAF across the 8 domains.
- 5 reported completed actions (R&I)
- No changes to current risk scores.
- 12 action timescale extension requests (1 Digital, 4 Finance, 1 People, 6 R&I).
- Planned action timescale range – April 2026 – April 2035.

STHFT

- There are 31 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 8 strategic risks are outside of approved risk appetite, of which there are 5 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 66 planned mitigating actions within the BAF across the 8 domains.
- 7 reported completed actions (R&I).
- No changes to current risk scores.
- 14 action timescale extension requests (4 Finance, 7 R&I, 3 Trust Estate).
- Planned action timescale range – March 2026 – April 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.

BAF Reporting 2026/27

Existing BAF arrangements have been carried forward into 2026/27 for Quarter 1. A BAF review is currently underway and going forward it is proposed to present the BAF on a quarterly basis and will be aligned to the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). The review will be completed in readiness to report the Quarter 2 position.

Risk Management Policy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Following the formation of the CSUs from 1st November 2025, the policy will need to be updated to reflect new naming conventions and reporting processes. The policy will also need to make reference to the revised BAF reporting arrangements. This action has been delayed pending the refresh of the BAF for 2026/27.

Risk Appetite

Risk appetite for 2026/27 has been presented to Board Committees in June 2026 in readiness to propose the risk appetite to the Board of Directors in July 2026 for approval.

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

An internal audit on Board Assurance Framework and Risk Management processes was completed in 2025/26 and provides 'Good Assurance' on current arrangements in place. The report will be presented to Audit Committee for oversight.

Recommendations:

The Board of Directors is asked to;

- Note the BAF carry forward arrangements into Quarter 1 of 2026/27.
- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th April 2026.
- Note the 7 red/high strategic risks for NTHFT and 5 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the ongoing work to refresh the BAF for 2026/27 in readiness for Quarter 2 reporting.

- Approve the risk appetite for the strategic objectives proposed by Board Committees for 2026/27.
- 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 30th April 2026)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 7 red/high strategic risks are outside of approved risk appetite (no change). • One step from approved risk appetite. • 65 planned mitigating actions. • 5 reported completed actions (R&I) • No changes to current risk scores. • 12 action timescale extension requests (1 Digital, 4 Finance, 1 People, 6 R&I). • Planned action timescale range – April 2026 – April 2035.	• 31 identified strategic risks. • 5 red/high strategic risks are outside of approved risk appetite (no change). • One step from approved risk appetite. • 66 planned mitigating actions. • 7 reported completed actions (R&I). • No changes to current risk scores. • 14 action timescale extension requests (4 Finance, 7 R&I, 3 Trust Estate). • Planned action timescale range – March 2026 – 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 2026/27 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.

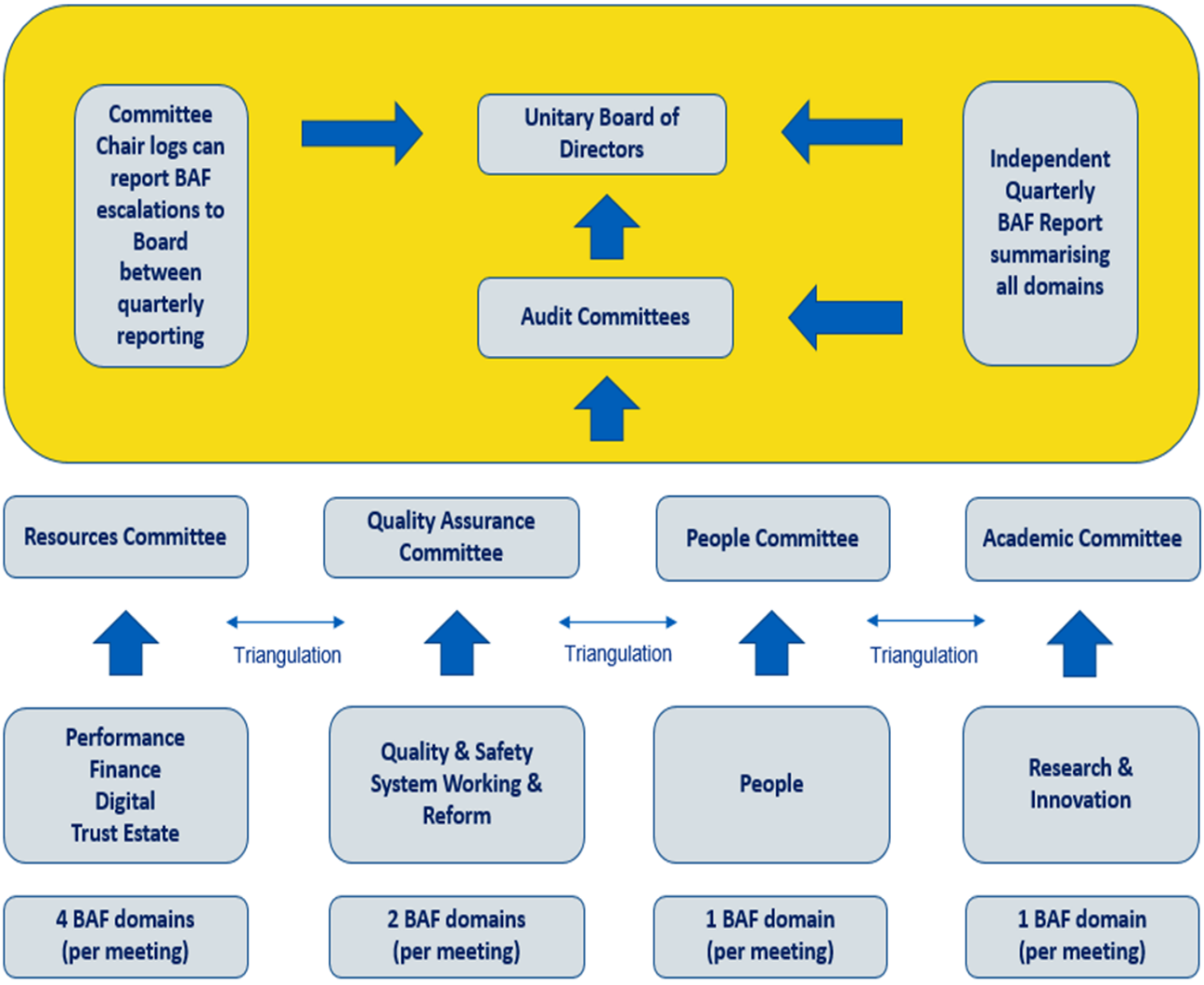
There are 8 BAF domains for each Trust. The BAF domains are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

The 8 BAF domains for each Trust are Director-led, 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	Chief Nursing Officer	Deputy Director of Patient Safety/Deputy Director of Quality	Quality Assurance Committee
Performance & Compliance	Chief Delivery Officer	Director of Planning & Intelligence / Associate Director of Planning & Performance	Resources Committee
People	Chief People Officer	Deputy Director of People Services/ People Risk & Compliance Manager	People Committee
System Working & Reform	Chief Strategy Officer	Associate Director of Group Development	Quality Assurance Committee
Finance	Chief Finance Officer	Deputy Chief Finance Officer/ Deputy Director of Finance	Resources Committee
Digital	Chief Information Officer	Interim Head of IT/ Deputy Chief Information Officer	Resources Committee
Trust Estate	Director of Estates	Associate Director of Estates & Capital (NTH Solutions LLP)/Deputy Director of Estates, Capital and Programmes	Resources Committee
Research & Innovation	Group Medical Director	Associate Director, TVRA/Director of Innovation	Quality Assurance Committee

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 are 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 confirms the strategic risks are linked to the BAF and are relevant for each organisation.

Risk Appetite

Board committees will review the risk appetite position for 2026/27 in June 2026 and the proposed risk appetite position for each strategic objective is set out in this paper, which broadly remains consistent with 2025/26. This will be presented to Board in July 2026.

2025/26 position

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

Risk domain	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
Digital	Open	Open	8-12
Finance	Open	Open	8-12
Research and Innovation	Open	Open	8-12
System Working & Reform	Open	Open	8-12

Proposed Risk Appetite (linked to strategic objectives) 2026/27

Strategic Objective	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
Putting patients first with consistent high-quality care that delivers best practice in effectiveness, safety and experience	Cautious	Cautious	4-6
Working with partners to tackle shared population health challenges and to reduce health inequalities for our population	Open	Open	8-12
Reforming models of care across our services and supporting the development of neighbourhood health systems	Open	Open	8-12
Developing excellence as a learning organisation through our work in research, education, improvement and innovation	Open	Open	8-12
Creating an outstanding experience for our people by leading well and being an employer of choice	Open	Open	8-12
Using our resources well by driving productivity in services to achieve financial sustainability	Open	Open	8-12

Risk Appetite Supporting Statements

As part of the BAF refresh exercise for 2026/27, Lead Directors will review existing risk appetite supporting statements and confirm statements for 2026/27. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by strategic objectives 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 and supporting statements for 2025/26 which have been rolled forward into 2026/27, pending the completion of the BAF review.

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	8	8
Performance & Compliance	3	4	**1**	0	1	0	7	8
Digital	4	4	0	0	0	0	13	7
People	4	4	0	0	0	0	6	6
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	9	14
System Working & Reform	2	2	0	0	0	0	11	11
Research & Innovation	5	5	**2**	**2**	1	1	6	7
Total Number	**30**	**31**	**10**	**8**			**65**	**66**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 10 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is April 2026 – April 2035.	• The Trust has 31 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 8 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 March 2026 – April 2035.

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

NTHFT Red/High Strategic Risks outside Approved Risk Appetite

The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite, which is static from the previous reporting period. 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
Non-compliance with national standards in accordance with NHS Oversight Framework 2025/26, and cancer recovery priorities as set out in the 2025/26 Operational Planning Guidance.	Performance & Compliance	**3 x 5 = 15**	3	Resources Committee
Failure of Trust infrastructure (including buildings).	Trust Estate	**3 x 5 = 15**	2	Resources Committee
Insufficient capital funding to maintain Trust estate.	Trust Estate	**5 x 4 = 20**	1	Resources Committee
Reduction of system capacity if the Trust is unable to provide services.	Trust Estate	**5 x 3 = 15**	2	Resources Committee
Innovation growth is limited by investment and resource constraints.	Research & Innovation	**5 x 3 = 15**	1	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 5 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Inability to controls costs within allocated resources	Finance	**4 x 4 = 16**	1	Resources Committee
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**	1	Resources Committee
Innovation growth is limited by investment and resource constraints	Research & Innovation	**5 x 3 = 15**	1	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**	2	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/UHT Risk Management Group

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 UHT Risk Management Group.

BAF Reporting 2026/27

Existing BAF arrangements have been carried forward into 2026/27 for Quarter 1. A BAF review is currently underway and going forward it is proposed to present the BAF on a quarterly basis and will be aligned to the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). The review will be completed in readiness to report the Quarter 2 position.

Risk Management Policy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Following the formation of the CSUs from 1st November 2025, the policy will need to be updated to reflect new naming conventions and reporting processes. The policy will also need to make reference to revised BAF reporting arrangements. This action has been delayed pending the refresh of the BAF for 2026/27.

External Assurance

The internal audit on Board Assurance Framework and Risk Management processes has concluded and 'Good Assurance' has been received on UHT arrangements. The report will be presented to Audit Committee for oversight.

Risk Appetite

Risk appetite for 2026/27 is being presented to the Board Committees in June 2026 for consideration and recommendation to Board in July 2026.

4. Conclusion/Summary

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

- The requirement to maintain and report separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF to the relevant Group strategic objectives.
- Approved risk appetites for each BAF domain and supporting statement for 2025/26 and proposed risk appetite for 2026/27.
- 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.
- The reported position of 30 strategic risks relating to NTHFT and there are 7 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.

- The reported position of 31 strategic risks relating to STHFT and there are 5 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- Report of the BAF 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 Board of Directors is asked to;

- Note the BAF carry forward arrangements into Quarter 1 of 2026/27.
- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th April 2026.
- Note the 7 red/high strategic risks for NTHFT and 5 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the ongoing work to refresh the BAF for 2026/27 in readiness for Quarter 2 reporting.
- Approve the risk appetite for the strategic objectives proposed by Board Committees for 2026/27.
- 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

Strategic Risks

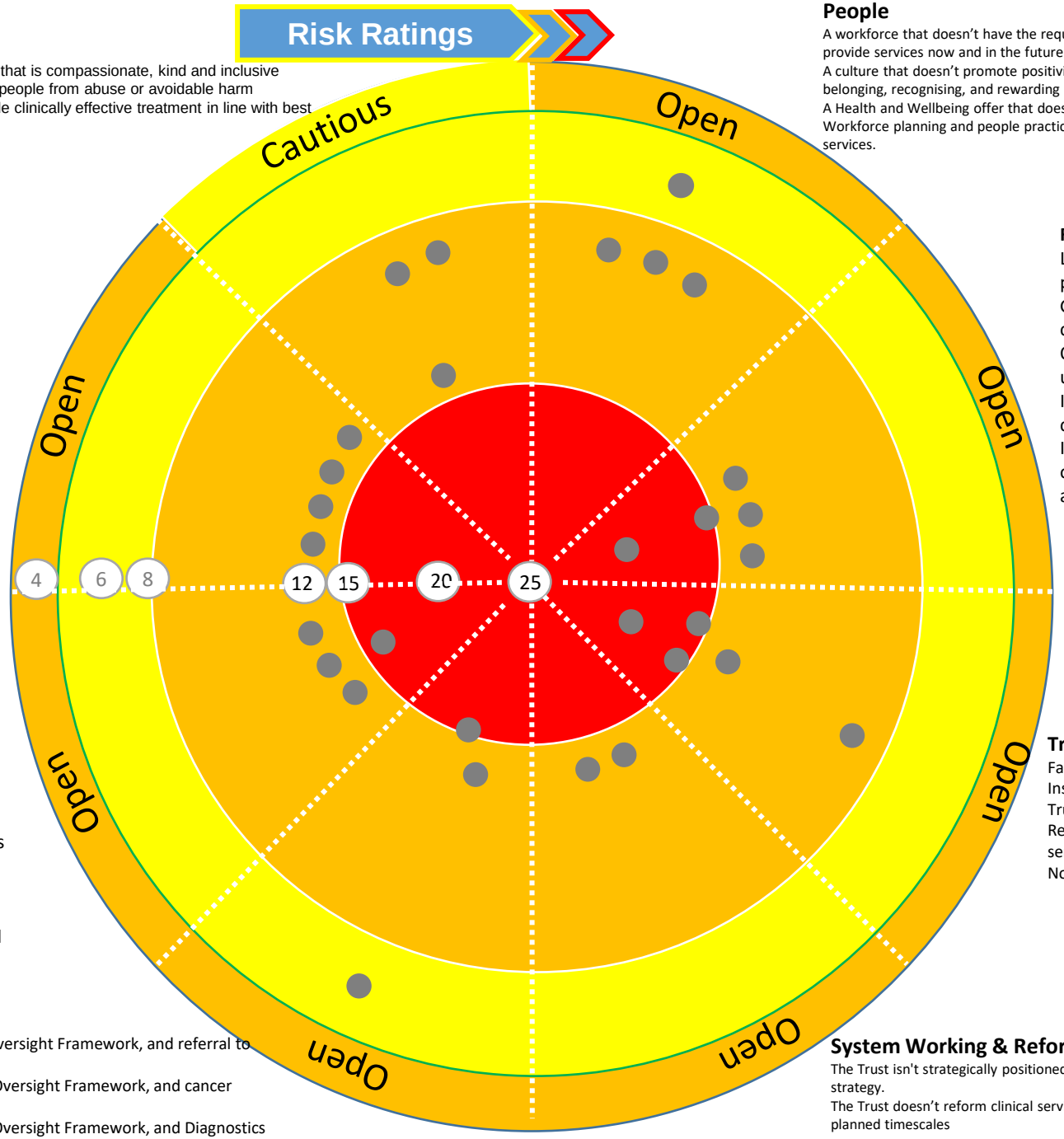
Quality & Safety	Digital	People	Finance	Performance and Compliance	System Working & Reform	Trust Estate	Research & Innovation
Patient safety – Failure to protect people from abuse or avoidable harm	Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and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

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

Appendix C

NHS
North Tees and Hartlepool
NHS Foundation Trust

30th April 2026
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

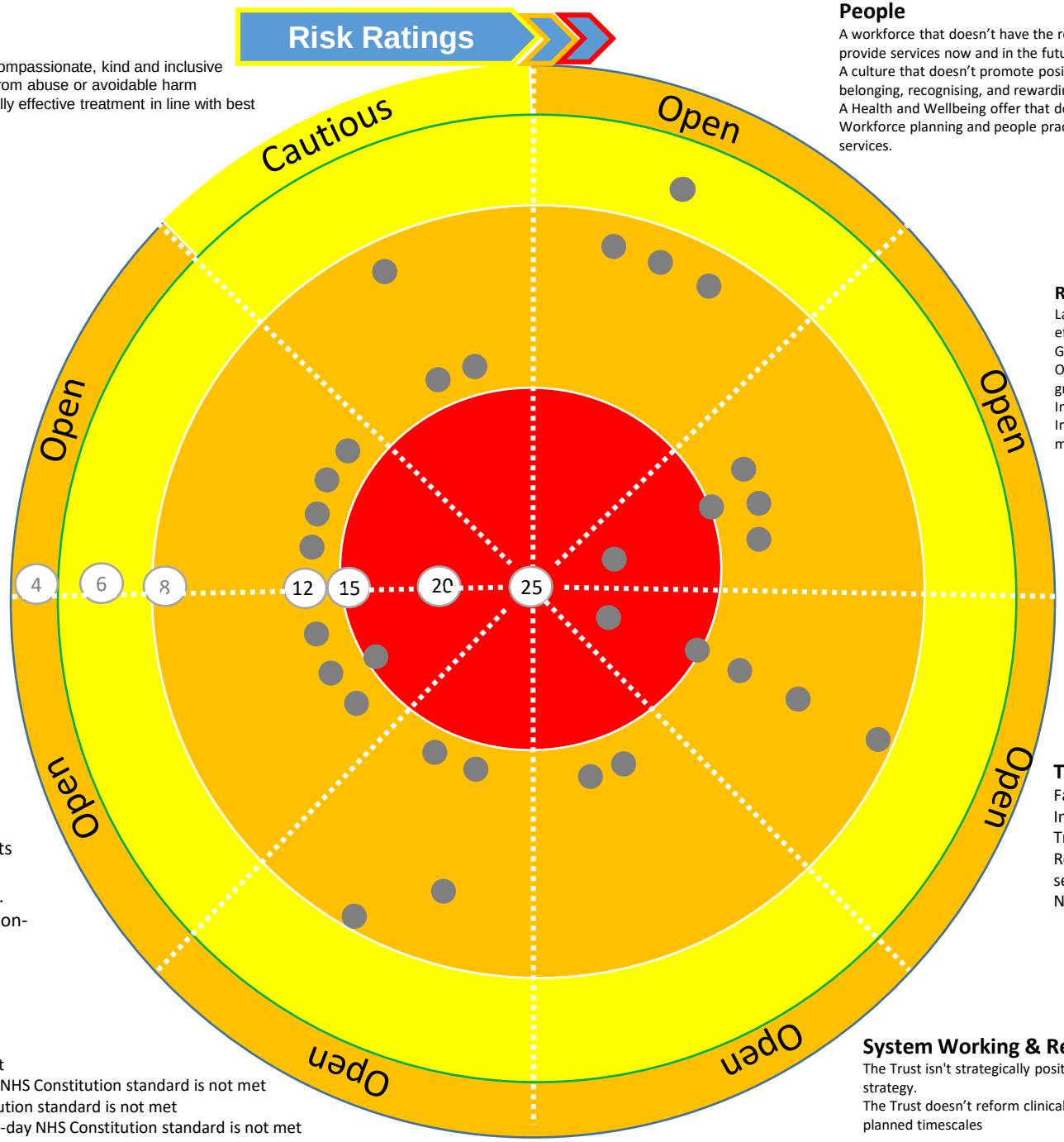
Strategic Risks

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

Appendix E

South Tees Hospitals NHS Foundation Trust

30th April 2026 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

Top 10 Operational Risks (30 April 2026)*

North Tees and Hartlepool NHS Foundation Trust

Appendix F

ID	Title of Risk	CSU/Corporate area	Risk Owner	Current Risk Score
121	Due to increasing demand for Histopathology support there is a potential for delays in results being available to support patient pathways, the patient outcome may be suboptimal.	Clinical Support Services	Sharron Pooley	20
427	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Clinical Support Services	Karl Hubbert	15
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 Services	Kerry McLean	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
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 Services	Emma Roberts	12
320	Due to a lack of confidence in current service delivery by the Stockton Quality Control Laboratory there is potential for service users to terminate contract therefore affecting the financial viability of the service.	Clinical Support Services	Donna Betham	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	Community & Neighbourhood Health Services	Wendy McGee	12
223	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton	Community & Neighbourhood Health Services	Fiona Hardie	12
275	Due to vacancies in the Speech and Language Therapy Service, there is a delay in delivering assessments and intervention which may result in poorer patient outcomes and experience	Family Health Services	Lisa Piggott	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 Services	Andy Brown	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	Family Health Services	Helen McCallan	12
290	Risk of suboptimal patient outcomes due to potential inability to provide Consultant emergency cover 24/7	Family Health Services	Emma Cowan	12
271	workforce and skill mix deficit in critical care impacting on service delivery and patient safety	Theatres, Anaesthetics & Critical Care Services	Steph Gale	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 Services	Stephen Cuthbert	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway	Digestive Health, Urology & General Surgery Services	Steve Heavisides	12
30	Fragility of Infection Prevention and Control Workforce can lead to a loss of service and affect patient outcomes	Corporate Services	Victoria Hancock	12
224	Due to staffing shortage, risk of deteriorating coding standards affecting recording of quality, performance and contract performance	Corporate Services	Sarah Hope	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 Services	Graeme Kelly	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	Family Health Services	Gemma Gordon	12
217	Due to insufficient staff to perform medicines reconciliation, the Trust does not meet NICE / CQC Standard of Medicine Reconciliation within 24 hours of admission. There is a risk of harm to patients if incorrect medication is administered	Clinical Support Services	Rebecca Alexander	12
343	Inability to deliver an end to end digital solution for the prompt identification and management of deteriorating patients leading to patient harm	Corporate Services	Ruksana Salim	12

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

Top 10 Operational Risks (30 April 2026)*

South Tees Hospitals NHS Foundation Trust

Appendix G

ID	Title of Risk	CSU/Corporate area	Risk Owner	Current Risk Score
613	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	Corporate	Julian Verity	20
550	Risk that patients come to harm due to poor image quality or critical failure of the Neuro angio unit equipment	Neuroscience Services	Richard Bore	16
560	Risk that patient privacy and dignity is compromised when trying to deliver rehabilitation psychology treatment to patients on ward 26	Neuroscience Services	Glynis Peat	16
427	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Clinical Support Services	Karl Hubbert	15
450	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.	Clinical Support Services	Lindsey Hardy-Laws	15
409	Loss of Radiotherapy HDR Brachytherapy Service due to loss of delivery of Ionising material by supplier as a result of Trust equipment not at the current national standard	Cancer Institute	Claire Huntley	15
618	Cyber breach or service outage by use of unsupported servers/clients/software which may result in business disruption or loss of service of critical operations impacting on patient care	Corporate Services	Ian Willis	15
546	Risk that the Trust does not meet General Provision of Intensive Care Services (GPICS) standards in neurosurgery HDU and spinal HDU	Neuroscience Services	Keir Rumins	15
551	Due to some replacement parts no longer being available for the Neuro 3T MRI equipment, the equipment may not be repairable in the event of failure resulting in reduced Imaging capacity affecting waiting time, timely interventions and extending lengt	Neuroscience Services	Richard Bore	15

584	Risk that cable fails due to age leading to a fire risk and impact to building.	Corporate Services	Lewis Fernandes	12
437	Risk that service provision in Biochemistry ceases as a result of drafting benching failure	Clinical Support Services	Nicola Bateman	12
438	Risk that failure of High Performance Liquid Chromatography prevents diagnosis/rule out rare tumours	Clinical Support Services	Nicola Bateman	12
593	Risk that services are affected due to insufficient resources available to fund capital replacement and new investment	Corporate Services	Brian Simpson	12
577	Risk that the Trust access control system will fail due to the phase out of the Granta portfolio at 31.12.21	Corporate Services	Geoffrey Sweeney	12
440	Risk that no back up labelling system as Stand alone EMIS not updating	Clinical Support Services	Jacqueline Gregson	12
444	Risk of vulnerable patients not being able to obtain medication by home delivery	Clinical Support Services	Jacqueline Gregson	12
475	Due to the IBD service not been registered on the IBD registry and no audit completed to date there is a governance risk.	Digestive Health, Urology & General Surgery Services	Prashantha Sambaiah	12
572	Risk that Governance and assurance arrangements for cyber security may be ineffective, and could lead to non compliance with nat	Corporate Services	Ian Willis	12
434	Risk that POCT is not being appropriately governed across services	Clinical Support Services	Karl Hubbert	12
612	Due to the deployment of S1 and the IUTC contract we will experience a delay in timely NHS Situational Reporting (SitRep) and will lack Real-Time Reporting (RAIDR, Live Dashboards etc) for Type 3 Attendances, Urgent Treatment Centre activity.	Corporate Services	Michael Souter	12

360	Due to the deployment of S1 and the IUTC contract we will experience a delay in timely NHS Situational Reporting (SitRep) and will lack Real-Time Reporting (RAIDR, Live Dashboards etc) for Type 3 Attendances, Urgent Treatment Centre activity.	General & Emergency Medical Services	Michael Souter	12
587	Risk that the high volume of deliverables will put the scale of Outpatient Transformation at risk (OP4)	Corporate Services	Tallulah McCue	12
417	Head and Neck care pathway	Trauma & Orthopaedics, Reconstructive & Plastic Surgery, ENT & OMFS, Dermatology &	Natalie Lynd	12
604	PAGER BLEEP SYSTEM	Corporate Services	Choi Cheng	12
570	Risk that there will be a loss of data due lack of business continuity and disaster recovery	Corporate Services	Ian Willis	12
571	Risk that the Trusts ability to deliver normal service could be severely disrupted by a major cyber incident.	Corporate Services	Ian Willis	12
533	Risk that patients may come to harm due to unavailability of critical care outreach practitioners to respond to a deteriorating patient	Theatres, Anaesthetics & Critical Care Services	Kerry Akther	12
534	There is a risk to the implementation of CHA CC due to the requirement to undertake significant estates work.	Theatres, Anaesthetics & Critical Care Services	Martin Johnson	12
457	The Avanto fit MRI scanner is past its replacement date and is now experiencing errors resulting in downtime which has resulted in reduced capacity and cancellation of scans.	Clinical Support Services	Joanne Smith	12
431	Risk of delay to provision of chemotherapy treatment due to ageing aseptic facilities	Clinical Support Services	James Harris	12
402	Inadequate staffing capacity in the Hospital transfusion team to meet regulatory and clinical requirements	Clinical Support Services	Helen Baxter	12

452	Risk that the unavailability of electronic requesting within the blood transfusion service affects patient safety	Clinical Support Services	Helen Baxter	12
382	Risk that overdue refurbishment / lifecycle upgrade to CITU is leading to risk of increased infections to patients and a working environment not in line with recommended standards	Cardiovascular Services	David Paul	12
627	Insufficient senior scientific and managerial staffing capacity within the Immunology service	Clinical Support Services	Daniel Payne	12
552	Risk that specialist IT system BEST fails in Disablement Services and patient data is lost and may be unrecoverable	Neuroscience Services		12
391	Cath Lab Refurb Risk to Patient Care	Cardiovascular Services	Rachel Campbell	12
520	Risk that the risk that the middle grade medical rota for Critical Care becomes unsustainable (1763)	Theatres, Anaesthetics & Critical Care Services	Tom Bingham	12
535	Risk that the temperature of the CCOT office is too hot to work in.	Theatres, Anaesthetics & Critical Care Services	Kerry Akther	12
548	Risk that existing Neurology patients come to harm as a result of limited capacity to deliver Botox service	Neuroscience Services		12
530	Risk that patients or staff come to harm from damaged and broken critical care pendants (2897)	Theatres, Anaesthetics & Critical Care Services	Karen Banks	12
527	Due to a lack of storage in critical care there is a risk that equipment becomes damaged or inaccessible when required leading to sub optimal outcomes, including fire assessment breaches. Risk that there is a of lack of storage in Critical Care for e	Theatres, Anaesthetics & Critical Care Services	Karen Banks	12
374	Risk that lack of funding for community dysphagia (and therefore limited service availability in SALT) will impact on Patient Safety	Community & Neighbourhood Health Services	Georgia Payne	12

523	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 care RaCi service	Theatres, Anaesthetics & Critical Care Services	Tom Bingham	12
501	Risk of Service User Morbidity as we do not use Patient Track to monitor MEOWS which would enable clearer identification of Deteriorating Patient.	Family Health Services	Grace Murray	12
521	Risk that a lack of Consultant Intensivists means that there is inadequate senior medical staff cover for 33 patients (2105)	Theatres, Anaesthetics & Critical Care Services	Tom Bingham	12
545	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.	Theatres, Anaesthetics & Critical Care Services	Tom Bingham	12
537	Delayed discharges from critical care causes psychological harm to patients, who are exposed to witnessing distressing events within critical care. This increases length of hospital stay and increased healthcare costs.	Theatres, Anaesthetics & Critical Care Services	Karen Banks	12
615	Due to an inability to decant patients from clinical areas there is a reduction in the ability to effectively manage the IPC risk to patients leading to an increase in patients acquiring HCAI's across the Trust.	Corporate Services	Sharron Lance	12
401	Ward 4 flooring	Cancer Institute	Clare Allinson	12
579	Risk that the FHN Water Culvert may be damaged as part of Theatre Development Project groundworks	Corporate Services	Lewis Fernandes	12
601	Governance and Assurance of Procedural Sedation Training - STNHSFT	Corporate Services	Bevereley Smith	12
364	Friary hospital stair case and Lift	Community & Neighbourhood Health Services	Bev Dredge	12
506	Risk of sub-optimal provision of care to Neonates leading to patient safety issues, such as; infection outbreaks and poor parent/patient experience due to the Neonatal estate	Family Health Services	Vrinda Nair	12

499	Risk that service delivery is compromised due to gaps in medical rota	Family Health Services	Maeve OSullivan	12
561	Risk that patients come to harm and patient privacy and dignity is compromised due to lack of appropriate facilities in Neuroradiology for assessment and care for patients presenting with hyperacute strokes	Neuroscience Services	Joanne Evans	12
502	Risk of Increased Levels of Nitrous Oxide (Entonox) potentially causing staff morbidity	Family Health Services	Lynne Staite	12
554	The Neurophysiology database containing all clinical reporting is held on an unsupported server which may result in patient reports being completely lost and unrecoverable in the event of system failure.	Neuroscience Services	Helen Brown	12

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

NHS
University Hospitals Tees

Quality Committee

Monday 22 June 2026

Connecting to: Board of Directors

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 & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT), there remain a number of medium and high operational risks linked to Quality and Safety, which may impact the achievement of the strategic objectives.

The Committee received the BAF presentation and agreed that the risk appetite for Quality and Safety remains at "cautious".

The Fuller Compliance Report demonstrated that there are 2 areas outstanding, the specialist survey for security which is not yet commissioned, and the Board still seeking assurance that all areas are compliant. However, all areas are on track to be fully compliant by September with a review in the Autumn, and there will be a single role across the whole of UHT with this area of responsibility (designated to the service manager). The hot weather has resulted in various cooling units failing across sites, with the main issue being at South Tees. This is being actioned.

The Safer Medication Monitoring Report indicated that medicine reconciliation rates are still an issue, in particular at weekends in North Tees. UHT are transitioning to a target operating model and significant progress is being made towards the planned Medicines Values Programme, which will have a longer term cost saving.

The Integrated Performance Report metrics (at month April 2026) remaining as "Alert" for Infection Prevention and Control, and include E.Coli, MSSA, Klebsiella, Pseudomonas. UHT has been part of a wider ICB piece of work regarding infections, and continues to promote

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the fundamentals of IPC, monitoring via the dashboard. Work is underway on aligning further IPC policies across UHT, and it was noted that premises remain an issue.

An update on the clinical audit forward plan was presented and the committee discussed the significant lack of engagement and compliance with meaningful audit and subsequent quality improvement across UHT. There is a lack of audit plans moving forward from CSUs with no clear movement. The Committee noted an escalation to QPRs this month and follow up plan to deliver the clinical audit forward plan.

Due to the lack of resources within the mortality review team, learning from deaths reviews are significantly delayed at North Tees and Hartlepool. There is a move to appoint a lead medical reviewer and subsequently a team of reviewers.

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 Quality Committee received the Board Assurance Framework domain report for System Working and Reform covering both NTHFT and STHFT (reporting to end of April 2026). No strategic risks are outside of approved risk appetite and there are 22 planned mitigating actions to minimise the strategic risks.

Safe Staffing monthly report indicated that sickness / absence fell marginally across UHT, and that monitoring of health improvement plans is contributing towards positive management of sickness / absence. The Committee noted no impact on quality and safety.

The Perinatal Quality Oversight Model report for April, included the crude rate for stillbirths at North Tees, a stillbirth report is in progress to look at themes and trends and possible quality improvement initiatives. At North Tees the training is below compliance due to clinical commitments, however all staff having training dates booked in. The Committee noted the imminently expected publication of 2 national maternity reviews (Ockenden Review of Nottingham and Amos national review) and agreed that updates will be provided to the next Committee.

The Health Inequality Report demonstrated good progress made across UHT although some services still seek recurring funding. NHSE have revised their strategic priorities with a focus on 5 areas, which UHT are aligned.

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

University Hospitals Tees Quality Accounts were revised and the committee commended how clear they were and the amount of work undertaken. The Committee recommended approval

The Safe Staffing Report demonstrated that temporary staffing is demand led, with a continued emphasis on redeployment of staff ahead of NHSP utilisation. This has contributed to a reduction in temporary staffing demand.

The Organ Donation Report was presented and demonstrated consistently good performance in patients being referred to the donation services. There is good engagement of the team in the entire process. South Tees has received a letter outlining their excellence in performance.

In maternity services, North Tees booking by 9+6 weeks has seen a sustained improvement at 70%

University Hospitals Tees

People Committee

27 May 2026 & 23 June 2026

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.

Appraisals and Mandatory Training – Lack of Delivery and Accountability

The Committee remains concerned and received limited assurance in relation to persistently poor appraisal completion and mandatory training compliance across UHT. While improvement plans are in place, these have yet to demonstrate sustained impact.

Clarity of the approach to strengthen assurance is required to achieve as a minimum the agreed standards. This would include clear accountability and recognition of the importance for the individual and the organisation.

Committee requests assurance on:

- Updated approach to improving appraisal and mandatory training compliance, with defined expectations and timelines.
- Clarification that the Accountability framework is understood and applied Board to Ward and Corporate areas.
- Clear Approach to underperformance and mechanisms for measurable improvement, and appropriate escalation

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Violence, Aggression and Discriminatory Behaviour

Through the Governors a question raised regarding application of the Violence and Aggression policy. The Committee noted that there are two historic policies at both Trusts and as with other policies being brought together as UHT policy, but nothing that the policies are in line with the NHS national guidance.

Concerns have been highlighted by some staff of a normalisation of anti-social behaviour that is impacting overall patient experience, staff wellbeing and organisational confidence. Work continues with partners such as Police and internal security colleagues to support staff in being able to report incidents in real time.

The Committee welcomes further work on:

- Timescales for the implementation of a UHT policy
- Board support for staff for reinforcing the policy and encouraging a zero-tolerance culture

The matter will return to People Committee for assurance in September 2026.

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.

Staff Survey

Each CSU and Corporate function is undertaking a focused six-week improvement sprint to review both quantitative results and qualitative free text feedback. The outputs will include a clear gap analysis and prioritised action plans, with findings and progress to be reported back to the People Committee for assurance on delivery, impact and consistency across UHT.

Employee Relations

- Committee were updated on ongoing employment tribunal, suspension and discrimination cases.
- The Committee noted the NHS England Improving Sexual Safety Letter strengthened focus on learning from serious sexual misconduct cases and building a culture that supports confidence to speak up and act. This was considered timely and aligned with the Committee's concerns regarding violence, aggression and discriminatory behaviour. However, the Committee highlighted ongoing delays in training for specialist investigators, which risks limiting organisational capability to respond effectively.
- The Committee noted the national expectations arising from the Lord Mann Review including requirements for NHS Boards and staff to complete anti-racism training and strengthen leadership accountability for addressing racism and discrimination. However, the Committee noted that antisemitism training is still not available.

Absence Management.
Committee noted improved controls and the implementation of a comprehensive action plan, including a revised policy and targeted staff engagement through roadshows, to strengthen management oversight. Encouragingly, sickness absence has reduced structurally to 5.5%, with 14 attendance-related dismissals recorded in May 2026, indicating increased rigour and application of policy.

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

WTE (Whole Time Equivalent) - Reductions

The Committee recognised the scale of workforce challenge, including substantive vacancies across nursing and support roles alongside the delivery of a significant WTE reduction programme.

The Committee was assured through a detailed deep dive that early progress against the planned reduction of WTE in 2026/27 in line with the MTFP, supported by £10m NHS funding for redundancy costs, is on track. The voluntary redundancy scheme is being implemented with appropriate controls, ensuring releases are only approved where organisational resilience, patient safety and return on investment are evidenced, with external NHS England oversight providing further assurance.

This represents a positive start to the financial year. Triangulation with QAC and Resources & Performance will continue to ensure assurance alignment. However, delivery remains dependent on wider enabling factors, including CIP delivery and a sustained reduction in absence. The Committee will maintain close oversight and continue to seek assurance on delivery, impact and risk throughout the year.

BAF Refresh Update & Risk Appetite

Committee received the BAF presentation deferred from the Board Development Session on 4th June 2026 and agreed an OPEN risk appetite.

The Committee recognised the heightened challenge of maintaining strategic oversight during a period of intense organisational change, restructuring and workforce activity

Transforming People Services Plan

Committee were updated on the national Transforming People Services programme represents a significant reform that will require future organisational change once regional implementation timelines are confirmed.

Recommendations:

The Committee requests assurance to address to deliver acceptable levels of appraisal and mandatory training compliance.

Academic Committee

11 June 2026

Connecting to: Board of Directors

Chair of Committee: Chris Day

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.

n/a

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.

- **Criteria and Future Plans for Academic Research Units**
  Jeremy Henning, Director of Research, provided an overview of the development of Academic Research Units (ARUs), highlighting the need for clear criteria for establishing new units, alignment with organisational strategy and operating models, and an appropriate balance between research and education.

  The Committee agreed that new academic units should demonstrate sufficient grant income, support both research and education, and align with thematic funding opportunities, CSU structures and the wider organisational model. Academic units should be inclusive of all professional groups, including Nursing, Midwifery and Allied Health Professionals, with leadership arrangements reflecting this diversity. A principles-based framework setting out criteria and operating models for new academic units will be developed and circulated to the Committee ahead of the next meeting

- **Horizon Scanning :Medical School Development**

- An update was provided on progress towards establishing a new medical school in partnership with Newcastle University. Positive engagement with the GMC and ongoing legal negotiations were reported, with plans to utilise Newcastle's curriculum and secure contingency arrangements. Due to delays in the allocation of government-funded student places, the school may initially recruit a small cohort of self-funding students while awaiting formal approval to expand. The Committee emphasised the importance of attracting local students and exploring scholarships and financial support to support access to medical education. Risks associated with reliance on self-funding and international student recruitment were noted, alongside suggestions to consider training Newcastle students at Teesside as an interim measure. Approval has been given to recruit a full-time Programme Director to lead the school's development and accreditation process

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 content of the report.

University Hospitals Tees

UHT People Plan Update

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 3.3

Report author: Gary Wright, Deputy Director of Education & Learning

Executive director sponsor: Rachael Metcalf, Chief People 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:

BAF strategic risk:

- A culture that doesn't promote positivity, respect, inclusion and a focus on recognising, respecting and rewarding achievements**.**

- A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future.
- Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleague's ability to deliver quality patient care.
- Workforce planning and people practices don't support the Trust to deliver its services.

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.

Whilst no specific areas require escalation at this stage, it is acknowledged that achievement of the ambitions related to the People Plan needs to be balanced with the strategic priorities of the organisation. The People Plan cannot be delivered in isolation and requires support from the CSU's and the wider leadership of the Group.

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.

Positive progress against metrics has been achieved, however, the below are areas of improvement over the coming reporting period:

- Some CSUs have not yet validated their hierarchy to allow full roll out of ESR Supervisor Self Service across ST which will prevent a number of key people plan actions progressing
- Mandatory training compliance across UHT – specifically resuscitation training
- Fragmented structures
- Appraisal compliance below threshold with declining position
- Absence rates above threshold, however, recent improvements
- Level of pay inaccuracies at ST specifically Overpayments and Underpayments,
- Lack of availability of management side job evaluation panellists which prevent Job Evaluation progression and length delays
- Reduction in wte across people services may impact on our ambitions over the forthcoming years.

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, positive progress has been made against the metrics associated with the UHT People Plan. Review of the metrics against the People Plan shows that we are have achieved 50% of our aim, with the remaining 50% in the process of completion.

Recommendations:

The Board of Directors are requested to acknowledge the progress to date and support key actions as they arise to further improve achievement of the ambitions set out on the UHT People Plan.

EXEXUTIVE SUMMARY

This report provides an update on progress against the University Hospitals Tees (UHT) People Plan (2025–2028), which aims to create an outstanding experience for staff, develop a strong organisational culture, and position UHT as an employer of choice. The plan is structured around four strategic enablers: Developing for the Future, Culture and Inclusion, Embedding Wellbeing, and Collaborative Ways of Working, and is aligned to both organisational priorities and the NHS People Promise.

Review of the metrics against the People Plan shows that we are have achieved 50% of our aim, with the remaining 50% in the process of completion, demonstrating steady advancement across the programme.

Significant achievements include the delivery of a restorative just culture framework, introduction of disability and race pay gap reporting, a refreshed leadership development offer, enhanced mental health support, and improvements to the onboarding experience. Embedding the People Plan within Clinical Business Units has also been completed, strengthening ownership and alignment across the organisation.

Progress is also evident in key strategic areas. Work to enhance culture and inclusion includes restorative practice training, anti-racism initiatives, strengthened partnerships with external organisations, and the development of policies addressing sexual safety and hate crime. In collaborative workforce delivery, structured programmes are in place to reduce sickness absence and improve management capability. Meanwhile, data and digital improvements, such as a group-wide people dashboard, are enhancing oversight of workforce metrics and enabling more proactive performance management.

Despite these advancements, several key risks and areas for improvement remain. These include:

- Below-target mandatory training and appraisal compliance
- Sickness absence rates above target, despite recent improvements
- ESR system implementation outstanding in some areas
- Pay accuracy issues and delays in job evaluation processes

Delivery of the People Plan is also dependent on wider organisational alignment and leadership support, as it cannot be achieved in isolation from operational priorities. External factors, such as changes to apprenticeship funding, present additional challenges to workforce development ambitions.

1. PURPOSE OF REPORT

The purpose of the report is to summarise the progress made by People Services against the UHT People Plan (appendix 1).

2. RECOMMENDATIONS

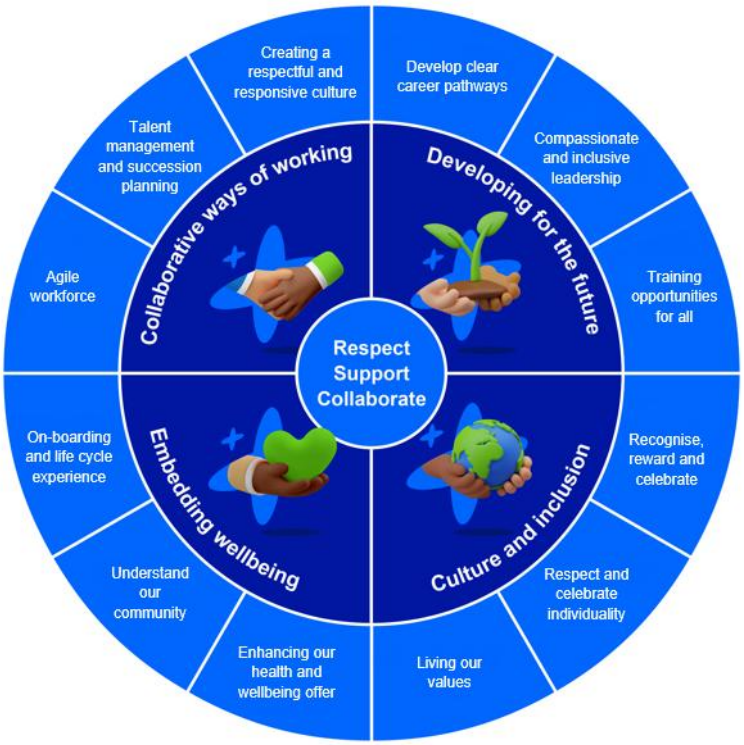
The Board of Directors are requested to acknowledge the progress to date and support key actions as they arise to further improve achievement of the ambitions set out on the UHT People Plan.

3. BACKGROUND

University Hospitals Tees (UHT) People Plan was launched in 2025 and runs to 2028. It has four strategic enablers, developing for the future, Culture and Inclusion, Embedding Wellbeing and Collaborative ways of working. The plan is our approach to creating an outstanding experience for our people by leading well and being an employer of choice.

The plan is underpinned by our Values, Respect, Support and Collaborate and our intention as People Service is that every interaction strengthens our culture.

The NHS People Promise has seven themes, and these are incorporated into the UHT People Plan. The diagram below shows the key components of the UHT people plan:



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4. DETAIL

Each of the four strategic enablers are underpinned by measures which are led by the appropriate People Services Deputy Director. The measures are reviewed monthly and actions tracked. Updates are provided to People Committee as part of the annual cycle of business. Measures for completion by 31/03/26 are as follows:

Measure	Due	Lead	Status	Sub Stream	Progress
Deliver harmonised restorative just & learning culture pathway	Mar 2026	JW & JH	Complete	Living our Values	Pathway, training & approach delivered
Introduce disability & race pay gap reporting	Mar 2026	JW	Complete	Celebrate Individuality	Reports presented at Committee March 2026
Develop group approach to reward & recognition	Mar 2026	JW	Complete	Recognise & Celebrate	Approved at Feb Committee
Deliver refreshed leadership development offer	Mar 2026	JW	Complete	Compassionate Leadership	Embedded into BAU
Improve mental health support (7-day consultation)	Mar 2026	BH	Complete	Health & Wellbeing	Pathway in place, functioning as BAU
Implement digital candidate & starter feedback	Mar 2026	BH	Complete	Onboarding Lifecycle	Embedded into BAU
Embed People Plan into all Clinical Business Units*	Apr 2026	JH	Complete	Respectful & Responsive Culture	Plans complete, QPR and people weeks in place
Deliver 12 month check in for new colleagues	Mar 2026	BH	In progress	Onboarding Lifecycle	Ready to go live, waiting for ESR data.
Develop one set of harmonised people policies (Top 5 first)*	June 2026	JH	In progress	Respectful & Responsive Culture	Top 7 policies signed off or expected to be signed off June 2026
Utilise 100% of apprenticeship levy	Oct 2026	GW	In progress	Training for All	Breakdown of spend over the last three years be provided for inclusion in the Chairs Escalation Log to the BoD

Health and Wellbeing checks available at UHT welcome day and opportunity for personalised 1:1 health checks by October 2026.	Oct 2026	BH	In progress	Onboarding Lifecycle	Slimmed back version trial due to being in a public area
Achieve mandatory training compliance threshold*	Mar 2027	GW	In progress	Training for All	May 2026 data UHT -0.97% below trajectory (CSU 8 above trajectory)
Achieve appraisal compliance threshold*	Mar 2027	GW	In progress	Training for All	Policy / documentation approval June 2026.
Reduce sickness absence by 1%	Mar 2027	JH	In progress	Agile Workforce	Reduced slightly by 0.4% to 5.8% in April 2026

4.1 Culture and Inclusion

Work is underway to strengthen and embed a consistent restorative approach across UHT to support workforce challenges, employee relations, civility, psychological safety and learning following patient safety incidents. A restorative approach focuses on repairing harm, strengthening relationships, accountability and learning, rather than blame, with the ambition of reducing sickness absence, formal disciplinary escalation and staff turnover.

To date, over 70 colleagues have received restorative training, supporting local capability and restorative conversations across services. Current priorities include establishing the baseline position through development of a restorative skills matrix, understanding existing provision and workforce capability, reviewing current pathways and documentation, and developing a standard operating procedure (SOP) and Terms of Reference to support consistency of approach. Refresher and advanced restorative training programmes are also being developed to further strengthen capability and support implementation across the Group.

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data has recently been submitted to NHS England, and work is currently underway to produce the associated reports. We have made a commitment to being a member of Become the Bridge which is an initiative hosted by the NEAR (North East Anti Racism) coalition which is challenging racism, with various other organisations, for a fairer and stronger North East.

As part of a regional approach to anti racism and all hate crime and social inequalities of our community, we continue to strengthen our connections with Cleveland Police, NEAR Coalition, VCAS and other external agencies. This includes having a named link at

Cleveland Police to better embed this work. Alongside our internal assurance we are developing practical pathways and guidelines to support staff in keeping safe, in and out of work. We continue to build links with Independent Advisory Groups (IAGs) within Tees Valley, focusing on Hate Crime.

Planning has commenced in the development of a Hate Crime event, as part of our November EDI conference focused on disability. The event will actively involve external stakeholders including Cleveland Police, local authorities and VCAS to highlight and raise awareness of the impact of hate crime, and signposting linked to reporting and support available. This supports the work we are doing in relation to anchor organisations. We have a monthly Tees Valley UHT Hate Crime operational group that meets to plan the event and discuss ongoing hate crime work across the Group.
A seven-point plan has been developed, working closely with Cleveland Police plan to support staff and managers following a hate crime or racist event which is to be presented, for awareness to colleagues across the Group.

We are working closely with our communications team in regard to posters around violence and aggression towards staff, reporting using Healthcare Guardian and reporting Hate Crime through Cleveland police and Crimestoppers as well the support available to staff who have been a victim of Hate Crime. These will be launched from June to November in the run up to our EDI conference.

The M3C programme (Multi Cultural, Communication and Connection) commenced in May with 12 participants. This programme is in collaboration with the Education and Training Collective (ETC) to promote inclusion and diversity within our organisation.

Work is continuing following our Staff Networks meeting with Group Board earlier this year in relation to sharing the good work taking place across the networks, priorities for the next 12 to 24 months and challenges network leads are facing in relation to progressing this work.

The appraisal documentation has been updated, taking into account feedback from stakeholders, this has been presented at People Group and People Committee. There is an option of managers conducting team appraisals, setting team objectives. An individual appraisal must still take place within 6 to 8 weeks of the team appraisal taking place. The revised Group document has been developed to ensure it is easy to navigate and also meets individual need from a quality perspective. This includes the availability of a talent management discussion around career advancement and progression if the individual wishes for this to take place and in-depth wellbeing support if required.

The sexual safety policy is going through final stages of ratification, with communication strategy planned to support the launch. Work is continuing in confirming individuals in response to the communication from NHS England, urging Trusts to identify relevant parties to attend ‘train the trainer’ investigator training and identify a pool of specialist sexual safety investors across UHT. Individuals to be trained have been identified across the Group,

and national training is taking place June and July 2026. Internal training of will then be rolled out to identified leads and specialist investigators in line with the national requirements and good practice. A UHT gap analysis was undertaken against the sexual safety charter to ensure we are achieving or working towards the pledges and to developing appropriate actions where further work is required.

Work is underway to have a pool of Sexual Safety Champions across UHT, including representation from senior Clinical Service Units and members from staff networks. This approach is intended to strengthen organisational capacity, ensure visible leadership support, and embed an intersectional perspective, drawing on the diverse experiences and insights of the workforce to support a safe and inclusive environment for all staff.

4.2 Collaborative Ways of Working

The Trust is required, as part of the 2026/27 national planning round, to deliver a sustained reduction in sickness absence, targeting a decrease from a 6% baseline to 5% in year one and to 4% over five years. A structured absence reduction programme is being implemented, with progress monitored through established governance routes including People Group, People Committee, and Board reporting, alongside external oversight via the ICB. Monthly absence trajectories have been developed at Trust and CSU level to support delivery of a minimum 1% reduction, aligning operational accountability with wider workforce and financial recovery priorities.

Delivery is underpinned by a comprehensive action plan focused on early intervention, consistent policy application, and strengthened management capability. Key measures include targeted absence assurance clinics, enhanced data visibility through real-time systems and Power BI, and improved occupational health access, including fast-track referrals and proactive wellbeing support. A revised Absence Management Policy will support consistent practice, alongside joint training with staff representatives to build manager confidence. Additional enablers include strengthened case management processes, quality assurance of formal reviews, development of automated tracking systems, and targeted leadership development to improve absence management, wellbeing conversations, and sustainable return-to-work outcomes.

Positive progress has been made with regards the harmonising of policies across UHT. In conjunction with our staff side colleagues, the first five policies (Absence, Recruitment, Disciplinary, Capability & Sexual Safety) have been ratified and work is underway with the next batch of policies.

4.3 Developing for the Future

Access to timely and accurate data is critical to support leaders and manages positively impact on training and appraisal compliance. People Services and Business Intelligence teams across UHT have developed a new group-wide people dashboard to improve visibility

and operational accessibility of compliance information. The dashboard will provide a unified view across all sites and services, enabling senior leaders and managers to review performance in real time and identify areas requiring targeted support. As part of the phased development, functionality will be expanded to allow drilldown reporting to CSU, team and eventually individual staff level. This enhanced granularity will support more proactive management of compliance, although this element remains a work in progress and will be rolled out as data quality and system capabilities mature. The dashboard will replace all previous manual reports circulated.

A Mandatory Learning Oversight Group (MLOG) has been established to oversee statutory and mandatory training across UHT. The initial focus is on the core topics contained within the Core Skills Training Framework; however, work is also underway to review and harmonise non-core topics. NHS England are in the process of reforming mandatory training to a more risk-based approach and UHT are represented on regional and national forums.

From April 2026, the Apprenticeship Levy transitioned to the Growth and Skills Levy, retaining the 0.5% payroll contribution for employers with pay bills over £3m but introducing significant changes to how funds can be used. The reforms aim to better align skills investment with national economic priorities and increase opportunities for young people. Key changes include a reduction in fund expiry from 24 to 12 months, removal of the 10% government top-up, and an increase in employer co-investment from 5% to 25% once levy funds are exhausted, placing greater emphasis on strategic workforce planning. In addition, from 2026, most learners aged 22+ will no longer be eligible for funded Level 7 apprenticeships, requiring organisations to reconsider leadership and development pathways.

Alongside these changes, a national review has identified 16 apprenticeship standards for defunding from September 2026, including high-volume leadership and management programmes, to redirect investment toward priority sectors and ensure value for money. Delivery of these standards will be capped during transition. A new model of “apprenticeship units” will also be introduced from April 2026, offering shorter, modular training (30–140 hours) focused on priority technical skills such as AI, renewable energy, and advanced manufacturing. These units will be fully funded for employed learners aged 19+, with strict delivery requirements and provider eligibility criteria. While this creates opportunities for more targeted upskilling, some operational details, including funding bands, remain unclear, presenting short-term planning challenges for employers.

The Changes pose significant risk to achieving full utilisation of the levy by October, however, work is underway to promote apprenticeships, aligned to workforce plans. In addition, work is also underway to improve forecasting of levy spend over the life span of programme.

4.4 Embedding Wellbeing

Increasing the use of ESR functionality underpins several of our key actions. The phased deployment of ESR Self Service is currently underway, ensuring that UHT has the solid

foundation required to support many of our related processes and also ensures that we a future ready for the new workforce solution

Although turnover at UHT has been stable and under threshold for a number of years, annual turnover insights reveal that a significant number of colleagues leave UHT within the first 2 years of service, this equates to approximately 40% of all voluntary turnover. To develop a further understanding of this, a 12 month check in with new colleagues has been developed to allow colleagues to share their experience and assess any appetite to leave. The survey platform and communications have been issued; feedback will be sought at each quarter and will inform development actions. Quarter 1 feedback will be sought in early July.

The newly developed UHT Welcome Day now provides new colleagues with the opportunity to have an individual discussion and personalised health check. Drop-in sessions are currently being developed for colleagues to be able to have personalised health checks and discussions, on track to be implemented by October 26.

An enhanced mental health support offer has been in place since the end of 2025, going beyond the core offer of counselling, colleagues now have access to personalised mental health support through Alliance, who ensure clients are offered an initial assessment within 5 working days of contact. The service receives high numbers of self-referrals and provides 24/7 support and access to a digital wellbeing hub. Users of the service report high rates of satisfaction and early returns from sickness absence

Both North Tees & Hartlepool NHS FT and South Tees Hospitals NHS FT have recently been awarded Ambassador status for the Better Health at Work Award, which tests and demonstrates UHTs commitment to improving the health and wellbeing of our colleagues**.**

5. Good Practice and Areas of Improvement

Outlined below is the areas of good practice and improvement related to the people plan:

5.1 Good Practice

Across People Services, we can identify good practice as follows;

- Our health and wellbeing offer and the almost instant access to mental health support.
- Increase in Occupational Health clinical capacity by 15% due to shared working model.
- The UHT welcome day, this receives positive feedback.
- The development of the onboarding applicant dashboard which is now live.
- The developing work to Anti-Racism and being one of six organisations to work with BRAP in their quiet revolution.
- Our approach to hate crime and the development of restorative work with our colleagues in the Police.
- Our re-framed MDT process for employment relations cases.

- Our offer for leadership and management training to all colleagues in the group.
- The service review and action planning facilitation provision to clinical areas.
- Resident Doctors 10-point plan report developed outlining progress against KPI's.
- SAR & QIP data gathering to support quality meeting with deanery.
- Established Careers Days at the HSCA with expanded T-Level offer.

5.2 Areas for Improvement

- Some CSUs have not yet validated their hierarchy to allow full roll out of ESR Supervisor Selve Service across ST which will prevent a number of key people plan actions progressing.
- Mandatory training compliance across UHT – specifically resuscitation training.
- Fragmented structures.
- Appraisal compliance.
- Absence rates – although some improvements have been made recently, further, sustained reductions needed.
- Level of pay inaccuracies at ST specifically Overpayments and Underpayments.
- Lack of availability of management side job evaluation panellists which prevent Job Evaluation progression and length delays.
- Reduction in wte across people services may impact on our ambitions over the forthcoming years.

6. CONCLUSION

Overall, in the twelve months since the People Plan was developed, positive progress has been made against the metrics associated for 2026. Review of the metrics against the People Plan shows that we have achieved 50% of our aim with the remaining 50% in the progress.

The People Plan is a key enabler for us to be an employer of choice and we acknowledge that it is too early in the plan for us to be able to say that this aim has been met.

The Board of Directors are requested to acknowledge the progress to date and support key actions to further improve achievement of the ambitions set out on the UHT People Plan. In addition, it is suggested that regular updates on progress are presented at People Committee for assurance.

APPENDICES

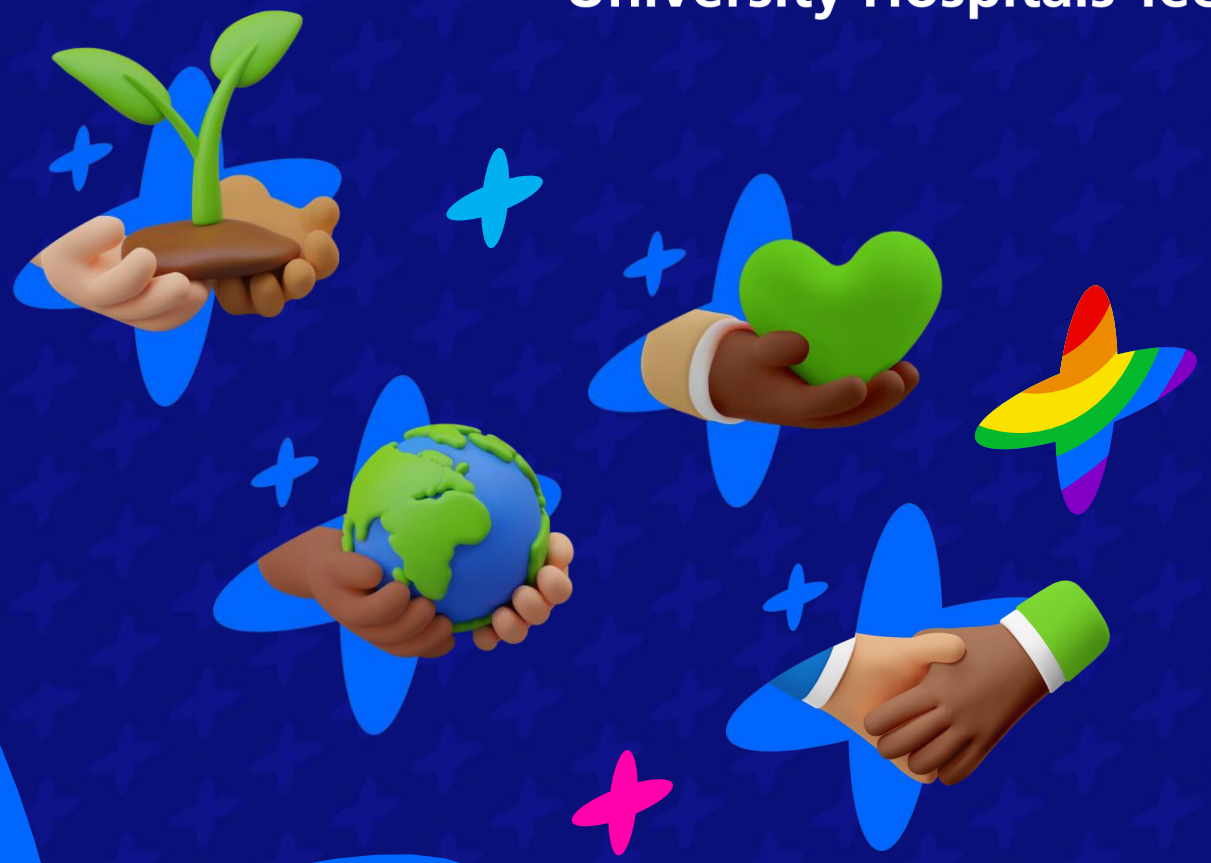
Appendix 1 UHT People plan

People Plan V 16.pptx

NHS
University Hospitals Tees

People Plan

2025 -2028



Caring Better Together

Foreword

University Hospitals Tees (UHT) comprising North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust officially formed as a group in January 2024.

Our two trusts are the area's largest employers, with a budget of around £1.2billion and more than 15,000 staff who deliver acute, tertiary and community health and care services across the Tees Valley, North Yorkshire, County Durham and beyond.

Our strategic objectives are:

- Putting patients first with consistent high-quality care that delivers best practice in effectiveness, safety and experience
- Working with partners to tackle shared population health challenges and to reduce health inequalities for our population
- Reforming models of care across our services and supporting the development of neighbourhood health systems
- Developing excellence as a learning organisation through our work in research, education, improvement and innovation
- Creating an outstanding experience for our people by leading well and being an employer of choice
- Using our resources well and driving productivity in services to achieve financial sustainability

Our People Plan has been created based on feedback from the staff survey and engagement with colleagues from across our group. We have also embraced the ethos of the NHS People Promise.

Welcome

Welcome to our University Hospitals Tees People Plan. This plan sets out our approach to creating an outstanding experience for our people, by leading well and being an employer of choice. We will also outline how we are dedicated to developing excellence as a learning organisation through our work in research, education, improvement and innovation.

Great care is delivered by great people, and we know that to continue to provide high-quality healthcare services, we need to support our colleagues to be the best they can be at work.

In recent years, those working in the NHS have continued to work with some considerable challenges. Our People Plan has been developed with this in mind. We know we have a considerable agenda to achieve as the NHS embarks on a journey of reform, and we need to develop robust financial plans and working collaboratively with other health and social care providers to make the most of our resources. We continue to develop our group model and align our services, with patients and our communities at the heart of our focus.

Caring Better Together

As a group, we do not work in isolation, and we will continue to work in collaboration with system partners at place and Integrated Care System (ICS) level in the delivery of our People Plan and our wider strategic objectives. We are aware of our role as an anchor organisation in our communities, and our dedication to working with our stakeholders will be critical to our success. We know so many of the socio-economic determinants of health are from outside of our NHS, these partnerships will help us to advance our communities health and care outcomes.

As a multi-site Group, we work collaboratively with partners across the Tees Valley and North Yorkshire systems.

Our People Plan is critical in developing our culture and underpinning our values in all that we do to attract, recruit, develop, retain and support our people and teams to meet the needs of our patients across our region.

The strategic enablers of our People Plan are:

1. **Developing for the future**
2. **Culture and inclusion**
3. **Embedding wellbeing**
4. **Collaborative ways of working**

Our values of respect, support and collaborate will thread through all our strategic enablers.

Rachael Metcalf
Group Chief People Officer

Our current workforce

University Hospital Tees is the largest employer within the area it serves, and we know that more than half of our colleagues live within the locality of the communities we support. This means that many of our colleagues and their families are our existing and future patients and our workforce for the future.

Our workforce is diverse and our people are committed and dedicated, with more than half of our colleagues staying with us for more than 5 years and more than 60% of staff across the Group stating they would strongly recommend us as a place to work, through the staff survey.

We stretch across multiple sites and cover a large geographical area. Our job range is vast, we employ more than 5000 Nurses, 1500 Doctors and over 3000 clinical support staff and there are occupations for all people, regardless of skills or qualifications, as we offer more than 300 careers. Once part of our team we will work with our colleagues to develop their career and fulfil their potential so that they can make a difference every day to our patients.

Caring Better Together

Total staff

16240

18%

of our workforce are global majority

6%

of our workforce are disabled

40%

of our workforce live with areas of highest deprivation

Nationalities across our workforce

Male 2917 18%

Female 13323 82%

0 — 16240

Workforce age range

Under 20	115	0.71%
51-60	3654	22.50%
31-40	4390	27.03%
41-50	3747	23.07%
21-30	2717	16.73%
61-70	1539	9.48%
Over 71	78	0.48%

Workforce disability

No	12988	79.98%
Yes	1003	6.18%
Not declared	2249	13.85%

Disability reason

Long-standing illness	281
Learning disability/difficulty	251
Yes - Unspecified	118
Mental health condition	102
Other	73

Workforce ethnicity

BME	2428	14.95%
White	13560	83.50%
Not Stated	252	1.55%

Workforce by continent

Africa	429	2.64%
Asia	1067	6.57%
Europe	14683	90.41%
North America	27	0.17%
Oceania	8	0.05%
South America	8	0.05%
Unknown	18	0.11%

Top 5 nationalities

British	14397
Indian	553
Filipino	272
Nigerian	234
Pakistani	79

Our values

Our values have been produced with input from over 6,000 of our colleagues. We know that when we work together, we are providing better patient care.

Our values are that we will respect, support and collaborate to provide the best patient care.

When we are working together, we need to be able to live our values, and so we have developed a Values into Action framework. We will use this framework to better work with each other and for our patients.

Respect

Enables
- promotion of equity, diversity and inclusion
- compassionate, inclusive patient care
- deliver the best possible care

In practice:
- treat others as we would wish to be treated
- holding myself and others to account to demonstrate professionalism and integrity
- listen and communicate to others
- be open to feedback
- be accountable for personal development and growth

Support

Enables
- patient centred care
- meeting individual needs with dignity and respect
- ensuring all staff and patients feel included and connected

In practice:
- work as a team
- listen with compassion and empathy
- speak and act with kindness
- offer and ask for help
- work through challenges together

Collaborate

Enables
- sharing knowledge & skills
- clear and honest communication, appreciating all contributions
- valuing each member of my team and my patients
- work together towards shared goals, across services and organisations

In practice:
- seek and respect other's views (even if we don't agree)
- take ownership and do what we say we are going to do
- show initiative and leadership
- build trusting relationships

Purpose of Our People Plan

By living our values to support, respect and collaborate with every interaction we will create an outstanding experience for our people by leading well and being an employer of choice and developing excellence as a learning organisation through our work in research, education, improvement and innovation. We will lead well and ensure that we collaborate with all partners to provide the best patient care.

The strategic enablers of our people plan are:

1 Developing for the Future

2 Culture and inclusion

3 Embedding wellbeing

4 Collaborative ways of working

The NHS people promise

The NHS People Promise sets out seven themes which have come from the staff who work in the NHS and identifies what it is that matters to them. These themes are incorporated into our University Hospital Tees People Plan, listening to colleagues in our Trust and identifying what is important to us.

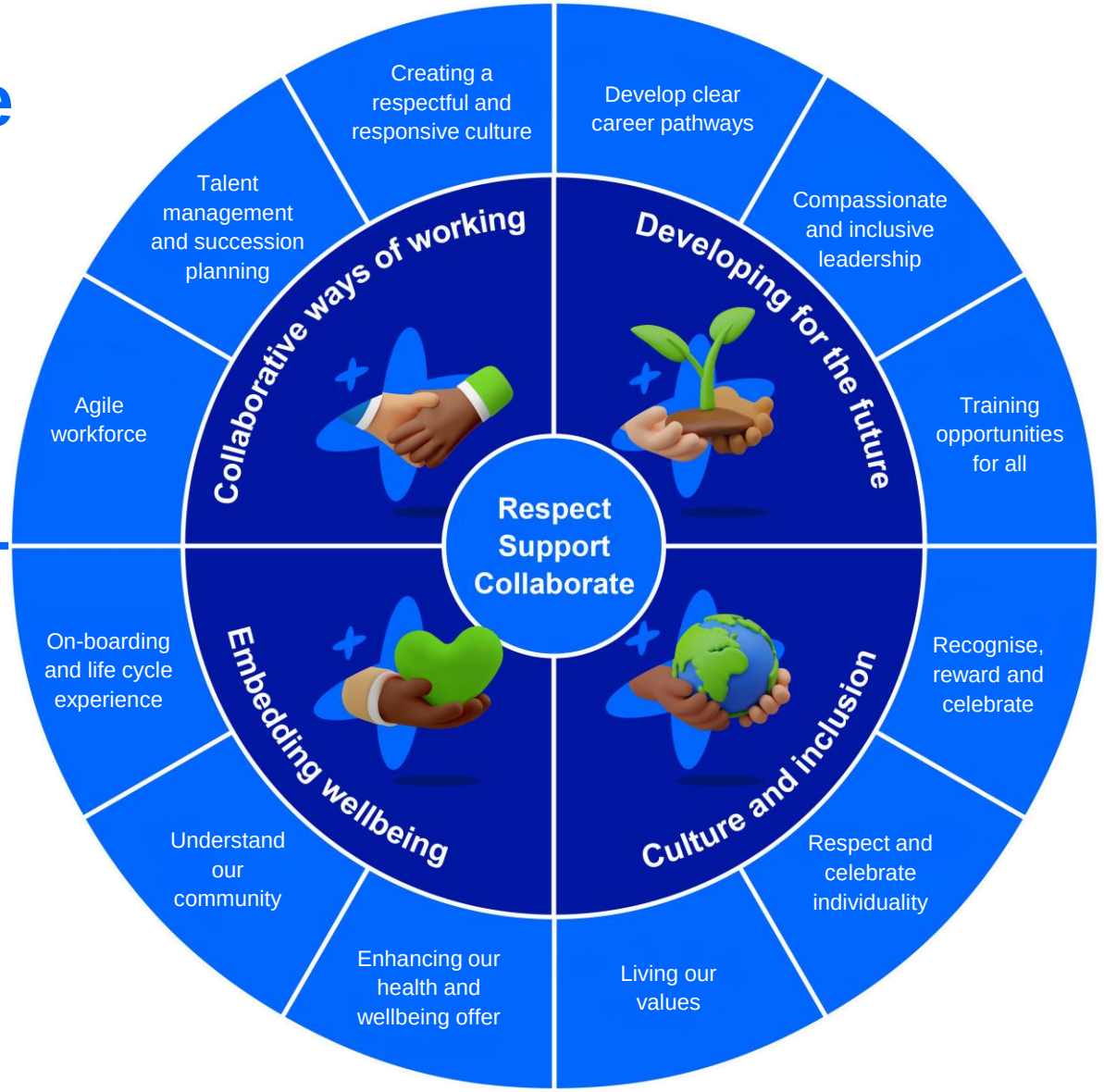
Our people plan on a page

Our aim is to make University Hospitals Tees a great place to work. We want to be an employer of choice for our existing people and potential new colleagues.

To achieve our aim we will, together, continue our improvement journey and deliver our People Plan through four strategic enablers with measurable actions.

Every interaction shapes our culture

Your role in achieving this aim is to demonstrate great leadership and ensure that you and your team benefit from the offers available. You are accountable for your own development.



Caring Better Together

Developing for the future

Our aim is to ensure our workforce has the knowledge, skills, values and behaviours they need to deliver compassionate, high-quality care to our service users. This will enable us to develop and retain staff with the right skills to deliver the organisational objectives, we will align our workforce plans with the people requirements of clinical and corporate services identifying talent pipelines and development opportunities.

We will enhance our existing relationships and build new partnerships across the education sector and develop relationships across the wider health and social care sector. It is vital that we support and equip our leaders with the skills required to lead in complex environments. We will provide access to high quality leadership development aligned to the national leadership framework to all our current and future leaders.

Develop clear career pathways

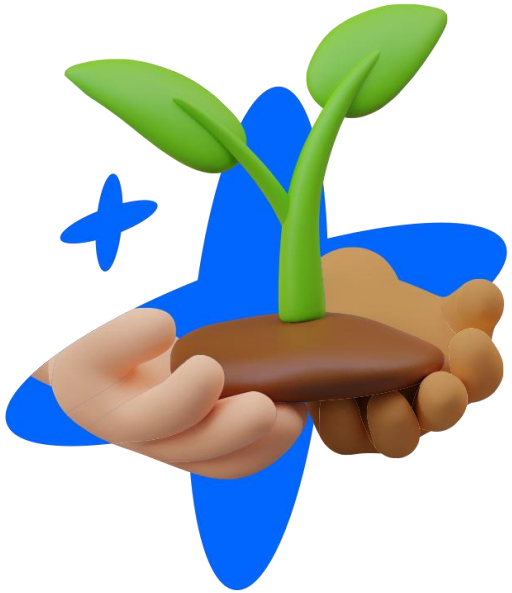
- Collaborate with key internal and external partners to plan our workforce for the future with robust workforce plans that outline career pathways.
- Developing innovative roles in partnership with stakeholders across the Health & Social Care System.
- Aligning our apprenticeship levy with future workforce need.
- To develop talent pipelines which offer realistic development opportunities.

Compassionate and inclusive leadership

- Investing in our people by developing effective, multi-professional leadership programmes.
- Alignment to NHS Leadership Framework.

Training opportunities for all

- Create a multi-disciplinary skills model that ensures alignment across professional and clinical education.
- Fully inclusive training offer.
- Developing effective processes for training aligned to National Care Skills Training Framework.



Developing for the future

What Success Will Look Like

- Each service area has a robust workforce plan which is used to inform decisions.
- Overall mandatory training compliance will meet the threshold set and be accessible to all staff
- We will have innovative and clear career pathways developed in conjunction with key stakeholders.
- Staff will have access to high quality and relevant leadership and management programmes that enhances their practice.
- We will develop and maintain relationships with a wider range of education providers across the Tees-Valley – embedding colleges into core workforce development, better utilising their local recruitment and training power resulting in a sustainable, agile and innovative future health and care workforce.
- Alignment of the apprentice levy, in line with our corporate responsibility.

Measures

- Meeting our mandatory training compliance threshold continuously by March 2026.
- Meet appraisal compliance threshold by March 2026.
- Refreshed Leadership development offer in place and embedded by March 2026.
- Utilising 100% of the apprenticeship levy by October 2026 with an increase in breadth and number of apprenticeship opportunities.
- Development of strategic multi-year workforce plan, in conjunction with clinical, operational and finance colleagues by October 2027.
- Suite of clear career pathways guides in place by October 2027.
- Strategic workforce planning tool introduced and embedded by March 2028.
- 10% of the workforce to have talent management plans in place by March 2027.
- Improvement in staff survey results in the ‘we are always learning’ theme.

Your role…

All staff

Complete all your mandatory training
Have an annual appraisal conversation

Leaders and Managers

Develop workforce plans to ensure your teams develop and meet their potential

Culture and inclusion

Our aim is to foster a culture of respect and inclusion, ensuring our workforce is engaged and supported. We will provide high value leadership and high performing team development and work with our values to deliver compassionate, collaborative, high quality inclusive care to both our colleagues and service users. We will work together with respect for all people and grow collaborative leaders who reflect our values.

We will give our people a voice and enhance our existing relationships, bringing life to our values and working in partnership in a restorative way. It is vital that we are at the forefront of the equity agenda, ensuring all our colleagues are included, we will work with regional colleagues to ensure that we enhance and consolidate our existing relationships.

Recognise, reward and celebrate

- Develop a Group reward and recognition strategy by listening to our people to understand what really matters to them.
- We will recognise and celebrate our achievements.
- Grow and embed our range of staff networks

Respect and celebrate individuality

- Being an employer of choice for all, regardless of background or protected characteristic.
- Build and develop a workforce that represents our communities at all levels, listening to and learning from lived experience of our community.
- Introduce a reciprocal Mentoring Programme across University Hospitals Tees.
- Developing a suite of training and development programmes covering various aspects of EDI, accessible to all colleagues and leaders.
- Enhancing our inclusive recruitment practices.

Living our values

- Continue to develop a restorative just and learning culture whilst embedding accountability.
- Foster a culture of respect, support and collaboration.
- Embed our values into an action behaviour compact.

Culture and inclusion

What Success Will Look Like

- Increased percentage of staff sharing their protected characteristics in more senior roles.
- Implementation of all six high impact actions under the NHS EDI improvement plan.
- Reduction of the number of colleagues reporting bullying, harassment or abuse at work.
- Increased completion of the staff survey through promotion of our staff survey results and continued implementation of action plans.
- Values based recruitment and appraisals for the Group.
- Our colleagues are confident to report inappropriate sexual behaviours in the workplace.
- Staff are rewarded and recognised.

Measures

- Introduction of a disability and race pay gap by March 2026.
- Develop a group approach to rewarding and recognising our people by March 2026.
- Achievement of ambitions in relation to increased representation and diversity in leadership positions by March 2027.
- Implementation of all six high impact actions under the NHS EDI improvement plan by March 2027.
- Increasing our staff survey score ‘we have a voice that counts from 6.67 to the upper quartile by March 2027.
- Improvement in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) outcomes by March 2027.
- An improvement in our staff survey result for reward and recognition from 5.89 to upper quartile by March 2028.

Your role…

All staff

Live the Group values and challenge or praise using our values into action compact
Take personal action for equity for all your colleagues

Leaders and Managers

Develop local plans for equity and inclusion

Embedding wellbeing

We know that a healthy and happy workforce provides better patient care, we also know that we are the largest employer within the area we serve and many of our new and existing colleagues are also our present and future patients. Therefore, the health and wellbeing of our colleagues continues to be a priority for us. We want to build on the excellent support we offer by developing an even deeper understanding of the demographics and health needs of our colleagues, this will help us shape individualised and meaningful wellbeing support that makes a positive difference.

Our commitment to caring for the wellbeing of our colleagues is not skin deep, we want to weave wellbeing throughout our culture (it's not a policy, it's our people). Our ambition is that there will be caring and supportive onboarding, with support before the ‘first day’ and this sets the tone for the future. We want to be an employer of choice, where our colleagues can say they feel cared for and supported.

We will work collectively and listen; we will help enable our colleagues to take greater personal responsibility in looking after their health and wellbeing.

Caring Better Together

Our colleagues have told us that mental health and financial hardship continues to be a real cause for concern, and we are committed to providing a greater level of support to help.

Enhancing our health and wellbeing offer

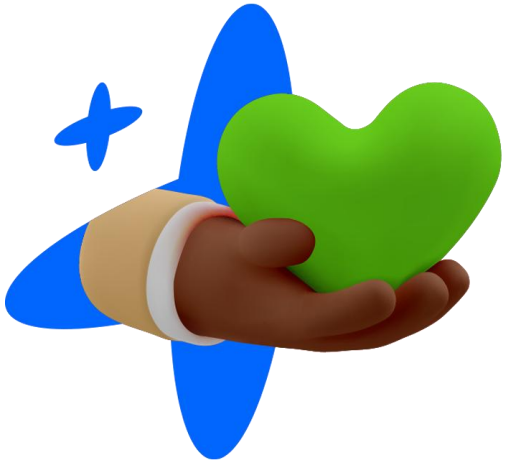
- Providing an individualised approach to mental health support.
- Providing money management support on a one-to-one basis.
- Regular, personalised health checks and lifestyle coaching.

Understand our community

- We recognise that our community are our colleagues, and we want to develop a deeper understanding of how our demographic may impact on our colleague's wellbeing.
- Developing an offer of individualised lifestyle coaching programmes.

On-boarding and life cycle experience

- Ensuring that our new colleagues are fully prepared and looking forward to their first day.
- Checking in with our new colleagues to find out how we are doing and how they are feeling.
- Meaningful ‘welcome days’ in place for all new colleagues.
- Learning from leaving, review and refine our exit process
- Development of internal people transfer system



Embedding wellbeing

What Success Will Look Like

- New colleagues feel well prepared for their first day and provide positive feedback on their onboarding experience.
- Our colleagues feel cared for from day one.
- We have a deep insight into the wellbeing needs of our colleagues.
- We shape our health and wellbeing support to the needs of our colleagues.
- We know and understand why colleagues may chose to leave within the first 2 years and can formulate preventative actions where needed.

Measures

Improved Mental health support provided for colleagues, with contact and pathway consultation to take place within 7 working days by March 2026.

Develop digital feedback from candidates, new starters and recruiting managers by March 2026.

12-month check in with new colleagues to share their experiences and develop a learning log by March 2026.

Health and Wellbeing checks available at UHT welcome day and opportunity for personalised 1:1 health checks by October 2026.

On site/remote workshops and the opportunity for 1-1 money management coaching available to all by March 2027.

Implement a digital solution which allows greater engagement with new colleagues throughout the recruitment process by July 2027.

Increased use of automation in people processes with a positive impact on user experience by July 2027.

Introduce onboarding companions for new colleagues by October 2027.

Your role…

All staff

Be responsible for your own health, take the steps to remain well and seek help and support
Check in on colleagues, ask ‘are you OK?’
Have an annual flu vaccination

Leaders and Managers

Work closely with all colleagues to ensure wellbeing in the workplace

Collaborative ways of working with you

We aim to further develop capability and promote innovation through working collaboratively with colleagues by enhancing our relationships across University Hospitals Tees. We will work together to;

- Offer new opportunities to deliver new, improved or more integrated services
- Develop a stronger more united voice
- Share knowledge and information

We will do this by working jointly with colleagues across our group to identify the people requirements of both clinical and corporate services.

Agile workforce

- Improve understanding of flexibility and flexible working by providing on-line workshops.
- Carry out a thorough analysis of flexible working arrangements, by examining the type of flexible working requests that are made and those factors we can influence to increase effective use of agile working.

Talent management and succession planning

- Identify development opportunities to equip our leaders with the skills and capabilities required to lead in a demanding environment
- Design a suite of easy to access, short, on-line development modules for managers to compliment the Management Essentials Programme.
- Workforce plans will include a succession plan for key roles within clinical and corporate areas, which include identified and agreed development requirements.

Creating a respectful and responsive culture

- Develop single people centric policies and processes that clearly set out expectations of everyone involved.
- Review and update the restorative pathway to include reasoned consideration and decision making on the correct course of action, with a focus on the impact on people.
- To improve internal people processes and policies, develop a ‘Your Views Matter’ action plan to address feedback received from information provided by staff, ensuring they are made aware of any action to be taken in a timely manner.

Collaborative ways of working with you

What Success Will Look Like

- Each Directorate has a robust workforce plan, including a succession and talent management plan to meet the needs of the national planning workforce return.
- Improvement in colleagues recommending UHT as a place to work as evidenced in the national staff survey.
- Develop a blended learning people management programme, providing managers with the skills to lead a complex workforce.
- A reduction in the number of colleagues involved in a formal employee relations process.
- People policies and processes are consistent across University Hospital Tees.
- Improvement from the 2024 staff survey metrics relating to flexible working.
- We will work towards significant reduction in sickness absence.

Measures

- Develop one single set of people policies for University Hospital Tees with the top 5 policies to be harmonised initially by March 2026.
- Creation and delivery of a harmonised University Hospitals Tees pathway for a restorative just and learning culture by March 2026.
- Embed the People Plan into all Clinical Business Units, with individual accountability by March 2026.
- Improvement in staff survey questions on flexible working from 6.07 to upper quartile by March 2028.
- Reduction in sickness absence by 1% from 2024 data by March 2026
- Increased completion of the staff survey through promotion of results and continued implementation of action plans. Increase from current UHT response rate of 36% to 40% by March 2028.
- A decrease in formal grievance rates to 10% by March 2028.
- Clinical and Corporate succession plans developed, which include the identification of successors for key roles and supported by individual development plans, by October 2027
- Reduction of the number of colleagues reporting bullying, harassment or abuse at work, from 2024 baseline by 10% by March 2028

Your role…

All staff

Complete your staff survey so that we can learn and grow
Raise concerns quickly and appropriately with a resolution focus not blame

Leaders and Managers

Foster a restorative culture within your teams
Attend training and understand our restorative approach

Safe Staffing Monthly Report (Apr 26 data)

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 3.4

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: Quality Committee and 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:

Safe

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

This report provides assurance on inpatient nursing staffing for April 2026. Robust processes are in place to ensure staff with the appropriate skills are deployed to meet patient need and maintain safe care. Daily Safe Care Staffing meetings review ward acuity, dependency and occupancy, enabling timely redeployment and escalation where required. Staffing risks are actively mitigated to the lowest feasible level through agreed actions overseen by senior nursing leadership.

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, turnover increased for both registered and unregistered staff during April 2026 (registered +0.59%, unregistered +2.16%). This aligns with a recurrent seasonal pattern, whereby turnover typically rises in April as resignations submitted at the end of the previous financial year take effect.

The largest variances between actual and required CHPPD were observed on Ward 9, Ward 25 Spinal Injuries and Ainderby.

The highest number of In-Phase incidents relating to staff shortages and skill mix were reported in Critical Care and Ward 12.

The financial ledger reports a vacancy position of 105.90 WTE for HCSWs.

At North Tees, the Band 5 Registered Nurse vacancy position across all in-patient and community services for April 26 is 15.11WTE. Work continues monthly to move fixed term NQNs into permanent posts as soon are they become available via natural turnover.

At North Tees, the Band 3 HCSW vacancy position across the Trust for April 26 has reduced from 75.58WTE in March 26 to 63.87WTE in April 26 following a recruitment drive earlier this year. The next recruitment centre for both B3 and B2 CSW roles are currently being arranged.

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.

At South Tees, sickness absence amongst registered staff fell by 0.5% to 6.03%, while unregistered staff sickness also declined by 0.3% month on month to 9.05%.

At North Tees and Hartlepool, total Registered Nurse sickness and absence have reduced from 6.87% in March 26 to 6.10% in April 26 and total Unregistered Nurse sickness and absence reduced slightly from 9.06% in March 26 to 9.01% in April 26.

At North Tees and Hartlepool, the total RN turnover has reduced from 4.62% in March 26 to 4.42% in April 26 and remains lower than the national average of 8%. The total turnover for CSWs has increased from 8.45% in March 26 to 8.99% in April 26.

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 South Tees, the average proportion of planned nurse shifts filled in April 2026 increased to 98.2%. In line with sickness reducing by 1.38% for both staff groups month on month.

Staff sickness at University Hospitals Tees continues to be proactively managed through Health Improvement Plans and twice daily SafeCare reviews, helping to mitigate the impact of absence and increased patient acuity on CHPPD compliance. Robust workforce oversight supports timely redeployment to maintain safe staffing levels.

Going forward, staff sickness rates will be routinely monitored and reviewed through the monthly Workforce Assurance Meetings to ensure sustained oversight and early identification of emerging trends.

Temporary staffing remains demand led, with a continued emphasis on redeployment ahead of NHSP utilisation. This approach has contributed to a reduction in both temporary staffing demand and bank filled hours during the month.

HCSW vacancies continue to be managed through the centralised recruitment process. The registered nurse workforce currently has –11.19 vacancies. There are robust plans within CSU's to convert these staff members from fixed term contracts into substantive posts.

At North Tees, the NHSP fill rates for both Registered and Unregistered nurses have increased with Registered nurse fill increasing from 81.3% in March 26 to 85.7% in April 26, and unregistered nurse fill increasing from 84.7% in March 26 to 87.9% in April 26.

Recommendations:

Members of the Trust Board are asked to: Note the content of this report and to note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout April 2026.

Nurse Monthly Safer Staffing Report: June 2026 (April 2026 data)

This exception report provides the Board of Directors with the monthly University Hospitals Tees nursing safer staffing position across all in patient areas. The report provides the People Committee with the assurance that arrangements are in place to staff services with the right skills in the right place to provide safe, sustainable and productive staffing.

- **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. All CSUs 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.

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 April 2026, several areas at South Tees reported fill rates below 80% for Registered Nurses, primarily due to ***patient acuity levels*** and ***staff sickness***:

<u>Day Shifts:</u>

- Ward 33
- Zetland - Stroke Rehabilitation
- Maternity Centre Friarage

<u>Night Shifts:</u>

- Ward 31
- Maternity Centre Friarage

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

- Ward 22 – Paediatric Surgery (Days and Nights)

These figures show the impact of clinical demand and service changes on fill rates and inform ongoing workforce planning to meet patient care needs.

In April 2026, the following areas at North Tees and Hartlepool presented a fill rate of less than 80%;

- Low Midwifery Care staff during the day on Delivery Suite.
- Low Care Staff fill rate during the day on SDU, Ward 22, ward 28, associated with sickness pressures and workforce vacancy levels.
- High Care Staff fill on ward 40 during the day due to Enhanced Care requirements.
- Low Care Staff fill rate during the night on Delivery Suite and ward 28.
- High care staff fill rate during the night within ward 38, 40, 41 and 42 likely associated with enhanced care requirements, sickness and CSW vacancy position.

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		**April 2026**
	RN/RMs (%) Average fill rate – DAYS	92.2%
	HCA (%) Average fill rate – DAYS	93.0%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	96.4%
	HCA (%) Average fill rate – NIGHTS	104.3%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**98.2%**

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

Overall, Ward Fill Rate		**April 2026**
	RN/RMs (%) Average fill rate – DAYS	91%
	HCSW (%) Average fill rate – DAYS	90%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%

	RN/RMs (%) Average fill rate – NIGHTS	98%
	HCSW (%) Average fill rate – NIGHTS	111%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**99%**

- **Nurse Sensitive Indicators**

At both South Tees and North Tees, safe staffing was not explicitly referenced in any PSIRF reviews concluded in April 2026. It should be noted that PSIRF investigations can take time to complete, typically between three and six months, and staffing factors may be identified as part of the ongoing investigative process. Future reports will include Nurse sensitive indicators in line with patient safety and quality metrics.

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

During April 2026, 4 staffing related red flags were reported at South Tees, and a total of 6 staffing-related red flags were raised at North Tees and Hartlepool. All red flags were raised due to a Shortfall in Registered Nurse time.

Documented actions and resolutions are recorded within the SafeCare system and log, providing assurance that appropriate responses were implemented 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.

InPhase Submissions

During April 2026, South Tees recorded 30 InPhase submissions relating to staffing, representing a reduction of one incident compared to the previous month. The highest number of incidents were reported in Critical Care and Ward 12.

At North Tees, in April 2026, there were a total of 17 InPhase reports relating to nurse staffing, an increase from 12 in March 2026. Safe staffing was maintained through actions agreed within the daily safe staffing meetings during April 2026.

Staff are encouraged to log any staffing related issues including shortages and skill mix which are reviewed and discussed as part of workforce assurance and governance meetings. All shortages raised were managed through the Safe Care process throughout April 26.

Vacancy & Turnover

The RN vacancy and turnover position across South Tees remains stable. To support workforce resilience during a period of zero registered nurse vacancies, UHT agreed to recruit newly qualified nurses on an over establishment basis. This approach provides planned backfill for maternity leave, long term sickness and natural turnover, reduces reliance on temporary staffing, and safeguards a sustainable RN pipeline in the context of acknowledged reductions in nursing programme applications. All NQNs are appointed on 12 month fixed term contract with a planned transition to substantive posts, supported by weekly oversight of NQN deployment. Success is monitored through ESR workforce reporting. In April 2026, six fixed term contracts were converted to substantive roles: five from the September 2025 cohort and one from the January 2026 cohort.

Key pressures identified during April include:

- Short notice sickness absence, impacting on roster stability
- Variation and increase in patient acuity, creating demand pressures not always reflected in planned staffing
- Skill mix challenges, particularly where experienced staff availability is limited
- Ongoing need for real-time staffing adjustments by senior nursing teams

While overall vacancy levels are minimal, these factors continue to influence operational staffing effectiveness at ward level.

Temporary staffing continues to play a key role in maintaining safe staffing levels, with ongoing use of NHSP bank staff to provide flexibility and cover gaps. Reliance on agency staff has reduced as a result of improvements in the substantive workforce supply. In addition, the implementation of an over establishment Newly Qualified Nurse model is contributing to a further decrease in the need for temporary staffing. All temporary staffing usage is closely monitored and reviewed through monthly Workforce Assurance meetings.

The South Tees financial ledger for April 2026 reports a total vacancy of –11.19 WTE across registered nursing and midwifery roles, and a total vacancy of 105.90 WTE for Healthcare Support Workers.

At North Tees, the Band 5 Registered Nurse vacancy position across all in-patient and community services for April 2026 is 15.11WTE. Work continues monthly to move fixed term NQNs into permanent posts as soon are they become available via natural turnover. At North Tees, the Band 3 HCSW vacancy position for April 2026 has reduced from 75.58WTE in March 2026 to 63.87WTE in April 26 following a recruitment centre earlier this year. The next recruitment centre for both B3 and B2 CSW roles are currently being arranged.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. This relates to the associated variance between the required care hours to safely care for patients and the actual care hours delivered by individual ward nursing

workforce models. Table 2 and Table 3 show the overall average CHPPD for the group. Most recent breakdown by ward for April 2026 can be reviewed in Appendix 2.

Table 2 South Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
February 26	9.38	8.83	-0.55
March 26	9.23	8.99	-0.24
April 26	9.38	9.04	-0.34

During April 2026, 12 inpatient areas at South Tees recorded average CHPPD above the required level. Areas operating below target were predominantly impacted by increased staff sickness and higher patient acuity. These pressures were actively managed through twice daily SafeCare reviews, enabling timely workforce planning and redeployment to unfilled shifts.

Variances reflect responsive workforce deployment aligned to fluctuations in patient acuity, case mix, and operational demand, with staffing managed through established safe staffing governance arrangements, including regular acuity assessment, professional judgement, and escalation processes.

The greatest variance between required and actual CHPPD was observed on Ward 9, Ward 25, Ainderby and Spinal Injuries Ward.

- **Ward 9:** Increased sickness absence in April 2026 contributed to the ward not achieving its required CHPPD. Registered staff sickness rose to 4.3% (+0.8%) and unregistered staff sickness increased to 9.7% (+1.7%). This is reflected in temporary staffing usage, with 76% of requests attributed to sickness absence. Additional demand was driven by maternity leave cover (20%) and extra activity lists (4%).

- **Ward 25:** Registered staff sickness increased to 6.5% (+1.2%), while unregistered staff sickness showed a marked improvement, reducing to 2.7% (-6.2%). This improvement is reflected in NHSP booking data, with sickness related requests decreasing to 33% of temporary staffing bookings, compared to 85% in the previous month. The ward also has HCSW vacancies equating to 1.61 WTE, which is contributing to variance against CHPPD. In addition, patient acuity remains high, with 21% of NHSP requests associated with supporting patients identified as being at risk of falls. Annual leave requests were within the 12–16% threshold, representing an improvement compared to the previous month when levels were significantly higher.

- **Ainderby:** Whilst registered staff sickness reduced to 3.9% (-0.6%), unregistered staff sickness increased to 11.6% (+2.2%) month on month. The ward currently has 2.36 WTE HCSW vacancies, which is reflected in NHSP data, with 25% of

unregistered requests attributed to vacancy gaps. Additional factors contributing to variance against CHPPD include the opening of escalation beds and sustained high patient acuity. This is evidenced in temporary staffing data, with 27% of requests required to support vulnerable patients needing 1:1 enhanced care and a further 19% relating to patients identified as being at risk of falls.

- **Spinal Injuries Ward:** Registered staff sickness reduced significantly by 6.2% to 4.5%, with unregistered staff sickness also decreasing by 0.8% to 9.4%. Despite this improvement, 98% of temporary staffing shifts were booked to cover sickness, indicating that CHPPD variance may be influenced by factors beyond sickness absence alone. For example, roster data shows maternity leave at 10%, suggesting a potential coding inconsistency whereby some shifts may have been recorded as sickness rather than maternity leave when selecting NHSP booking reasons.

The reasons recorded for NHSP bookings were mixed, with some aligning to the staffing pressures outlined above and others appearing inconsistent **(Appendix 3).**

Table 3 North Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
February 2026	8.74	9.11	+0.36
March 2026	9.03	9.12	+0.19
April 2026	9.14	8.99	-0.15

In April 2026, the total variance is in a slightly positive position, this is due to areas including Critical Care, Elective Care and Paediatric presenting an average positive variance of >17.35 collectively.

The areas highlighting a higher negative variance level (>1) at North Tees, and thus, not delivering the required CHPPD were;

- Acute Cardiology Unit
- Ward 24 – Respiratory and RSU
- Ward 25 – Respiratory and RSU
- Ward 26 - Gastroenterology
- Ward 27 – Gastroenterology
- Ward 36 – Endocrinology
- Ward 41 - Stroke

These areas were highlighted as requiring investment into the nursing workforce models as part of the last bi-annual nurse establishment review and will continue to present proposals for changes to the nursing workforce establishments/models in the up-coming review.

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).

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

Temporary Staffing

At South Tees, demand for nursing and midwifery bank and agency staffing in April 2026 decreased by **5.6%** compared to April 2025. Bank filled hours also declined by **9.1%** over the same period. These reductions provide clear evidence that current workforce optimisation measures are sustainably improving staffing efficiency and reducing reliance on temporary staffing solutions.

Nursing agency usage at South Tees continues to remain low. In April 2026, a total of **121** nursing agency hours were booked, representing a 78 hour decrease month on month. Usage was concentrated within theatre services, with 102 hours in Friarage Theatres and 19 hours in Orthopaedic Theatres.

ODP agency usage remains present within the Trust. In April 2026, a total of **482** ODP agency hours were utilised, reflecting a 262 hour decrease month on month. This usage was primarily within Orthopaedic Theatres (389 hours), with additional use in Friarage Theatres (84 hours) and Cardio Theatres (9 hours).

A planned exit strategy supports a phased reduction in agency staffing, aligned to the training programme and competency progression of NQNs and ODPs. Agency ODP utilisation has reduced steadily in recent months, with current hours at their lowest level since August 2025.

Throughout April 2026, bank staffing spends increased by £32,994 (+2.8%). This increase is attributable to the CSW Band 2 to Band 3 pay uplift effective from April 2025.
Year on year agency spend for nursing increased by £4,175 while agency spend on ODPs in theatres decreased by £2,171.

Overall demand and fill reduced during the reporting period, reflecting the impact of workforce optimisation initiatives such as workforce assurance processes, strengthened approval controls, and improved staff deployment, which have collectively reduced reliance on temporary staffing. However, despite this reduction in activity, expenditure has increased due to underlying cost pressures, including pay uplifts, resulting in a disconnect between reduced demand and higher overall spend.

The overall bank and agency fill rate for April 2026 was 85.6%, a decrease compared to 88.8% in the same period last year. However, this represents a month-on-month improvement of 1.7%.

Despite the year-on-year reduction, the fill rate remains strong, indicating a healthy level of shift coverage across the nursing workforce. This suggests that demand management controls are effectively supporting a more accurate alignment between requested shifts and actual staffing requirements on the wards.

At North Tees and Hartlepool, temporary staffing usage is now presented and discussed via the monthly workforce Assurance meetings in place for all Nursing, Midwifery, A&C and AHP services.

The following summary provides a breakdown of the total North Tees temporary staffing spend (all staff groups) in April 2026;

Agency Nursing & Other spend YTD is £10k lower than previous year
–Cell Path and Panacea are now the only material users of Non-Medical Agency

Bank spend YTD is £256k lower than previous year
–In M1 there is a correction of £172k from M12
–The winter ward closed a month earlier (in March) than it did in 25/26 (in April)

Overtime spend YTD is £22k higher than previous year
–April will include arrears from March, likely linked to additional sprint funding

Key Priorities

Following the Group workforce assurance meetings in April 2026, priorities identified for alignment include:

- Achieve group-wide alignment of temporary staffing booking reasons, supported by the production and publication of a guidance document to support ward managers in selecting the appropriate reason for use of temporary staffing.
- Strengthen workforce oversight through triangulation of safe staffing metrics, acuity data, escalation activity, and patient outcome measures.
- Deliver a continued reduction in agency expenditure through improved roster effectiveness, optimisation of bank utilisation, and robust approval process.
- Strengthen oversight and assurance through the routine review of sickness absence and headroom/unavailability reports at Workforce Assurance Meetings from April.
- Approve the Project Initiation Document (PID) for Cost Improvement Programme targets set by NHSE, ensuring alignment with workforce priorities and safe staffing requirements.
- Further develop and implement the NQN model for upcoming cohorts, maximising transition into substantive roles.
- Improve alignment between workforce deployment and patient demand to support safe and efficient care delivery.
- Reduce reliance on agency and bank staffing, with a focus on optimising internal bank utilisation.
- Strengthen rostering practices and skill mix across wards through the Workforce Assurance framework.
- Support staff wellbeing and reduce sickness absence, informed by workforce data and insights.

Recommendations

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

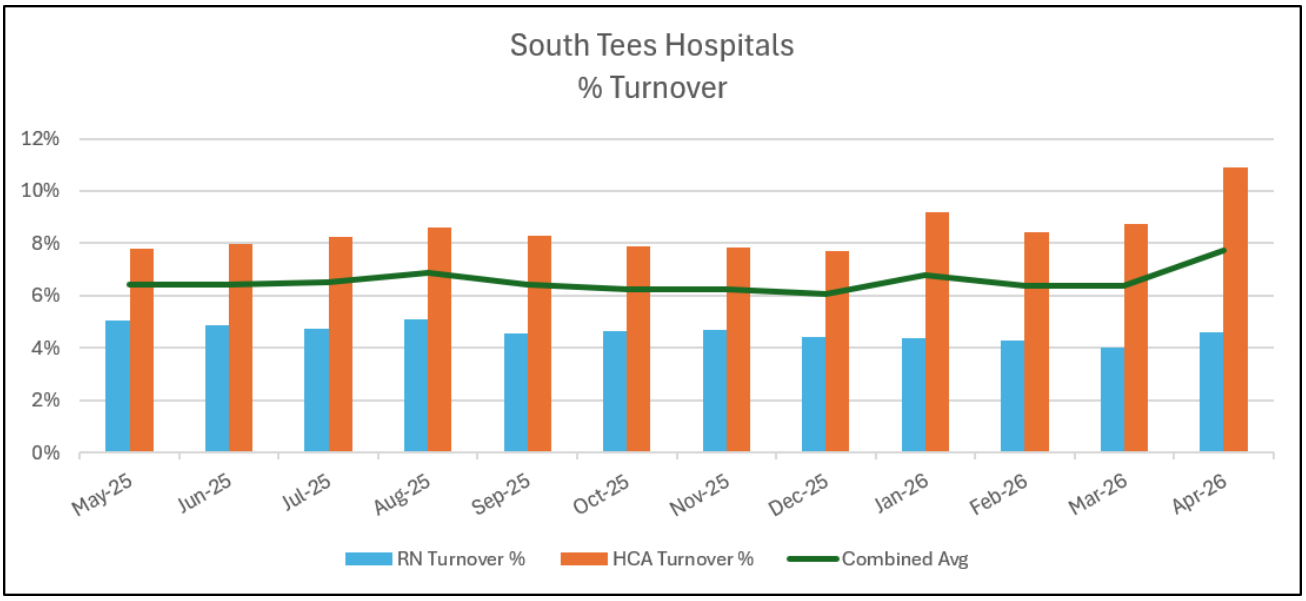
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

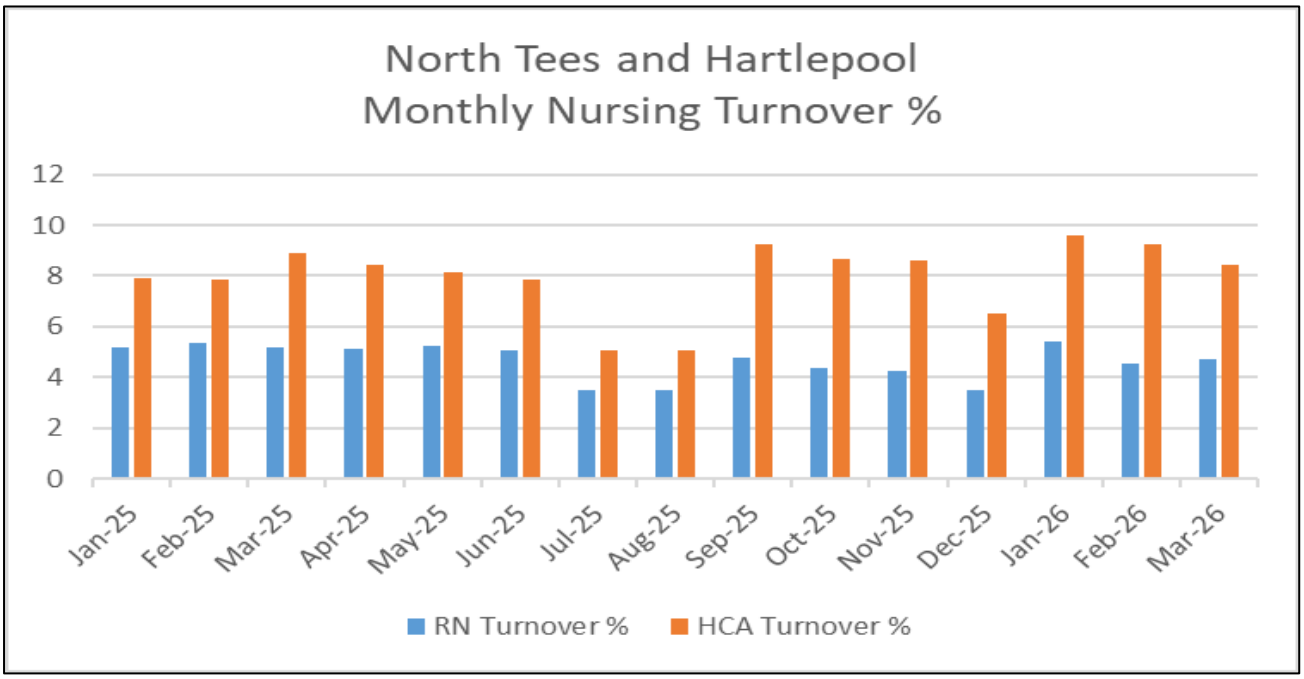
The Board are asked to acknowledge the development of this report in the coming months to ensure that the two current reporting methods across both site teams continue to align. This

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 April 2026





Caring Better Together

Appendix 2

South Tees Average CHPPD Breakdown by Ward (April 2026):

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ainderby Ward	10.61	7.24	-3.37
Cardio HDU	10.46	13.41	2.95
Cardio MB	6.74	7.98	1.24
CCU JCUH	13.42	10.75	-2.67
CDU FHN	8.13	7.08	-1.05
CICU	23.53	24.42	0.89
Critical Care	19.97	27.03	7.07
Friary Ward	6.47	7.60	1.12
Gara Ward	7.53	13.14	5.61
NNU	14.09	13.72	-0.37
PCCU	15.47	23.05	7.58
Romanby Ward	7.27	6.52	-0.75
Rutson Rehab Ward	9.48	7.12	-2.36
Spinal Injuries Ward	9.63	6.33	-3.31
Tocketts Ward	7.84	6.46	-1.38
Ward 02	8.48	8.61	0.13
Ward 03	7.77	5.81	-1.96
Ward 04	8.44	6.61	-1.84
Ward 05	6.38	5.33	-1.05
Ward 06	5.75	6.00	0.24
Ward 07	5.27	4.81	-0.46
Ward 08	6.15	5.32	-0.84
Ward 09	8.67	4.48	-4.19
Ward 10	6.34	5.46	-0.88
Ward 11	8.83	6.20	-2.63
Ward 12	8.71	6.30	-2.42
Ward 14	7.19	5.74	-1.45
Ward 21	9.95	11.60	1.65

Ward 22	14.36	14.33	-0.04
Ward 24	8.44	7.88	-0.56
Ward 24 HDU	10.77	19.64	8.88
Ward 25	10.50	7.31	-3.19
Ward 26	8.62	6.88	-1.74
Ward 27	9.14	12.08	2.94
Ward 28	8.52	6.17	-2.35
Ward 29	5.92	5.17	-0.75
Ward 31	9.51	6.52	-2.98
Ward 32	7.43	6.02	-1.40
Ward 33	8.03	6.44	-1.58
Ward 34	8.03	6.36	-1.67
Ward 35	8.79	7.44	-1.36
Ward 36	6.57	5.77	-0.80
Ward 37	10.85	8.30	-2.56
Zetland Ward	8.83	7.36	-1.47
Grand Total	**9.38**	**9.04**	**-0.34**

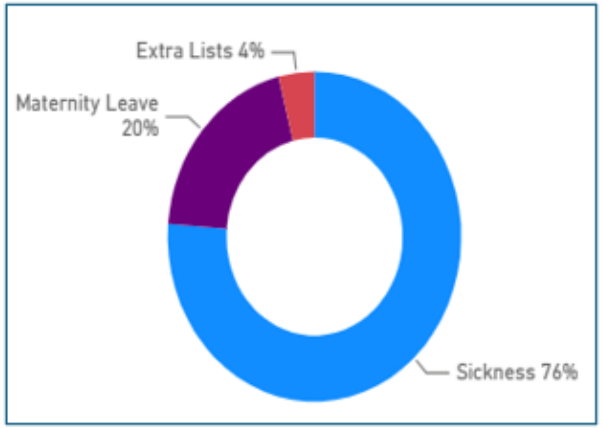
North Tees Average CHPPD Breakdown by Ward (March2026):

Unit Previous month	Required CHPPD	Actual CHPPD	CHPPD Variance
Acute Cardiology Unit	7.35	6.09	-1.26
Critical Care North Tees	20.94	25.18	4.24
Elective Care Unit	5.39	12.77	7.38
Emergency AMB	7.86	8.54	0.68
Neonatal Unit	10.85	17.09	6.23
Paediatrics	10.07	10.48	0.41
SDU	9.17	11.57	2.40
Ward 24 (Respiratory)	8.88	6.20	-2.68
Ward 24 RSU (Respiratory)	12.35	9.33	-3.02
Ward 25 (Respiratory)	10.27	7.88	-2.39
Ward 25 RSU (Respiratory)	13.53	11.80	-1.73
Ward 26 (Gastroenterology)	7.97	5.96	-2.00
Ward 27 (Gastroenterology)	7.89	6.49	-1.40
Ward 28 (Surgery)	6.28	5.91	-0.37
Ward 31 (Surgical Observation Unit)	7.77	8.52	0.76
Ward 32 (Fragility Fracture)	8.50	8.44	-0.06
Ward 33 (Orthopaedic & Spinal)	6.79	7.10	0.32
Ward 36	8.52	6.28	-2.24
Ward 37	6.75	8.66	1.91
Ward 38	6.79	6.16	-0.63
Ward 40 (Acute Elderly)	7.91	7.18	-0.73
Ward 41 (Stroke Unit)	7.41	6.99	-0.42
Ward 42 (Elderly Rehabilitation)	8.40	7.28	-1.13
Average	**9.03**	**9.21**	0.19

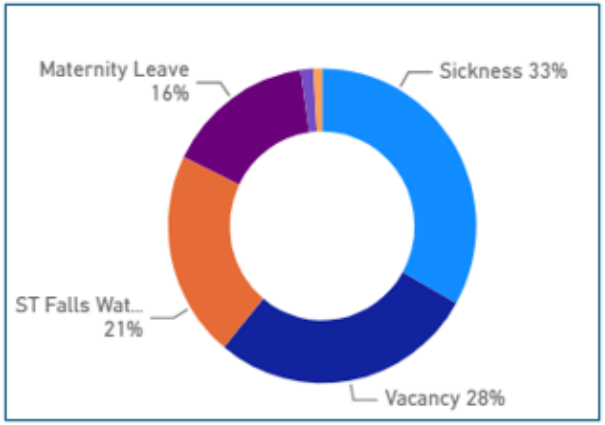
Appendix 3

Analysis of NHSP booking reasons in South Tees areas with highest CHPPD variance (April 2026)

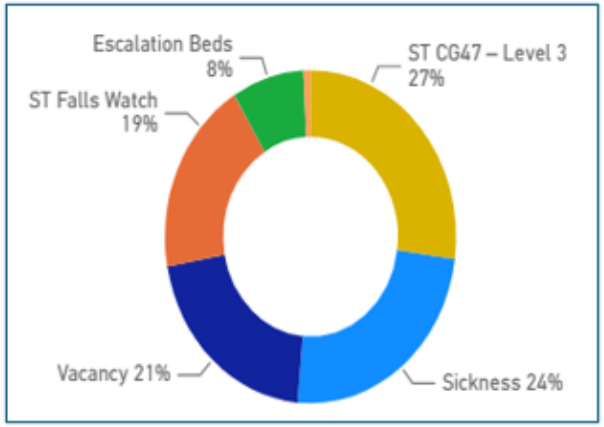
Ward 9



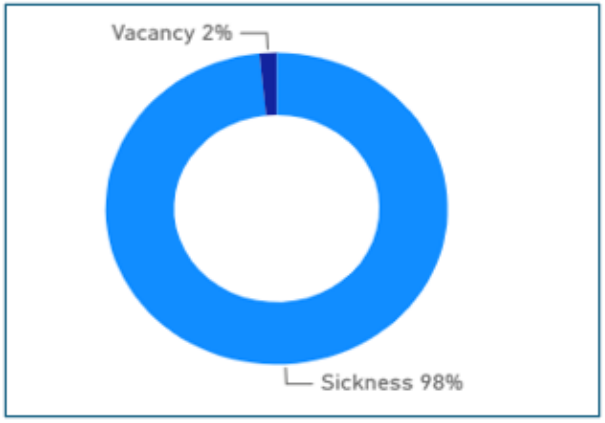
Ward 25



Ainderby



Spinal Injuries



NHS
University Hospitals Tees

Resources and Performance Committee

27 May 2026

Connecting to: Board of Directors

Chair of Committee: Celia Weldon

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.

Performance *MARCH 2026 data*

For NTHFT, the following 4 performance metrics within the Responsive domain remain as Alert:

- RTT 52 Week Waiters (%)
- RTT Incomplete Pathways (%)
- RTT time to first appointment (%)
- Readmission rate

For STHFT, Cancer 31 Day Standard remains as 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.

5 performance metrics have all been regraded from Alert to Advise for NTHT with improved performance:

- 12-Hour ED Breaches Rate

Caring Better Together

    - Cancer 62 Day Standard
    - Cancer faster Diagnosis
- Ambulance Handovers within 45 Minutes (%)
- 4-Hour A&E Standard

For STHFT following 3 performance metrics have all been regraded from Alert to Advise with improved performance

- Community UCR 2 hr response
- Diagnostic 6 week standard
- RTT time to first appointment:

Community over 52 week waiters has been regraded from Assure to Advise

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

Finance

At the end of Month 1 (April 2026), the Group is reporting a YTD position in line with plan. However, this has been achieved through additional non-recurrent measures totalling £1.8m YTD.

CIP position is 93% of plan YTD and *recurring* CIP measures are £0.7m behind plan.

WTE reduction is reported as an adverse variance of 139 WTE to the YTD plan. The Resource and Performance Committee, People Committee and Quality and Compliance Committee continue to ensure a joined-up focus on WTEs in 2026/2027.

Use of Bank staff is £0.2m adverse to the YTD plan.

Digital Strategy

The Committee received a presentation on progress with procurement of a new UHT wide EPR system. An update will be received by the Board in August.

Estates

The Committee received an update on the capital business cases relating to the 'Return to Constitutional Standards. The Committee agreed that the business cases should be submitted to NHSE and would continue to receive updates as the schemes progress.

NHS
University Hospitals Tees

Resources and Performance Committee

25 June 2026

Connecting to: Board of Directors

Chair of Committee: Celia Weldon

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.

Performance Against Key Metrics: The committee reviewed 20 metrics, noting improvements in some areas with ongoing challenges with long waits, particularly in RTT and cancer pathways. Theatre refurbishment impacted patient throughput, with cancer patients were prioritised.

For NTHFT Cancer Faster Diagnosis has been escalated to Alert from Advise – there is now a focus on improvement in Urology and Respiratory pathways

For STHFT Community 52ww has been escalated to Alert from Advise – the lists are being validated, longest waiters are being brought forward and increased capacity in some areas.

Operational Challenges and Mitigations: Recovery space limitations at James Cook led to patient cancellations, with efforts underway to identify additional capacity. The committee noted high DNA rates and community wait times, with plans for a deep dive into outpatient transformation at the next meeting.

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.

Caring Better Together

Targeted Improvement Projects: Initiatives include a corporate outpatient project focusing on partial booking, clinic template standardisation, and increasing patient-initiated follow-up rates. A new theatre scheduling process (642 session) was piloted to maximise utilisation.

The majority of IPR metrics remain graded Advise, for both Trusts, including the majority of performance metrics and financial position versus plan.

Theatres

The recent flood in theatres at NTH has led to cancelled appointments, 4 of the 7 theatres are now back up and running, work continues on the remaining 3 this has impacted around 400 patients. Performance on 52ww is now in the expected range but the closures have had an adverse impact on this position.

Finance

The Group plan for the 2026/27 financial year is to deliver an overall break-even position, with a break-even plan for both NTH and for STH. At the end of Month 2 the Group is reporting a year-to-date (YTD) position in line with plan. The reported position includes additional non-recurrent measures totalling £2.1m year-to date across the Group. The forecast outturn position remains in line with plan as at Month 2. However, achievement of the financial control total will require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

The Group's plan assumes workforce reductions across the financial year. Month 2 shows a net overall decrease of WTE Worked across the Group, compared to the previous month.

NHSE have set organisation caps for expenditure on Bank and Agency for 2026/27. Year-to-date Agency expenditure was £39k less than plan and £0.2m less (17%), adjusted for inflation, than that incurred at the same point in the previous year. Year-to-date Bank expenditure was £0.1m higher than plan but £0.6m (12%) less, adjusted for inflation, than that incurred at the same point in the previous year.

Across the Group, overall year-to-date reported CIP delivery is £10.1m (95% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £0.7m behind plan at the end of Month 2. Against the overall CIP target of £81.7m, £11.9m is classified as 'opportunity' and £31.4m still assessed as 'high risk'.

Medicines Manufacturing Centre LLP

The MMC is a flagship development for the NHS in the North East and North Cumbria and involves collaboration between all 8 of acute and community providers. The MMC will produce large volumes of chemotherapy treatment, 'pre-labelled' medicines and other 'ready to administer' drugs. It will release capacity in local aseptic production units allowing them to focus on more complex, bespoke medicines close to patients and free up more time for nursing care. The Full Business Case (FBC) for the MMC development and for the formation of the LLP, was approved by all 8 Foundation Trust Boards in April 2024, and by NHS England and the Department of Health and Social Care in September 2024.

This paper will also be presented to the Trust Board for approval – all members of the LLP are being asked to approve and sign the Membership Agreement for the Medicines Manufacturing Centre (MMC) Limited Liability Partnership (LLP).

The committee received a paper which summarised the three documents which make up the Governance Framework along with the LLP Membership Agreement. The Committee discussed the arrangements and received assurance and recommends that the Group Board approves the LLP membership agreement at its meeting in July 2026.

Digital – Cyber security Risk

The Committee discussed a letter from NHSE which has been sent to all NHS trusts and ICBs. The letter asks boards and executives to assure themselves that cyber security risks are being managed effectively, with clear, sustained programmes for improvement.

The letter includes a link to Cyber security guide for executive and non-executive directors - NHS England Digital which is a very helpful document for all board members to read.

The Committee will continue to receive updates on progress being made and will update the board accordingly. At the meeting in June, the Committee agreed:

- the appointment of the Chief Information Officer as the executive team member responsible for cyber security to assist the organisation's board of directors in meeting their accountabilities.
- To continue to gain assurance of the organisation's emergency preparedness, with a particular focus on the operational impact of cyber incidents, which often have effects that last months and years. This should include exercises to assess clinical and operational readiness to cope with such disruptions
- Receive an annual report outlining recovery plans for critical systems, including evidence that these plans have been tested
- To provide assurance to Board that the above recommendations have been agreed.

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

A BI dashboard has been developed to provide aggregate financial information across UHT to support the leadership teams of the new Clinical Service Units (CSUs).

A formal Cash Committee (as a sub-committee of the Resources & Performance Committee) will be introduced during 2026/27.

External assurance on the year-end financial position is received from the Group's external auditors.

National Cost Collection Pre-submission

The Committee was assured that robust arrangements are in place to deliver the annual submission within the timescale with delegated authority given to the Chief Finance Officer for approval and submission.

Clinical Coding

The Committee received a planned update on clinical coding and work being done to continually improve the processes including development of the use of AI. The Committee received assurance on the arrangements in place.

University Hospital North Tees – Condition Appraisal

The Committee had asked for a deep dive into the recent 6-facet survey of the UHNT buildings condition. A detailed presentation covered:

- the amount of backlog maintenance currently and projected forward to 2032 and the work to raise and maintain the profile of this at a regional and national level
- the level of critical structural issues within the latest external review and prioritisation of the capital programme in response
- the impact of the condition of the buildings including theatre closures
- the importance of the business continuity planning arrangements.

The Committee will continue to receive updates in this area.

Board Assurance Framework

This was the last presentation of the BAF in its current format, the revised BAF will be received quarterly from Q2 2026/2027 and is currently being finalised. There were no significant changes to any of the four elements covered by the Committee and requests for extensions to actions were agreed.

The Committee received an update on the revised BAF and also considered Risk Appetite in relation to ‘Using our resources well by driving productivity in services to achieve financial sustainability’. The committee agreed with the proposal for risk appetite to be ‘Open’. A supporting statement will be developed shortly.

Month 2: 2026-27 Finance Report

Meeting date: *2 July 2026*

Reporting to: Board of Directors

Agenda item No: 4.2

Report author: *Chris Hand, Chief Finance Officer*

Executive director sponsor: *Group Chief Finance Officer*

Action required: *Information*

Delegation status: *Jointly delegated item to Group Board*

Previously presented to: *Resources & Performance 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 2026/27 financial year is to deliver an overall break-even position, with a break-even plan for both NTH and for STH.

At the end of Month 2 the Group is reporting a year-to-date (YTD) position in line with plan.

The reported position includes additional non-recurrent measures totalling £2.1m year-to-date across the Group.

The forecast outturn position remains in line with plan as at Month 2. However, achievement of the financial control total will require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

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.

Month 2 shows a net overall decrease of 162.89 WTE Worked across the Group, compared to the previous month. Compared to the same period last year (Month 2 2025/26) WTEs were lower by 355.83wte.

NHSE have set organisation caps for expenditure on Bank and Agency for 2026/27.

Year-to-date Agency expenditure was £39k less than plan and £0.2m less (17%), adjusted for inflation, than that incurred at the same point in the previous year.

Year-to-date Bank expenditure was £0.1m higher than plan but £0.6m (12%) less, adjusted for inflation, than that incurred at the same point in the previous year.

Across the Group, overall year-to-date reported CIP delivery is £10.1m (95% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £0.7m behind plan at the end of Month 2.

Against the overall CIP target of £81.7m, £11.9m is classified as 'opportunity' and £31.4m still assessed as 'high risk'. De-risking of the CIP programme and maximising recurrent in-year delivery continues to be a key area of focus for the Financial Recovery Oversight Group and CSU CIP meetings.

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

A BI dashboard has been developed to provide aggregate financial information across UHT to support the leadership teams of the new Clinical Service Units (CSUs).

The Resources Committee will receive monthly assurance reports on the financial performance throughout the year.

External assurance on the year-end financial position is received from the Group's external auditors.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 2 2026/27

Board of Directors
2 July 2026

Month 2: 2026/27 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 2 of 2026/27.

2. BACKGROUND

The 2026/27 financial year marks a movement from a system-based approach to planning and delivery, with a return to focus on individual organisational accountability. Both North Tees and Hartlepool NHS Foundation Trust (NTH) and South Tees Hospitals NHS Foundation Trust (STH) continue to be aligned to the North Cumbria (NENC) Integrated Care System (ICS).

The Group plan for the 2026/27 financial year is to deliver an overall break-even position, with a break-even plan for both NTH and for STH.

NTH and STH are required to plan and report to NHSE on a consolidated group basis, including the financial position of each of the trust's subsidiary companies. The financial performance in this report therefore includes the consolidated positions of Optimus Health Ltd and North Tees & Hartlepool Solutions LLP for NTH and South Tees Healthcare Management Ltd for STH.

The Group financial plans for NTH and STH for the 2026/27 financial year were developed based on a number of assumptions, which were reviewed throughout the planning period by the executive team, Resources Committees and meetings of the Trust Board.

3. MONTH 2 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 2 2026/27, shown by trust:

STATEMENT OF COMPREHENSIVE INCOME	NTH			STH			GROUP		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating income from patient care activities	72,640	73,027	387	163,165	161,803	(1,362)	**235,805**	**234,830**	**(975)**
Other operating income	5,744	6,123	379	10,228	10,203	(26)	**15,972**	**16,326**	**354**
Employee expenses	(54,430)	(55,181)	(751)	(106,891)	(106,235)	656	**(161,321)**	**(161,416)**	**(95)**
Operating expenses excluding employee expenses	(24,317)	(24,403)	(86)	(65,602)	(64,669)	934	**(89,919)**	**(89,072)**	**848**
OPERATING SURPLUS/(DEFICIT)	**(363)**	**(434)**	**(71)**	**900**	**1,102**	**202**	**537**	**668**	**131**
FINANCE COSTS									
Finance income	428	414	(14)	1,020	678	(342)	**1,448**	**1,092**	**(356)**
Finance expense	(146)	(108)	38	(3,506)	(3,509)	(3)	**(3,652)**	**(3,617)**	**35**
PDC dividends payable/refundable	(598)	(599)	(1)	(126)	0	126	**(724)**	**(599)**	**125**
NET FINANCE COSTS	**(316)**	**(293)**	**23**	**(2,612)**	**(2,831)**	**(219)**	**(2,928)**	**(3,124)**	**(196)**
Other gains/(losses) including disposal of assets	0	4	4	0	8	8	**0**	**12**	**12**
Corporation tax expense	(8)	(7)	1	(4)	0	4	**(12)**	**(7)**	**5**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(687)**	**(730)**	**(43)**	**(1,716)**	**(1,721)**	**(5)**	**(2,403)**	**(2,451)**	**(48)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0	**0**	**0**	**0**
Remove capital donations/grants I&E impact	0	43	43	422	422	0	**422**	**465**	**43**
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	10,932	10,559	(373)	**10,932**	**10,559**	**(373)**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(12,824)	(12,446)	378	**(12,824)**	**(12,446)**	**378**
Adjusted financial performance surplus/(deficit)	**(687)**	**(687)**	**0**	**(3,186)**	**(3,186)**	**(0)**	**(3,873)**	**(3,873)**	**(0)**
Less Non-Recurrent Deficit Funding	0	0	0	0		0	**0**	**0**	**0**
Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding	**(687)**	**(687)**	**0**	**(3,186)**	**(3,186)**	**(0)**	**(3,873)**	**(3,873)**	**(0)**

At the end of Month 2 2026/27 the Group is reporting a year-to-date (YTD) position in line with plan, across both trusts.

The forecast outturn position remains in line with plan as at Month 2. However, achievement of the financial control total will require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

The main drivers of the **NTH Month 2 position** are:

- Clinical Income is ahead of plan by £0.4m. This is mainly due to a non-recurrent benefit from reconciliation of prior-year variable depreciation income.
- Other operating income is £0.4m ahead of plan, including cancer alliance and education funding.
- Interest receivable is broadly in line with plan
- Pay is £0.7m behind plan, including cost pressures from industrial action and slippage on CIP delivery.
- Non-Pay is £0.1m behind plan
- The position includes the impact of additional non-recurrent measures of £0.4m ahead of plan.

The main drivers of the **STH Month 2 position** are:

- Clinical Income is behind plan by £1.4m, mainly relating to variable high-cost drugs and devices income.
- Other Operating Income is on plan.
- Pay is underspent by £0.7m, with underspends on substantive pay, agency and bank year-to-date.
- Non-Pay is underspent by £0.9m, mainly relating to cost and volume drugs and devices.
- Interest receivable is behind plan by £0.3m.
- The position includes the impact of additional non-recurrent measures of £1.7m, 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 2026/27 planning guidance included requirements to make further reductions to agency spend by at least 30% and to reduce bank spend by a further 10%.

Each trust has been set a cap on agency and bank expenditure reflecting these expected reductions. The 2026/27 expenditure caps for the Group are shown in the table below:

	NTH	STH	UHT
Agency Cap £000	1,457	3,201	**4,658**
Bank Cap £000	9,847	15,385	**25,232**

The tables below show the position on agency and bank expenditure for the Group to the end of Month 1, comparing the year-to-date expenditure with the same period in the previous financial year (adjusted for inflation).

Across the Group, **YTD agency** expenditure was £1.0m. This was £39k less than plan (which has been set in line with achieving the annual expenditure caps imposed by NHSE). Total agency expenditure was also £0.2m (17%) less than the agency expenditure incurred at the same point in the previous year (adjusted for inflation).

Across the Group, **YTD bank** expenditure was £4.4m. This was £0.1m higher than plan (which has been set in line with achieving the annual expenditure caps imposed by NHSE), largely relating to Nursing and Resident Doctors. Total bank expenditure was £0.6m (12%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	7	0	(7)	26	(26)	-100%
AHP and Sci&Tech	81	124	43	100	24	24%
Other Clinical	0	0	0	0	0	-
Consultants	211	212	1	323	(111)	-34%
Career/staff grades	20	34	14	0	34	-
Trainee grades	5	7	2	10	(3)	-32%
Non Clinical	2	1	(1)	4	(3)	-76%
TOTAL	**326**	**378**	**52**	**464**	**(86)**	**-19%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	732	702	(30)	872	(170)	-19%
AHP and Sci&Tech	113	99	(14)	102	(3)	-3%
Other Clinical	704	733	29	1,018	(285)	-28%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	152	152	0	152	-
Non Clinical	92	88	(4)	106	(18)	-17%
TOTAL	**1,641**	**1,774**	**133**	**2,098**	**(324)**	**-15%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	50	26	(24)	21	5	26%
AHP and Sci&Tech	139	135	(4)	70	65	92%
Other Clinical	0	0	0	0	0	-
Consultants	535	423	(112)	657	(234)	-36%
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	29	29	0	29	-
Non Clinical	23	43	20	35	8	22%
TOTAL	**747**	**656**	**(91)**	**783**	**(127)**	**-16%**

BANK YTD	STH					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,164	1,349	185	1,286	63	5%
AHP and Sci&Tech	16	55	39	24	31	131%
Other Clinical	1,144	1,000	(144)	1,179	(179)	-15%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	180	140	(40)	272	(132)	-48%
Non Clinical	139	70	(69)	136	(66)	-49%
TOTAL	**2,643**	**2,614**	**(29)**	**2,897**	**(283)**	**-10%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	57	26	(31)	46	(20)	-44%
AHP and Sci&Tech	220	259	39	170	89	52%
Other Clinical	0	0	0	0	0	-
Consultants	746	635	(111)	980	(345)	-35%
Career/staff grades	20	34	14	0	34	-
Trainee grades	5	36	31	10	26	248%
Non Clinical	25	44	19	39	5	12%
TOTAL	**1,073**	**1,034**	**(39)**	**1,247**	**(213)**	**-17%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 25/26	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,896	2,051	155	2,158	(107)	-5%
AHP and Sci&Tech	129	154	25	126	28	22%
Other Clinical	1,848	1,733	(115)	2,196	(463)	-21%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	180	292	112	272	20	7%
Non Clinical	231	158	(73)	243	(85)	-35%
TOTAL	**4,284**	**4,388**	**104**	**4,995**	**(607)**	**-12%**

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 Group's plan assumes a net reduction in workforce of 503wte across the financial year. The Workforce Plan submissions (and monthly PWR submissions) report contracted WTE for substantive staff (with no adjustments for additional hours worked or reduced hours worked for parental or sickness absence), with additional WTE worked for Bank and Agency staff.

Internal WTE monitoring focuses on the WTE worked data (taken directly from the General Ledger), which provides a better correlation to actual pay expenditure (and ensures consistency between reporting periods).

The table below shows the WTE actual worked in Month 2 2026/27 (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, 2024/25 and the previous financial year 2025/26
- the WTE worked in the equivalent month of the previous financial year; and
- the previous month.

WTE Worked	Mth 1 26/27	Mth 2 26/27	Change from prior month	Change from M2 25/26	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from 25/26 avg
NTH								
Agency	23.59	23.07	(0.52)	4.48	2.69	(40.82)	(12.10)	8.43
Bank	209.29	187.00	(22.29)	(62.09)	0.55	(47.11)	(60.00)	(57.52)
Substantive	5,207.49	5,176.66	(30.83)	(111.38)	517.19	46.43	(149.28)	(82.49)
Sub Total	**5,440.37**	**5,386.73**	**(53.64)**	**(168.99)**	**520.43**	**(41.50)**	**(221.38)**	**(131.58)**
STH								
Agency	26.49	12.86	(13.63)	(0.96)	(12.65)	(21.76)	(5.87)	(9.18)
Bank	279.06	234.23	(44.83)	(44.69)	36.22	(158.82)	(113.17)	(53.61)
Substantive	9,498.24	9,447.45	(50.79)	(141.19)	1,610.77	212.38	(44.98)	(111.13)
Sub Total	**9,803.79**	**9,694.54**	**(109.25)**	**(186.84)**	**1,634.34**	**31.80**	**(164.02)**	**(173.93)**
UHT GROUP								
Agency	50.08	35.93	(14.15)	3.52	(9.96)	(62.58)	(17.97)	(0.76)
Bank	488.35	421.23	(67.12)	(106.78)	36.77	(205.93)	(173.17)	(111.13)
Substantive	14,705.73	14,624.11	(81.62)	(252.57)	2,127.96	258.81	(194.26)	(193.62)
Grand Total	**15,244.16**	**15,081.27**	**(162.89)**	**(355.83)**	**2,154.77**	**(9.70)**	**(385.40)**	**(305.50)**

Month 2 shows a net overall decrease of 162.89wte worked across the Group, compared to the WTE worked reported in the previous month. The in-month change in WTE was a 53.64wte decrease at NTH and a 109.25wte decrease at STH.

Compared to the same period last year (Month 2 2025/26) WTEs were lower by 355.83wte.

WTEs worked in month were 305.50wte lower than the average of the previous financial year.

WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,154.77wte (16.7%). However, the increase over this time period includes workforce investment to remedy CQC safety and quality concerns and also to deliver additional commissioner funded services

The table below provides an analysis of WTE worked data split by staff grouping:

WTE Worked	Mth 1 26/27	Mth 2 26/27	Change from prior month	Change from M2 25/26	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from 25/26 avg
NTH								
Nursing & Midwifery	1,706.37	1,680.93	(25.44)	(19.63)	299.81	73.42	(1.37)	(27.65)
Medical & Dental	576.96	594.22	17.26	(5.56)	59.08	38.75	8.27	(3.29)
AHP, Sci., Ther.&Tech.	570.38	570.05	(0.33)	11.77	29.73	(18.23)	(33.94)	5.62
HCAs & Support Staff	1,027.15	1,004.32	(22.83)	(26.47)	54.80	(47.32)	(45.69)	(33.91)
Non Clinical	1,559.51	1,537.21	(22.30)	(129.10)	77.01	(88.13)	(148.66)	(72.35)
Sub Total	**5,440.37**	**5,386.73**	**(53.64)**	**(168.99)**	**520.43**	**(41.51)**	**(221.38)**	**(131.58)**
STH								
Nursing & Midwifery	3,171.20	3,125.17	(46.03)	(18.57)	619.11	167.04	29.67	(32.91)
Medical & Dental	1,413.38	1,385.28	(28.10)	(4.76)	142.52	66.34	9.00	(14.89)
AHP, Sci., Ther.&Tech.	1,609.51	1,604.17	(5.34)	29.41	378.97	119.41	33.59	3.22
HCAs & Support Staff	1,608.26	1,586.01	(22.25)	(66.19)	161.66	(169.64)	(86.68)	(50.20)
Non Clinical	2,001.44	1,993.91	(7.53)	(126.73)	332.08	(151.36)	(149.59)	(79.15)
Sub Total	**9,803.79**	**9,694.54**	**(109.25)**	**(186.84)**	**1,634.34**	**31.80**	**(164.02)**	**(173.93)**
UHT GROUP								
Nursing & Midwifery	4,877.57	4,806.10	(71.47)	(38.20)	918.93	240.46	28.30	(60.56)
Medical & Dental	1,990.34	1,979.50	(10.84)	(10.32)	201.60	105.09	17.27	(18.18)
AHP, Sci., Ther.&Tech.	2,179.89	2,174.22	(5.67)	41.18	408.70	101.18	(0.35)	8.84
HCAs & Support Staff	2,635.41	2,590.33	(45.08)	(92.66)	216.46	(216.96)	(132.38)	(84.10)
Non Clinical	3,560.95	3,531.12	(29.83)	(255.83)	409.09	(239.49)	(298.25)	(151.50)
Sub Total	**15,244.16**	**15,081.27**	**(162.89)**	**(355.83)**	**2,154.77**	**(9.71)**	**(385.41)**	**(305.51)**

The Month 2 position includes a reduction of 255.83wte Non Clinical staff compared to the same period last financial year, with an in-month decrease of 29.83wte across the Group.

Efficiency

The plan assumed delivery of an overall efficiency target for the Group of £81.7m. The table below shows the current planning position against the target:

	NTH				STH				GROUP			
2026/27 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	1,975	9,626	7,651	487%	7,624	30,156	22,532	396%	9,599	39,782	30,183	414%
Plans in Progress	13,804	7,830	-5,974	57%	33,934	22,192	-11,742	65%	47,738	30,022	-17,716	63%
Opportunity	9,221	7,544	-1,677	82%	15,142	4,352	-10,790	29%	24,363	11,896	-12,467	49%
Unidentified	0	0	0	-	0	0	0	-	0	0	0	-
Total	**25,000**	**25,000**	**0**	**100%**	**56,700**	**56,700**	**0**	**100%**	**81,700**	**81,700**	**0**	**100%**
High Risk	14,681	11,943	-2,738	81%	29,051	19,489	-9,562	67%	43,732	31,432	-12,300	72%
Medium risk	5,506	6,922	1,416	126%	17,784	20,990	3,206	118%	23,289	27,912	4,623	120%
Low Risk	4,813	6,135	1,322	127%	9,865	16,221	6,356	164%	14,679	22,356	7,677	152%
Total	**25,000**	**25,000**	**0**	**100%**	**56,700**	**56,700**	**0**	**100%**	**81,700**	**81,700**	**0**	**100%**

De-risking of the CIP programme and maximising recurrent in-year delivery continues to be a key area of focus for the Financial Recovery Oversight Group and CSU CIP meetings.

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 £11.9m remains defined as 'Opportunity'. £31.4m of the programme is categorised as High Risk (which is a reduction of £12.3m since plan submission).

The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 2 Delivery	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery
Pay	1,731	1,768	37	102%	2,308	2,617	309	113%	4,039	4,385	346	109%
Non Pay	1,547	934	-613	60%	4,297	3,498	-799	81%	5,844	4,432	-1,412	76%
Income	160	386	226	242%	657	922	265	140%	817	1,308	491	160%
Total	**3,438**	**3,088**	**-350**	**90%**	**7,263**	**7,037**	**-226**	**97%**	**10,700**	**10,125**	**-575**	**95%**
Recurrent	2,749	2,138	-611	78%	5,288	5,184	-104	98%	8,036	7,322	-714	91%
Non-recurrent	689	950	261	138%	1,975	1,853	-122	94%	2,664	2,803	139	105%
Total	**3,438**	**3,088**	**-350**	**90%**	**7,263**	**7,037**	**-226**	**97%**	**10,700**	**10,125**	**-575**	**95%**
Recurrent %	80%	69%	-11%	-	73%	74%	1%	-	75%	72%	-3%	-

Across the Group, overall year-to-date delivery is £10.1m (95% of target). However, this position includes a number of non-recurrent schemes. Delivery of recurrent savings is £0.6m behind plan at the end of Month 2, constituting 72% of YTD delivery across the Group.

Liquidity

The cash balance at the end of Month 2 stood at £142.6m for the Group. The month end revenue cash balance at NTH was £46.6m (equating to 37.5 operating expenditure days) and £57.6m at STH (equating to 21.2 operating expenditure days). The year-end balance sheet cash balance is forecast to be £60.0m at NTH and £35m at STH.

The continued strong cash balances have supported overall compliance with the Better Payment Practice Code for both trusts, as shown in the tables below:

	NTH		STH		GROUP	
Better Payment Practice Code	**YTD Number**	**YTD Value £000**	**YTD Number**	**YTD Value £000**	**YTD Number**	**YTD Value £000**
Total bills paid in the year	11,631	41,798	19,236	120,681	30,867	162,479
Total bills paid within target	11,439	41,420	18,350	106,380	29,789	147,800
Percentage of bills paid within target	**98.3%**	**99.1%**	**95.4%**	**88.1%**	**96.5%**	**91.0%**

Statement of Financial Position

The table below shows the draft balance sheet position for the two Trusts as at the end of Month 2 2026/27:

	NTH £000	STH £000
Non-current assets		
Intangible assets	3,122	6,533
On-SoFP IFRIC 12 assets	0	138,513
Other property, plant and equipment (excludes leases)	150,184	165,078
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	15,635	33,405
Receivables: due from NHS and DHSC group bodies	512	1,123
Receivables: due from non-NHS/DHSC Group bodies	1,429	2,399
Credit Loss Allowances		(685)
Total non-current assets	**170,882**	**346,366**
Current assets		
Inventories	6,631	15,438
Receivables: due from NHS and DHSC group bodies	4,632	16,428
Receivables: due from non-NHS/DHSC Group bodies	27,260	14,104
Credit Loss Allowances	(4,525)	(4,057)
Other Assets	218	10,125
Cash and cash equivalents: GBS/NLF	50,436	89,140
Cash and cash equivalents: commercial/in hand/other	6	3,021
Total current assets	**84,658**	**144,199**
Current liabilities		
Trade and other payables: capital	(2,508)	(18,671)
Trade and other payables: non-capital	(55,502)	(158,946)
Borrowings	(4,260)	(23,127)
Other financial liabilities	0	0
Provisions	(1,938)	(1,357)
Other liabilities: deferred income including contract liabilities	(7,559)	0
Total current liabilities	**(71,767)**	**(202,101)**
Total assets less current liabilities	**183,773**	**288,464**
Non-current liabilities		
Borrowings	(28,554)	(247,169)
Provisions	(1,455)	(1,304)
Total non-current liabilities	**(30,009)**	**(248,473)**
Total net assets employed	**153,764**	**39,991**
Financed by		
Public dividend capital	215,014	507,293
Revaluation reserve	12,836	25,627
Other reserves	0	26,476
Income and expenditure reserve	(74,086)	(519,405)
Total taxpayers' and others' equity	**153,764**	**39,991**
Debtor Days	**23.0**	**12.1**
Creditor Days	**172.0**	**181.2**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 2 2026/27

University Hospitals Tees

Integrated Performance Report (reporting to end April 2026)

Meeting date: 2 July 2026

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: Russell Nightingale, 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 April 2026 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 four performance metrics remain as Alert.

- MSSA infections
- Readmission Rate
- Mandatory Training
- Sickness Absence (%)

In addition, **Never Events**, regraded from assure; one new event reported in April 2026, following 7 consecutive months with zero reported. There is a continuing focus to strengthen the approach to national safety standards. **Cancer faster diagnosis** regraded from advise as performance in April is outside expected variance, there is a continued focus on improvement in urology and respiratory pathways.

Performance compliance for cancer waiting times and elective access standards remain strategic risks on the BAF, with improvement action plans on place.

For STHFT, the following eight performance metrics remain as alert assurance:

- *Klebsiella* infections
- Breast feeding at first feed
- Incidents per 1000 bed days
- Inpatient Experience %
- Maternity Experience%
- Feedback acknowledged in 3 days
- Annual Appraisal
- Mandatory Training (%)

In addition, **Community Over-52 week waiters %** regraded from advise as performance deteriorated to the upper limit of expected variance in April 2026, and consistently below plan. There is focused validation of reported position and bringing forward the longest waiters to improve this position. Capacity for paediatric therapy interventions, and specialist weight management is being addressed with recovery plans 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 majority of IPR metrics remain graded advise, for both Trusts.

For NTHFT, five metrics have been regraded to advise in April 2026.

RTT Incomplete Pathways is regraded to advise from alert as performance recovered above plan in April.

Community 52-Week Waits% regraded from assure as performance has returned within statistical range of plan. Focused validation of reported position and bringing forward the longest waiters is a priority.

RTT 52 Week Waiters (%) regraded from alert; compliance now within expected variation. There is a wider strategic focus in reducing long waits for patients through proactive mutual support.

Summary Hospital-Level Mortality Indicator is regraded to from assure performance is within expected variance, a higher than average SHIMI reported; previously assured as better than the national benchmark.

Community 18-Week Compliance is a new metric within the IPR in April 2026. This is in line with plan and improving but is currently not statistically assured.

For STHFT, four metrics have been regraded to Advise in April 2026.

- **Never Events** regraded from Alert as no new never events reported in April 2026.
- **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** regraded from Alert as rate has returned within expected variation.

- **Cancer 31 Day Standard** regraded from Alert as performance is within statistical range of 26/27 plan.

- **Community 18-week compliance** is a new metric in the IPR in April 2026, the trust is currently above plan but performance is below expected in March and April 2026.

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 seven metrics:

- C. difficile Infections
- Pseudomonas infections
- Neonatal Mortality Rate (rolling 12 months per 1,000 births)
- Discharge Delay average days
- A&E Experience (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

In addition further ***E. coli* infections** regraded from alert, with fewer cases than trajectory.

For STHFT, assurance continues for three metrics:

- Summary Hospital-Level Mortality Indicator
- Discharge Delay average days
- Staff Turnover (%)

In addition, ***E. coli* infections** regraded from alert, with fewer cases than trajectory in April 2026. ***C. difficile* infections,** regraded from advise, with fewer cases than trajectory reported and ***Pseudomonas* infections,** regraded from alert with fewer cases than trajectory in April 2026

Recommendations:

The Board of Directors are asked to:

- Receive the Integrated Performance Report for the reporting period April 2026.
- 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:

April 2026

Caring
Better
Together

Index of metrics

SAFE DOMAIN
Responsibility: Quality Assurance Committee

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
Falls with Harm per 1000 Bed Days
C. difficile infections
MRSA infections
E. coli infections
MSSA infections
Klebsiella infections
Pseudomonas infections
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 18 Week Wait Compliance (%)
(new metric)
Community over 52-week Waiters (%)

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)

METRIC REMOVED
Number of births
RTT time to first appointment % in 18 weeks

Caring Better Together

North Tees & Hartlepool assurance summary

No change in assurance

- MSSA Infections
- Readmission Rate

ALERT

- Sickness absence (%)
- Mandatory Training (%)

New ALERT indicators

- **Never Events**, regraded from Assure: one new reported in April 2026. following 7 consecutive months with zero reported.
- **Cancer Faster Diagnosis** regraded from Advise due to April performance outside expected variance.

No change in assurance

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Falls with Harm per 1000 Bed Days
- MRSA Infections
- *Klebsiella* infections
- Still Births Rate (Rolling 12 months, per 1000 Births)
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- Breast feeding at first feed
- Community UCR 2 Hour Response (%)
- Cancelled operations not rebooked in 28 days

ADVISE

- Ambulance Handover within 45 minutes
- 4 Hour A&E Standard
- 12-Hour ED Breaches Rate (%)
- Cancer 31 Day Standard
- Cancer 62 Day Standard
- Diagnostic 6 Week Standard
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Annual Appraisal (%)
- Cumulative YTD Financial Position (£Millions)

New ADVISE indicators

- **RTT Incomplete Pathways (%)** regraded from Alert as performance recovered above plan in April.
- **RTT 52 Week Waiters (%)** regraded from Alert; compliance now within expected variation.
- **Community 52-week waits%** regraded from Assure as performance has returned within statistical range of plan.
- **Summary Hospital-Level Mortality Indicator** regraded from Assure, performance returned within expected variation.
- **Community 18-week compliance** is in line with plan and improving but not yet assured (new metric)

No change in assurance

- *C. difficile* Infections
- *Pseudomonas* infections
- Neonatal Mortality Rate (rolling 12 months per 1,000 births)
- Discharge Delay average days

ASSURE

- A&E Experience (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

New ASSURE indicators

- ***E. coli* infections** regraded from Alert, with fewer cases than trajectory.

Caring Better Together

South Tees Hospitals assurance summary

No change in assurance	ALERT	New ALERT indicator
• *Klebsiella* infections • Breast feeding at first feed • Incidents per 1000 Bed Days	• Inpatient Experience (%) • Maternity Experience (%) • Feedback Acknowledged in 3 Days (%) • Annual Appraisal (%) • Mandatory training (%)	• **Community over 52-week Waiters (%)** regraded from Advise, performance deteriorated negatively to upper limit April 2026, and consistently below plan.

No change in assurance	ADVISE	New ADVISE indicator
• Patient Safety Incident Investigations • Falls with Harm per 1000 Bed Days • MRSA infections • MSSA infections • Still birth rate (Rolling 12 months per 1000 Births) • PPH >= 1500ml rate per 1,000 births • 3rd/4th Degree Tear (%) • Readmission rate • Ambulance handovers within 45 minutes • 4-Hour A&E Standard (%) • 12-Hour ED Breaches Rate (%) • Community UCR 2 Hour Response (%)	• Cancelled operations not rebooked in 28 days • Diagnostic 6 Weeks Standard (%) • Cancer Faster Diagnosis • Cancer 62 Day Standard • RTT Incomplete Pathways (%) • RTT 52 Week Waiters (%) • A&E Experience (%) • Outpatient Experience (%) • Community Experience (%) • Complaints Closed Within Target • Sickness absence (%) • Cumulative YTD Financial Position (£Millions)	• **Never Events** regraded from Alert as no new never events reported in April 2026. • **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** regraded from Alert as rate has returned within expected variation. • **Cancer 31 Day Standard** regraded from Alert as performance is within statistical range of 26/27 plan. • **Community 18 week compliance** is above plan but lower than expected in March and April 2026. (new metric).

No change in assurance	ASSURE	New ASSURE indicator
• Summary Hospital-Level Mortality Indicator • Discharge delay average days	• Staff Turnover (%)	***E. coli* infections** regraded from Alert, with fewer cases than trajectory in April 2026. ***C. difficile* infections,** regraded from Advise, with fewer cases than trajectory. ***Pseudomonas* infections,** regraded from Alert with fewer cases than trajectory.

Caring Better Together

SAFE DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

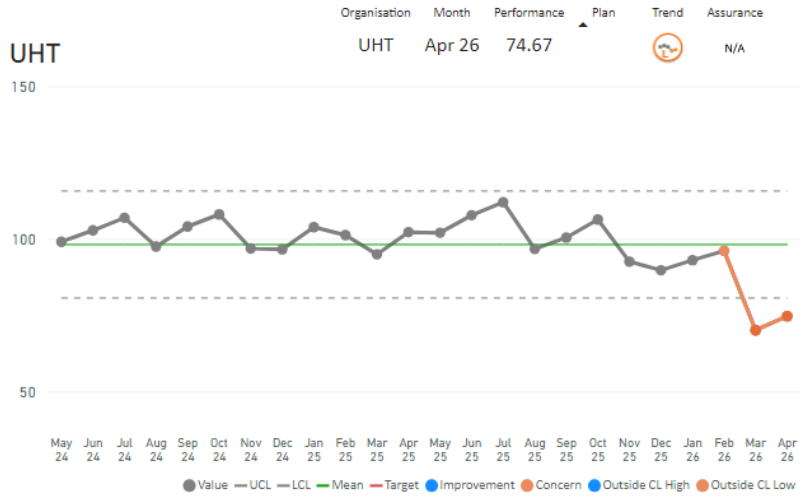
An external evaluation of the Group's implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These form the development of the UHT PSIRF implementation plan which includes the development of a joint PSIRF plan and policy. The reporting of incidents is seen as a positive indicator of a safety culture; the move from Datix to Healthcare Guardian for STHFT, led to a reduction which is being monitored closely, there is a known risk of reporting being temporarily impacted by a change in reporting systems. The incident reporting data for April displays an upturn in the STHFT reporting.

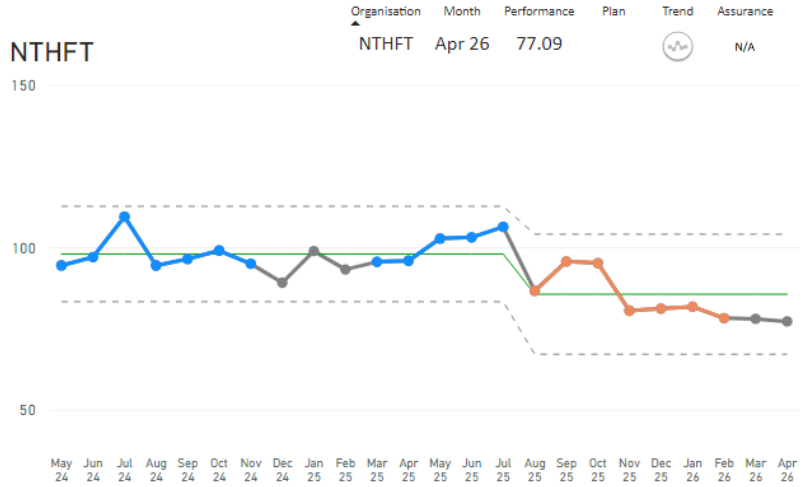
Healthcare-acquired infections (HCAI) plans are mapped against the NHS England target trajectories. HCAI continue to be closely tracked by the Infection Prevention Strategic Group and an Improvement Plan developed and monitored, this is also again aligned to the Trust Quality Priorities for 2026/27. Opportunities for reducing HCAIs is centred on Antimicrobial Stewardship with the Trust Antimicrobial Working Group having a clear focus on NHS England KPIs aligned to prescribing. Identified and defined medical leadership is an organisational priority for this. The IPC Board Assurance Framework encompasses all these measures.

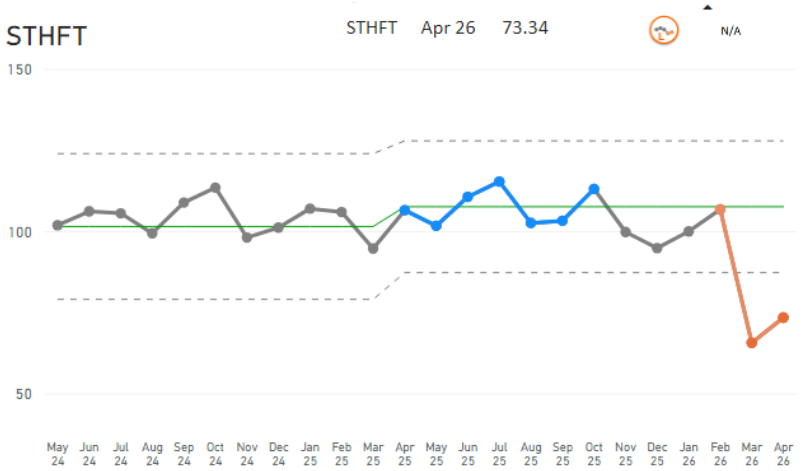
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Incidents Per 1000 Bed Days		102.61	103.01	106.22	86.51	95.56	95.05	80.38	81.04	81.61	78.12	77.88	77.09
Patient Safety Incident Investigations		1	1	3	1	2	0	0	0	0	0	0	1
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	1
Falls With Harm Rate (Per 1000 Bed Days)		0.28	0.29	0.14	0.21	0.07	0.21	0.07	0.21	0.19	0	0.42	0.3
C-Difficile	5	1	4	4	6	8	2	8	5	4	4	5	2
MRSA	0	0	0	0	0	1	1	0	0	0	0	0	0
E-Coli	6	10	6	12	12	10	9	6	12	7	6	12	4
MSSA	3	3	4	3	5	5	6	1	3	5	3	3	4
Klebsiella	1	4	4	2	0	2	3	2	4	3	5	5	1
Pseudomonas	1	3	1	2	0	1	0	0	1	0	0	0	0

South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Incidents Per 1000 Bed Days		101.62	110.54	115.23	102.48	103.18	112.97	99.71	94.73	99.89	106.66	65.57	73.34
Patient Safety Incident Investigations		0	1	2	1	1	0	0	1	1	0	2	0
Never Events	0	0	0	2	0	0	0	0	1	1	0	3	0
Falls With Harm Rate (Per 1000 Bed Days)		0.12	0.17	0.2	0.08	0.25	0.08	0.21	0.12	0.19	0.09	0.28	0.2
C-Difficile	10	11	11	9	8	13	13	12	7	12	13	10	8
MRSA	0	0	1	1	1	0	2	1	0	0	1	0	0
E-Coli	12	11	14	14	14	14	8	11	13	10	11	11	10
MSSA	7	10	5	8	11	6	7	5	6	9	7	8	8
Klebsiella	5	2	3	4	5	9	9	5	7	8	7	8	8
Pseudomonas	2	3	1	4	1	1	3	1	3	0	2	0	1

SAFE Incidents Per 1000 Bed Days





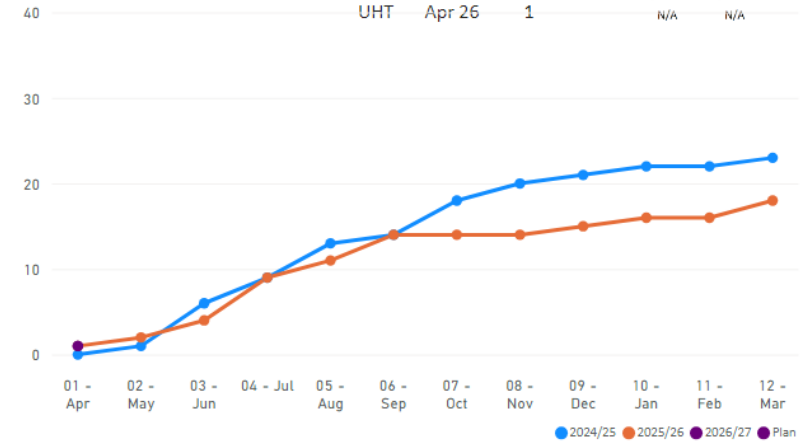


Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Overview of incident reporting.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: Advise, following a drop in reporting in November 2025 the rate has now stabilised. STHFT: Alert, outliers in March and April 2026 following implementation of new system, Healthcare Guardian.
Assurance: n/a.
Action taken: Incident reporting during April continues to show the impact of the change to Healthcare Guardian, which has combined the CSU reporting across UHT. This expected reduction had previously been alerted, although during April there has been a positive upturn in reporting for STHFT. All CSUs have been asked to examine all areas of reporting and implement actions to further promote reporting. Following feedback, additional drop-in sessions and educational materials have been developed to support staff accessing and using the new system.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Patient Safety Incident Investigations (YTD)

UHT

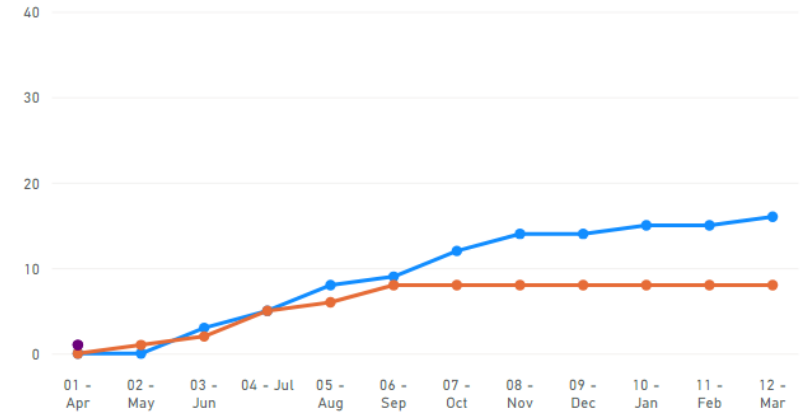
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	1		N/A	N/A



Metric: PSIIs initiated, cumulative annually from April.
Plan: n/a. An open reporting culture is encouraged.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: One new PSII recorded in April, One PSII YTD. STHFT: Zero PSIIs in April 2026, Zero PSIIs YTD.
Assurance: n/a
Action taken: Incidents are reviewed at weekly group panels to determine how they are investigated
under PSIRF. Recommendations from an external evaluation of PSIRF across UHT are being actioned.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

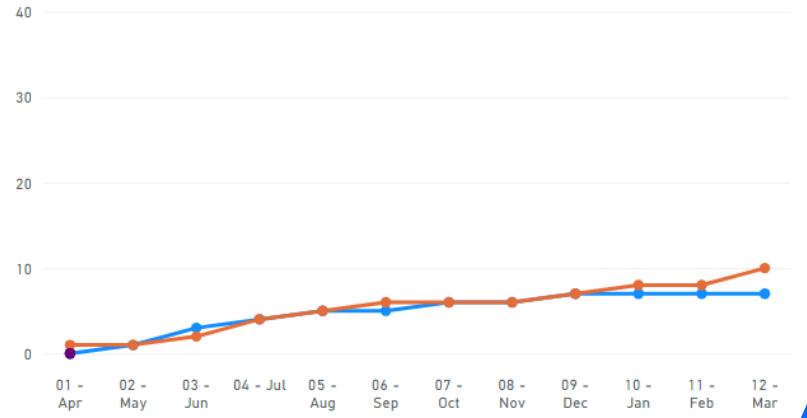
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	1		N/A	N/A



STHFT

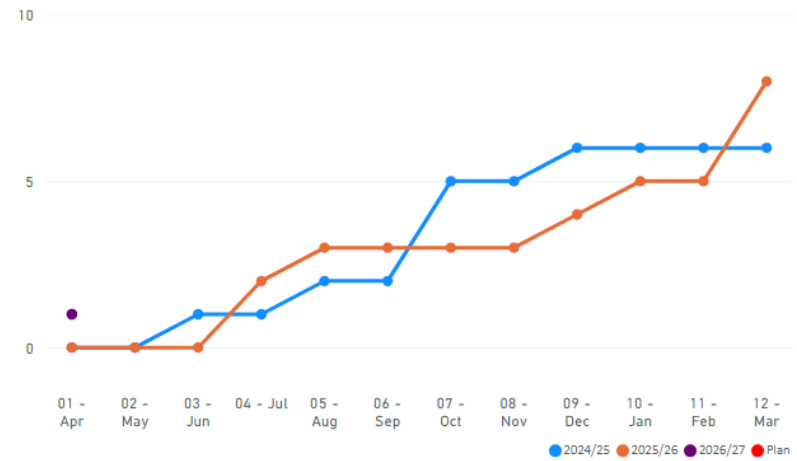
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	0		N/A	N/A



SAFE Never Events (YTD)

UHT

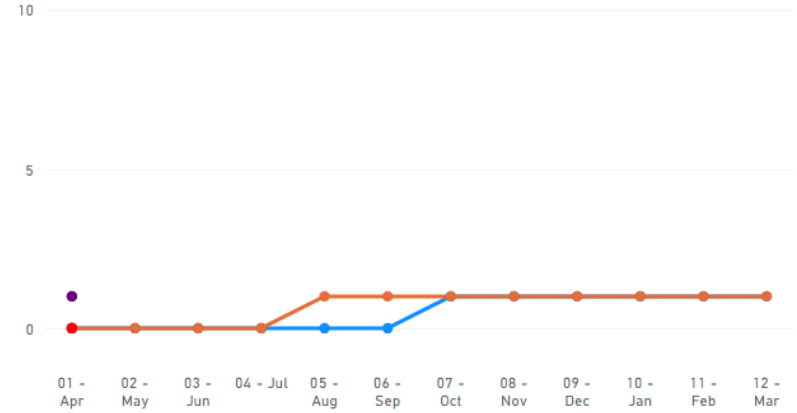
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	1		N/A	N/A



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: One new never event reported in April 2026. STHFT: Zero new events recorded in April 2026.
Assurance: NTHFT: Alert, 1 YTD. STHFT: Advise, zero YTD.
Action taken: There is ongoing focus to strengthen UHT's approach to using national safety standards for invasive procedures. This is promoting collaborative approaches across the trusts in the development of joint LocSSIPs. The NHSE consultation is completed; further workshops will be held in 2026 to review the future of the Never Event framework. All are reported onto the national reporting system, with a proportionate investigation (not necessarily PSII).
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

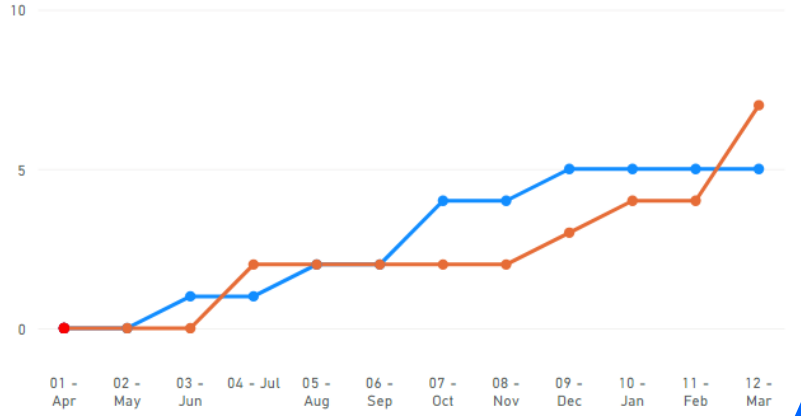
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	1	0	N/A	N/A



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	0	0	N/A	N/A

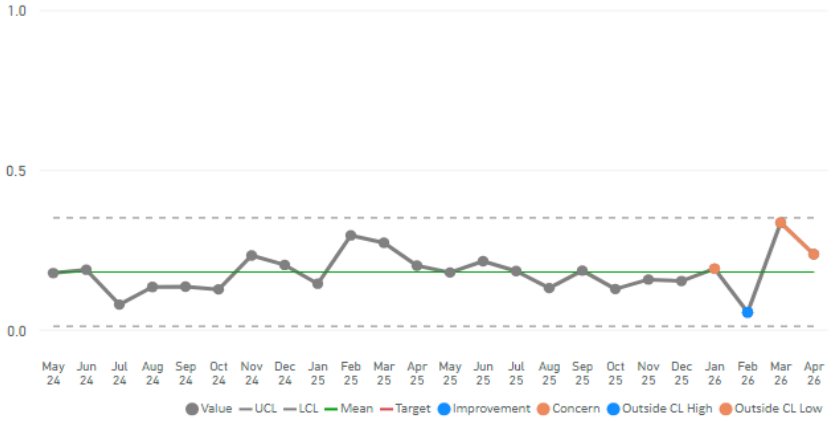


SAFE Falls With Harm Rate (Per 1000 Bed Days)

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.
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. The Falls improvement group has now moved to combined group
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

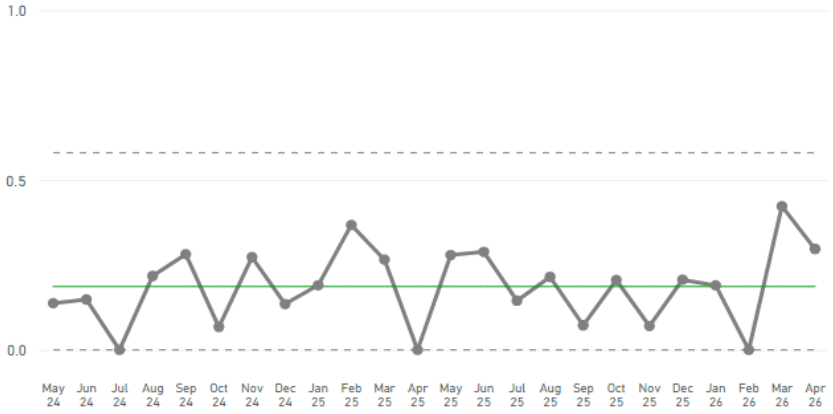
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	0.24			N/A



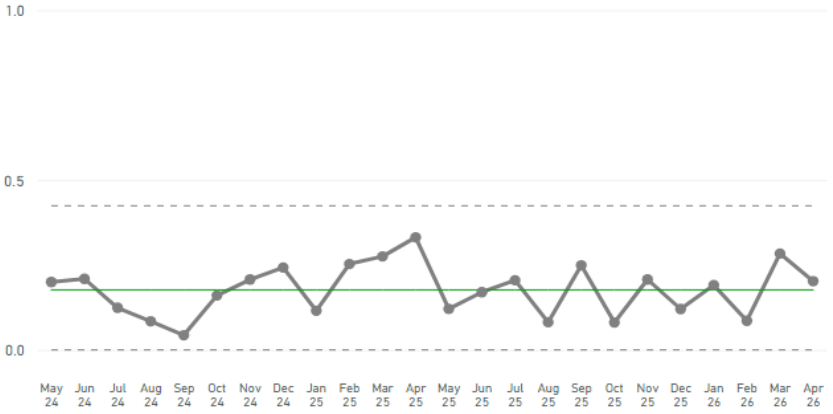
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	0.3			N/A



STHFT

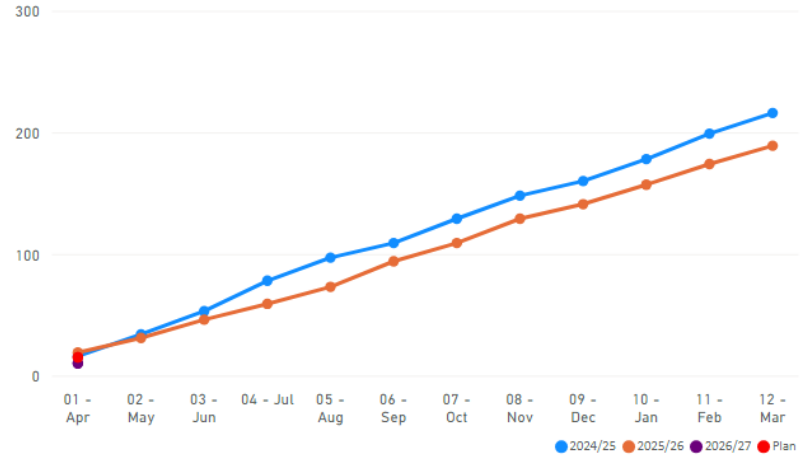
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	0.2			N/A



SAFE C-Difficile (YTD)

UHT

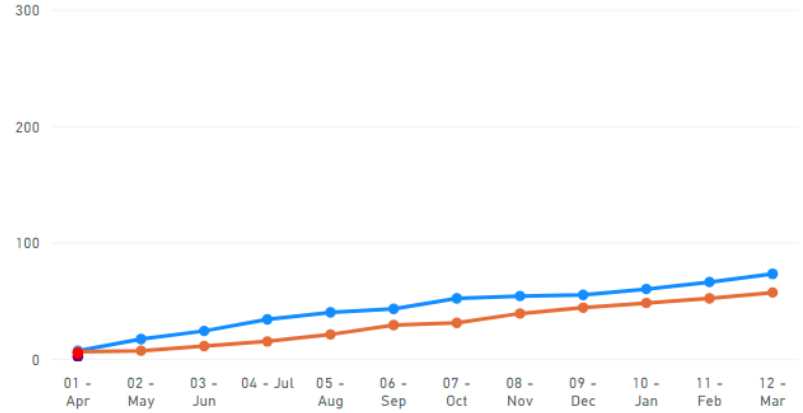
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	10	15	N/A	N/A



Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2025 calendar year cases. Plan for 2026/7 to be confirmed.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 2 new cases in April (trajectory of 5). STHFT: 8 new cases in April (trajectory of 10).
Assurance: NTHFT: Assure; 60%, 3 cases, better than trajectory YTD. STHFT: Assure; 20%, 2 cases, better than trajectory YTD.
Action taken: Appropriate decant facility to be established. HPV fogging continues as gold standard. Case review alignment planned across UHT with improved process through Healthcare Guardian.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

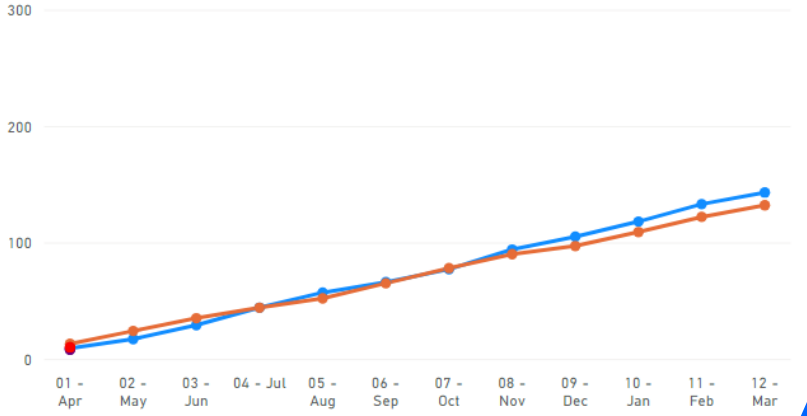
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	2	5	N/A	N/A



STHFT

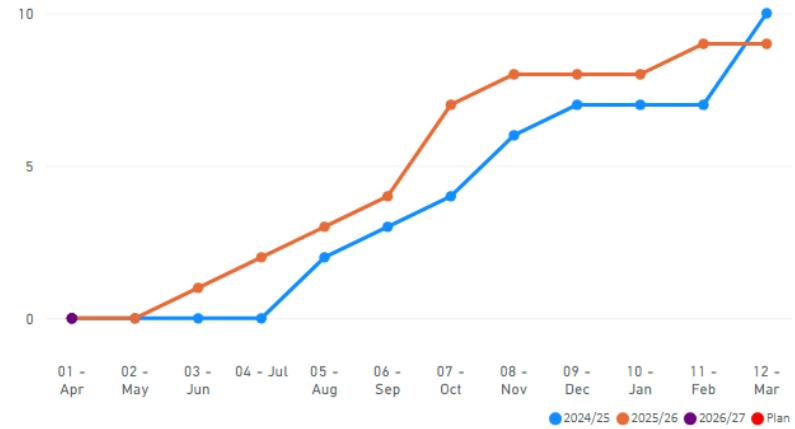
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	8	10	N/A	N/A



SAFE MRSA (YTD)

UHT

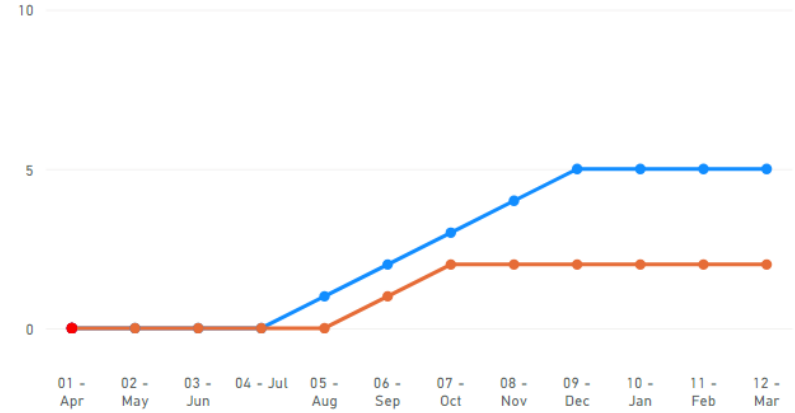
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	0		N/A	N/A



Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: No new cases in April 2026 at either Trust.
Assurance: NTHFT: Advise, 0 YTD, STHFT: Advise, 0 cases YTD.
Action taken: Alignment of policies to increase MRSA screening. Increased audit and education. Detailed learning is shared. Regional review to be developed due to regional increase last year.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

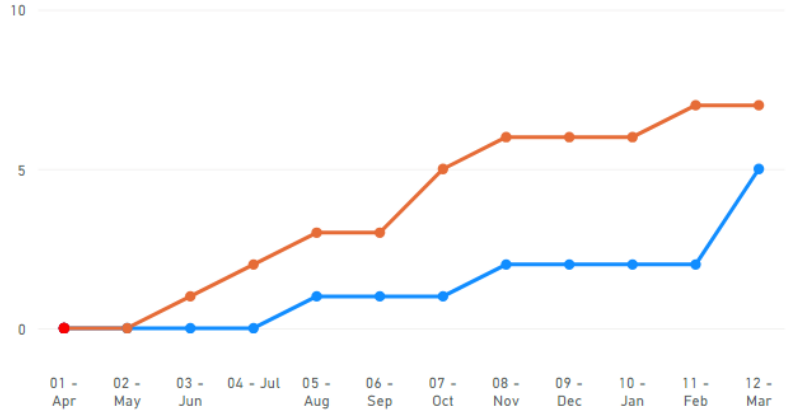
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	0	0	N/A	N/A



STHFT

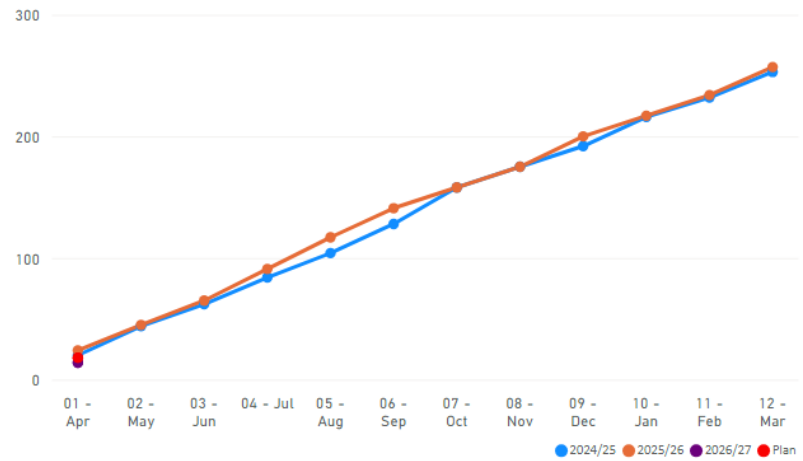
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	0	0	N/A	N/A



SAFE E-Coli (YTD)

UHT

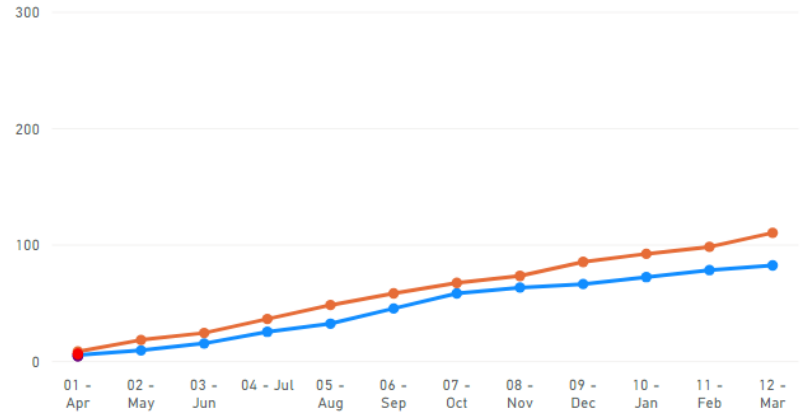
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	14	18	N/A	N/A



Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Plan for 25/26 to be confirmed.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 cases April 2026 (trajectory of 6). STHFT: 10 cases in April 2026 (trajectory of 12).
Assurance: NTHFT: Assure, 2 cases, 33% better than trajectory YTD. STHFT: Assure, 2 cases, 17% better than trajectory YTD.
Action taken: Focus stays on catheter care with a particular community focus, supported regionally. Focussed training for community and care home staff to support the Acute across the ICB.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

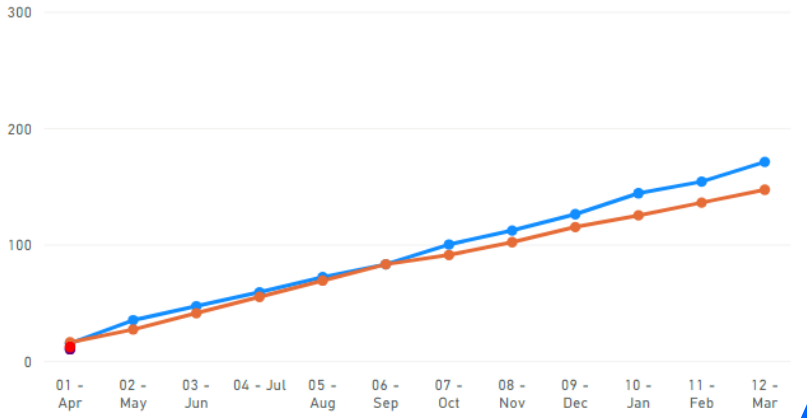
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	4	6	N/A	N/A



STHFT

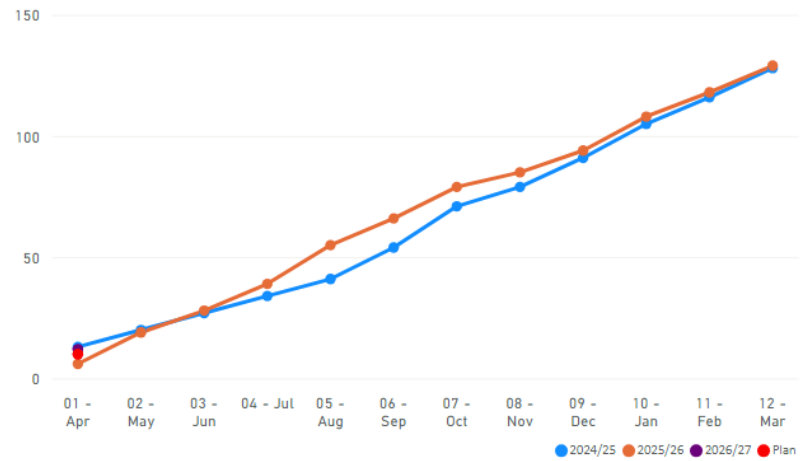
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	10	12	N/A	N/A



SAFE MSSA (YTD)

UHT

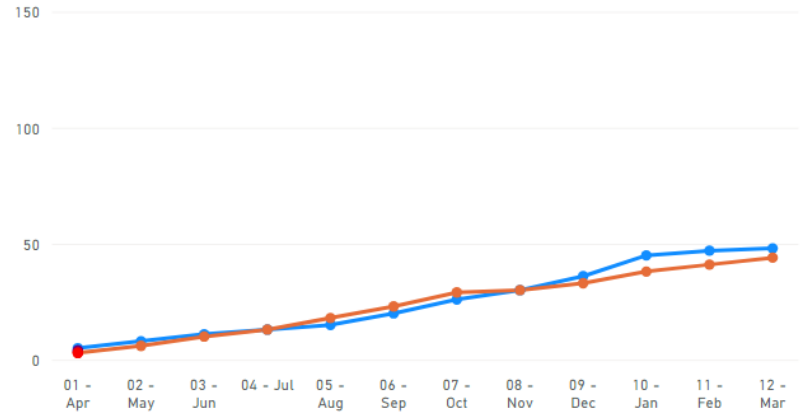
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	12	10	N/A	N/A



Metric: Healthcare associated cases of MSSA annually from April.
Plan: Local plan for 25/26 trajectory until 26/27 plan agreed (no contractual plan).
Rationale: In line with other NHS Contract indicators.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in April 2026 (trajectory of 3). STHFT: 8 new cases in April 2026 (trajectory of 7).
Assurance: NTHFT: Alert, 1 case, 33% worse than trajectory YTD. STHFT: Advise, 1 case, 14% worse than trajectory YTD.
Action taken: UHT focus group continues with alignment of processes in respect of line care. Detailed audit and education aligned. Planned audits relating to cannulation and line care.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

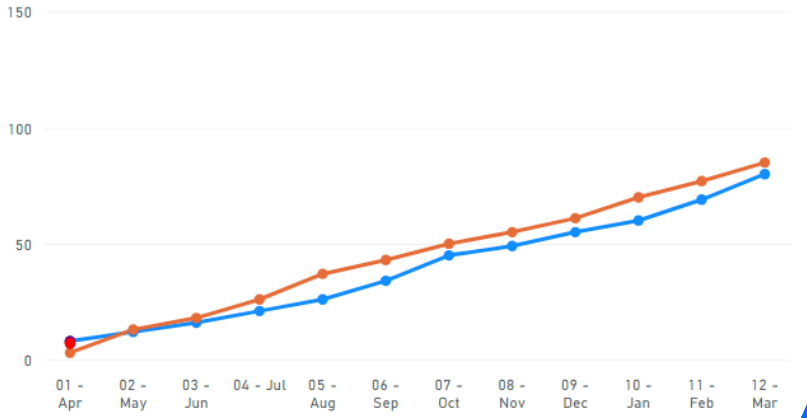
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	4	3	N/A	N/A

NTHFT



Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	8	7	N/A	N/A

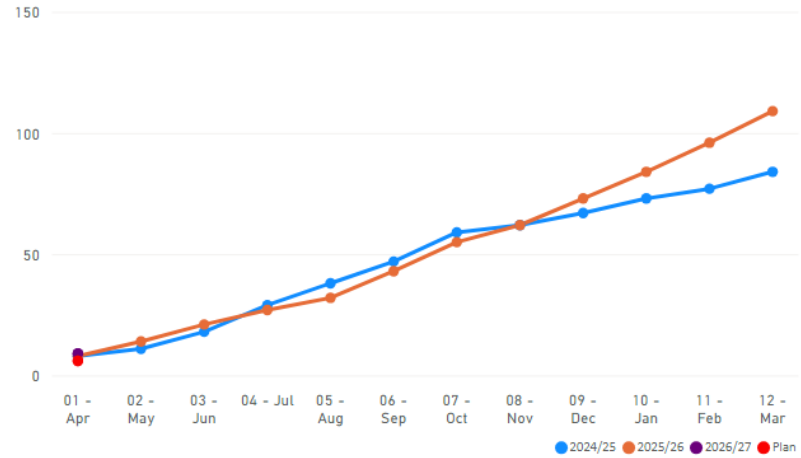
STHFT



SAFE Klebsiella (YTD)

UHT

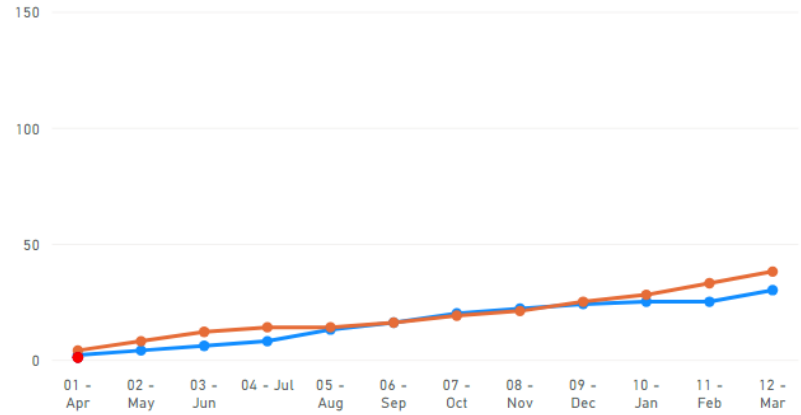
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	9	6	N/A	N/A



Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Plan for 26/27 to be confirmed.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 1 new cases in April 2026 (trajectory of 1). STHFT: 8 new cases in April 2026 (trajectory of 5).
Assurance: NTHFT: Advise, within tolerance YTD. STHFT: Alert, 3 cases, 60% worse than trajectory YTD.
Action taken: Urinary catheters indicated in cases, links to organisational focus on catheters. Increased communication on hand hygiene and line care.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

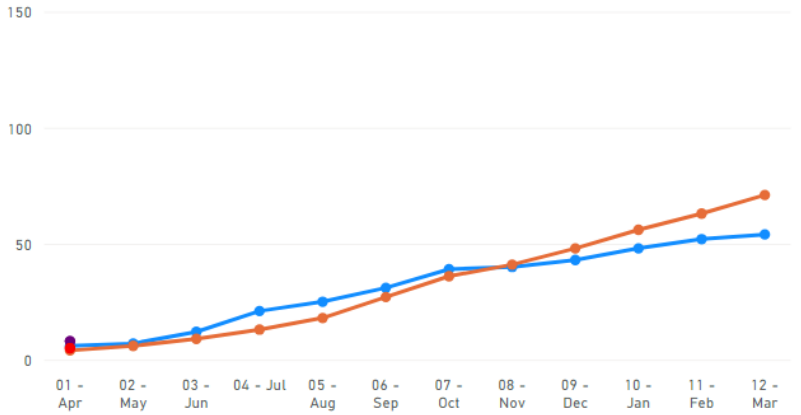
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	1	1	N/A	N/A



STHFT

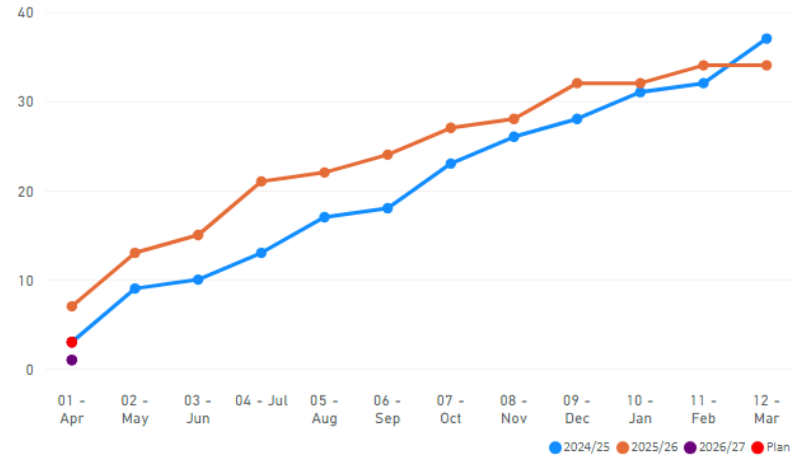
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	8	5	N/A	N/A



SAFE Pseudomonas (YTD)

UHT

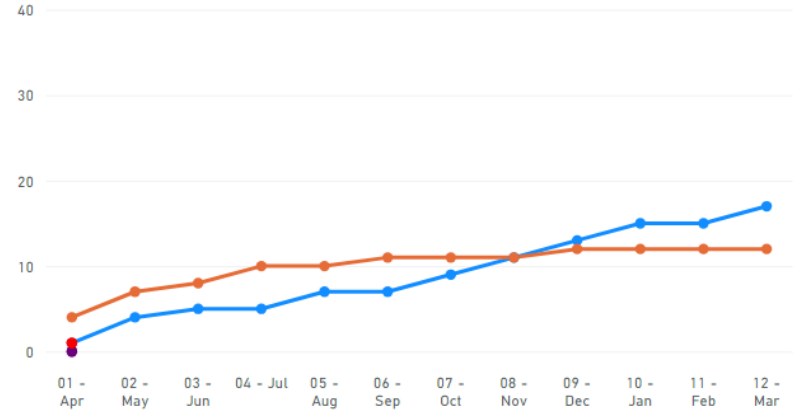
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	1	3	N/A	N/A



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2025 calendar year cases. Plan for 26/27 to be confirmed.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases in April (trajectory of 1). STHFT: One new case in April (trajectory of 2).
Assurance: NTHFT: Assure, better than trajectory YTD. STHFT: Assure, 1 case, 50%, better than trajectory YTD.
Action taken: Heightened awareness on water safety reporting and governance. Focussed drive on use of sinks and 'dangers in damp' campaign.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

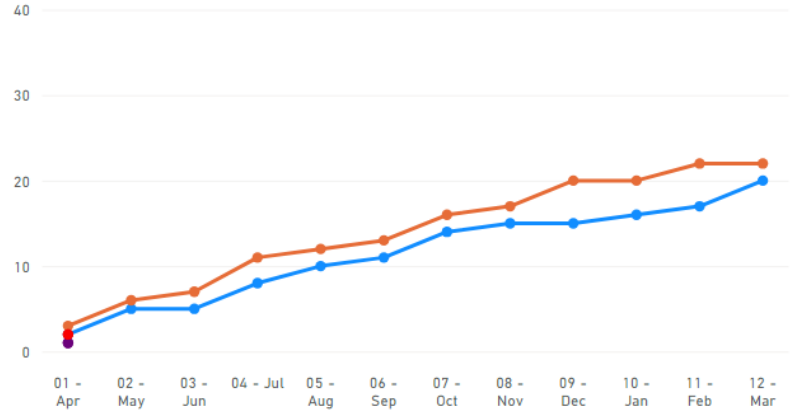
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	0	1	N/A	N/A



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	1	2	N/A	N/A



SAFE MATERNITY SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

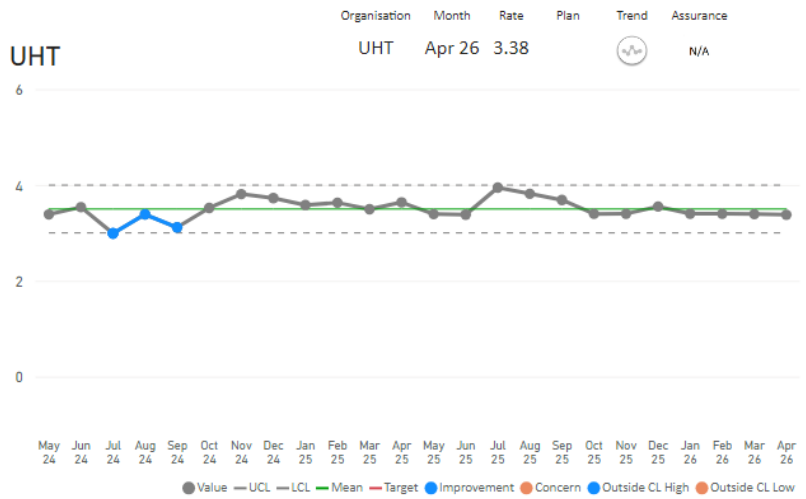
Maternity services metrics reflect the different case mix at the two trusts, with a greater proportion and the more complex of the high-risk pregnancies being cared for at the James Cook University Hospital. The stillbirth rate at NTHFT now shows a decreasing rate.

Breastfeeding rates are alerted to Board for South Tees. 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.

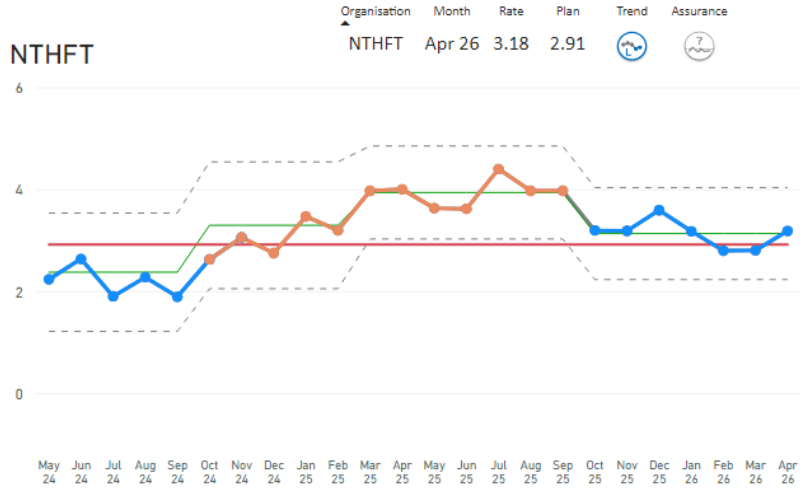
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Still Birth Rate (Rolling 12 months, per 1000 births)	2.91	3.63	3.61	4.39	3.97	3.97	3.19	3.18	3.59	3.17	2.79	2.8	3.18
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	0.99	0	0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Breast Feeding at First Feed	72.3%	50.9%	46.2%	49.5%	46.3%	47.5%	47.3%	52.4%	42.8%	55.1%	46.2%	53.3%	48.6%
PPH >= 1500ml Rate per 1000 Births	31	38	33	24	13	18	41	38	11	9	37	15	33
3rd/4th Degree Tear (%)		5.8%	2.9%	8.9%	3.2%	1%	3%	2.5%	1.2%	3.6%	3%	3.2%	0.9%

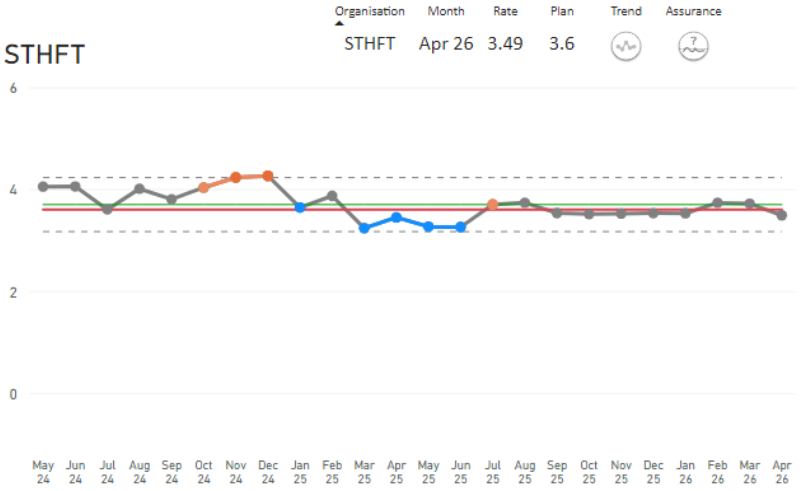
South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Still Birth Rate (Rolling 12 months, per 1000 births)	3.6	3.26	3.25	3.7	3.73	3.53	3.51	3.52	3.53	3.52	3.73	3.72	3.49
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1.84	1.31	1.74	1.75	1.32	1.55	1.54	1.54	1.77	2.21	1.98	1.76	1.97
Breast Feeding at First Feed	77.1%	65.3%	64.5%	62.3%	63.5%	69.5%	65.7%	65.7%	68.1%	65.5%	69.4%	68.3%	68.8%
PPH >= 1500ml Rate per 1000 Births	31	29	32	25	28	29	51	32	41	26	22	31	33
3rd/4th Degree Tear (%)		1.3%	3.4%	1.3%	1.8%	2.7%	3.5%	5.2%	1.1%	3.1%	4.3%	2.6%	1.4%

SAFE Still Birth Rate (Rolling 12 months, per 1000 births)

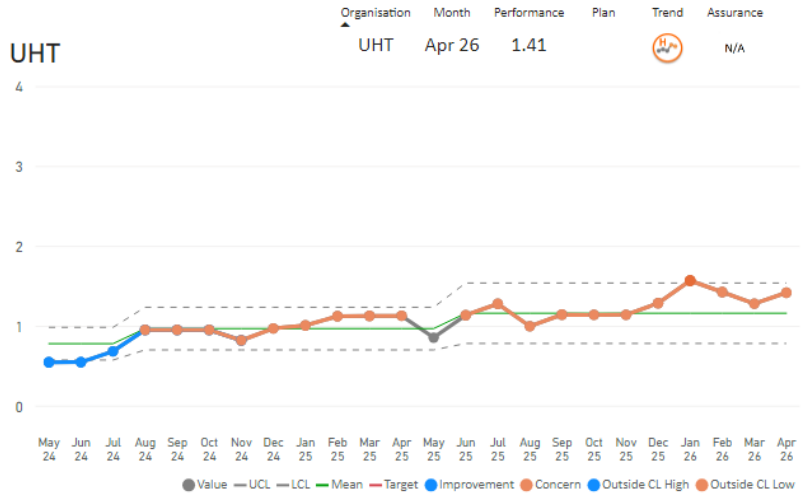


Metric: Still birth rate (rolling 12 months per 1000 births).
Plan: MBRRACE comparator group crude average 2024.
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: Positive, reduced rate from October 2025. STHFT: No current trend.
Assurance: NTHFT: Advise. STHFT: Advise
Action taken: Perinatal losses 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

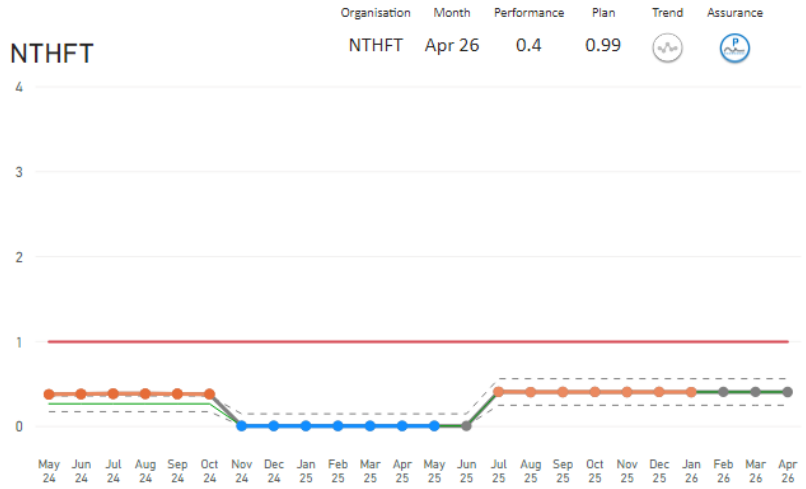


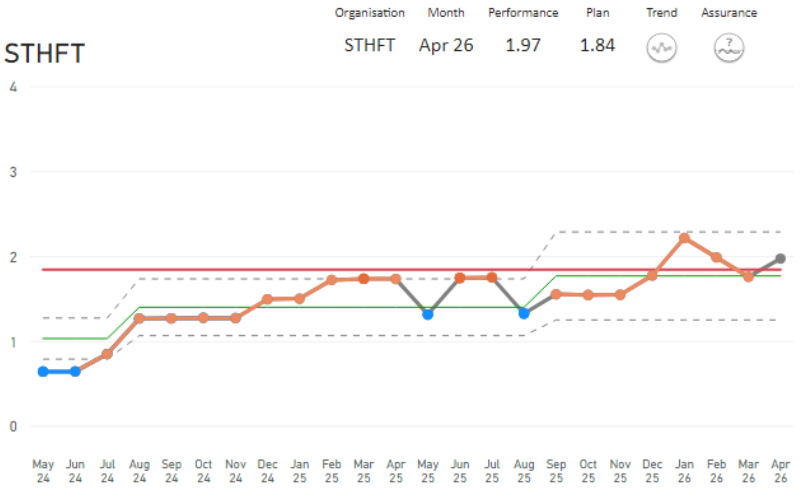


SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)

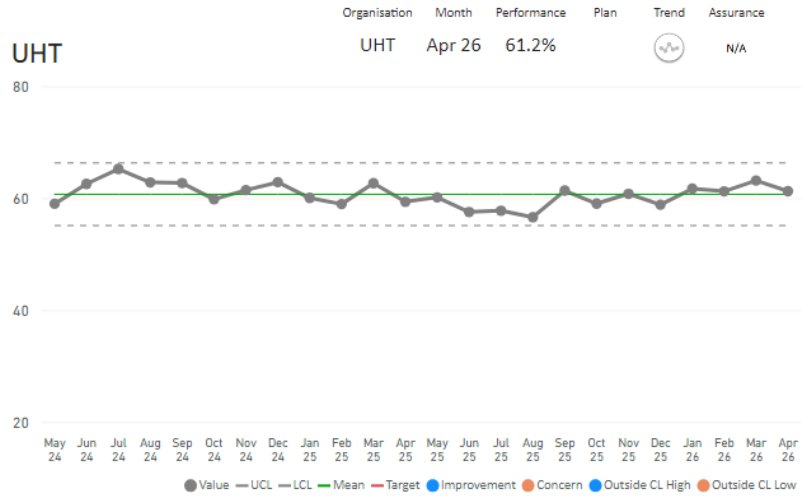


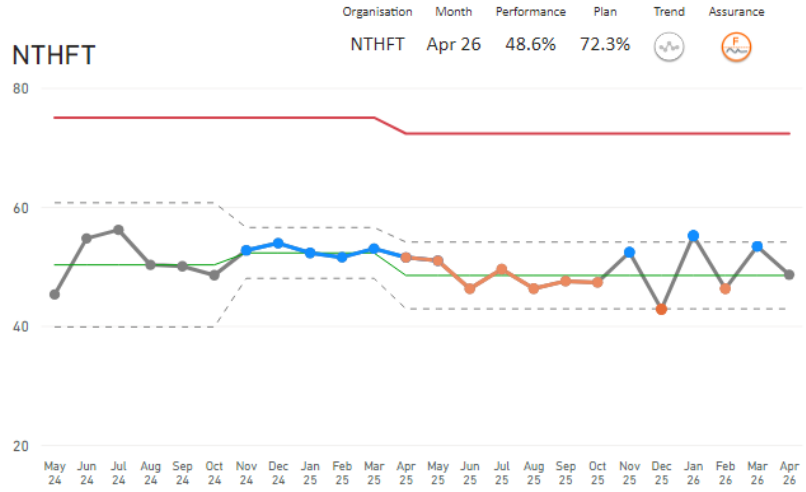
Metric: Neonatal mortality rate**,** rolling 12 months per 1,000 births.
Plan: MBRRACE audit comparator group average 2024.
Rationale: National Maternity Indicator.
Data quality: Assured, validated crude data, not case-mix adjusted.
Trend: NTHFT: No trend. STHFT: No trend
Assurance: NTHFT: Assure. STHFT: Advise, rate has returned within expected variance.
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

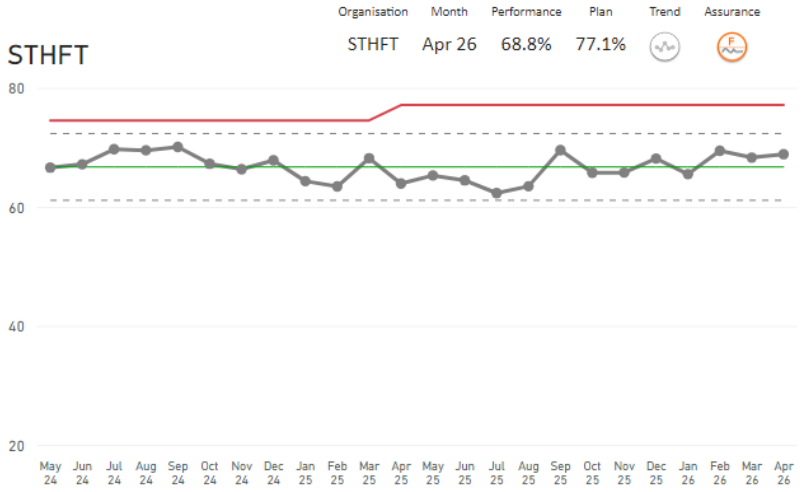




SAFE Breast Feeding at First Feed

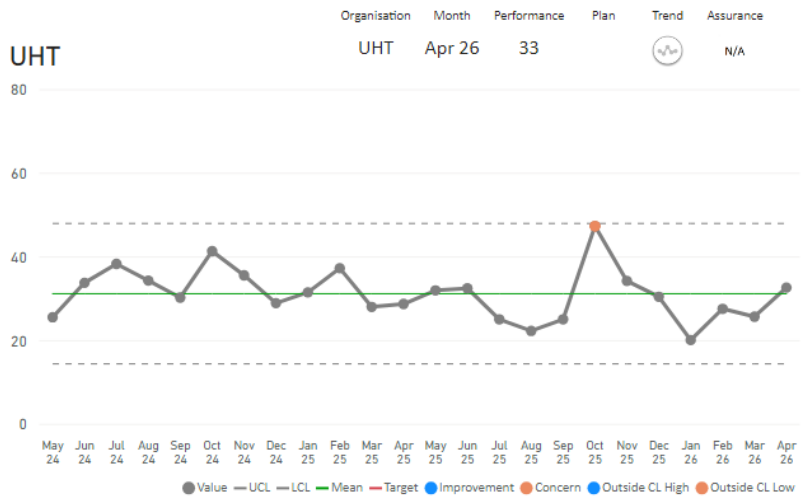


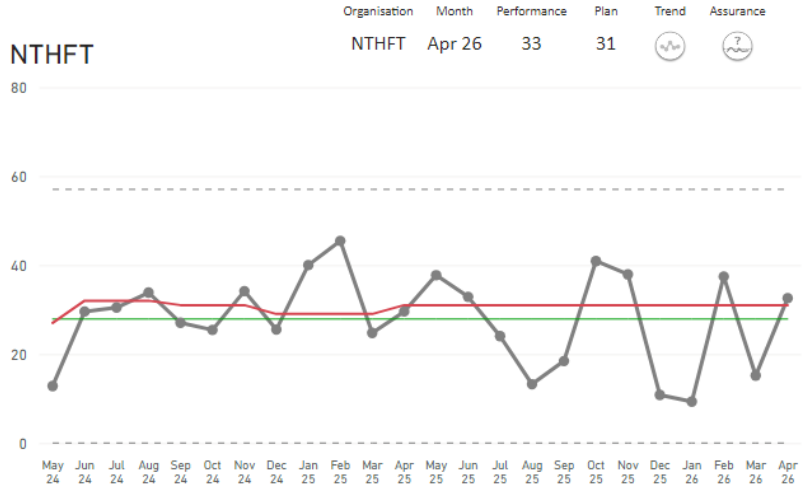


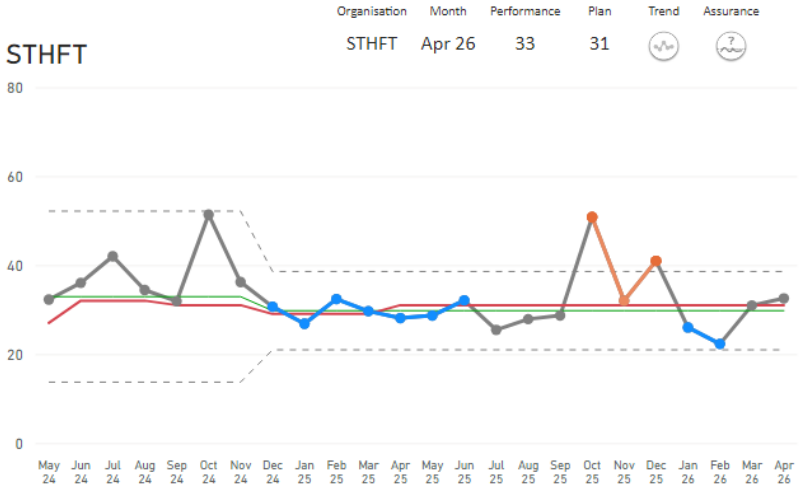


Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: National maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: Positive outliers for January and March 2026, plan is not statistically in range of current performance. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: ongoing collaboration to share learning and improvement insights.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE PPH >= 1500ml Rate per 1000 Births

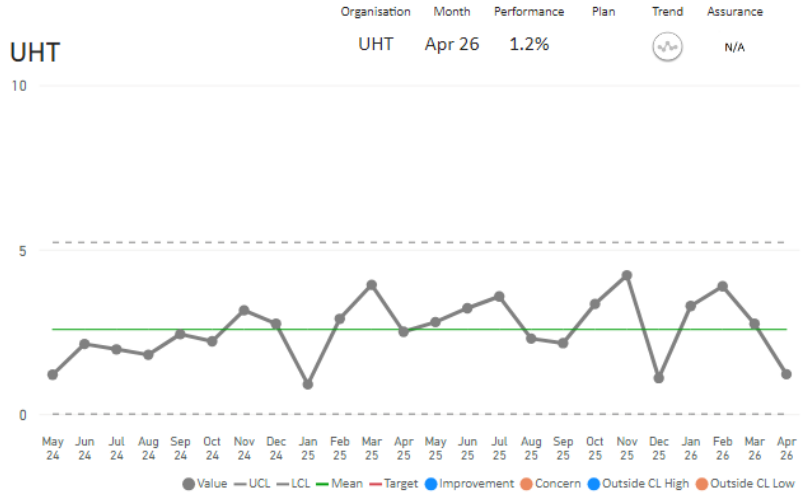




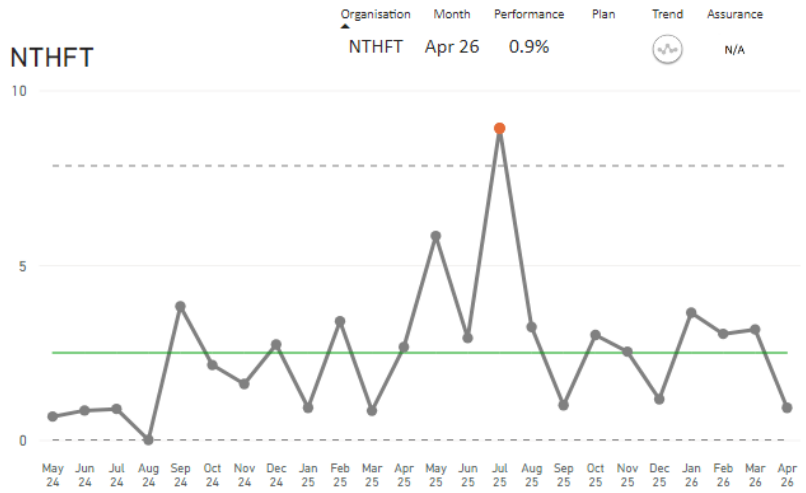


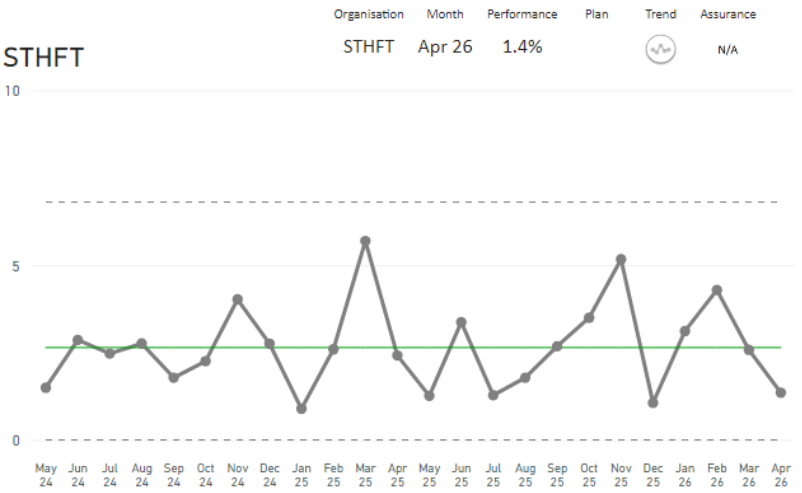
Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births.
Plan: North East and North Cumbria ICB regional average.
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend but recent wide variance in performance.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT and STHFT participate in a research study on effectiveness of interventions to reduce PPH. STHFT are undertaking an additional review of all PPH >1500ml to highlight any learning.
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 aligned to national descriptor, July 2025.
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.

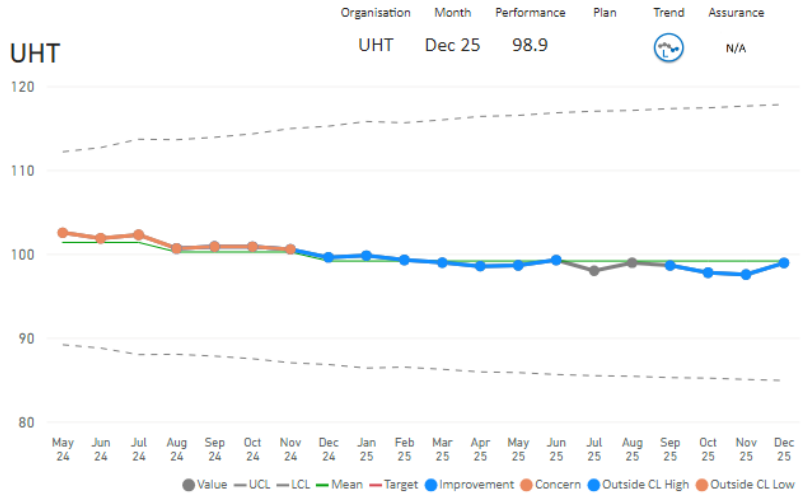
Both trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. This is focusing initially on readmissions of patients with a diagnosis of COPD, as this cohort of patients has a higher readmission rate. The COPD audit is complete and the findings discussed in the Quality Oversight Group in March 2026.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. Both Trusts consistently perform better than the 24/25 national average.

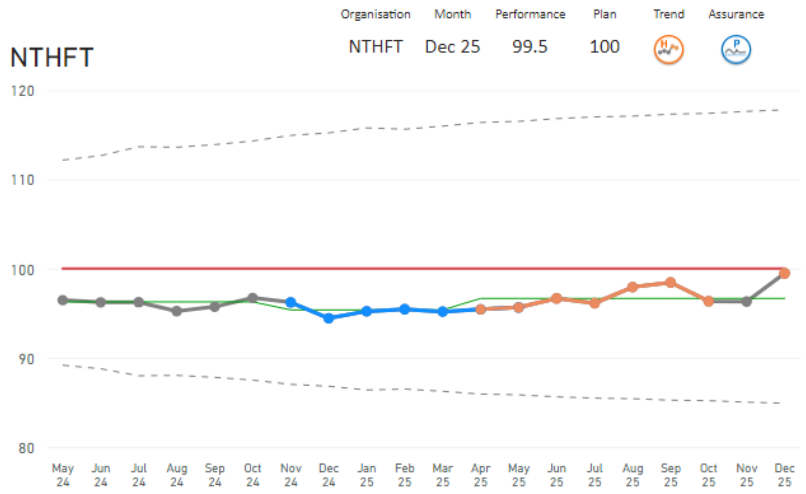
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Summary Hospital-Level Mortality Indicator	100	95.6	96.6	96.1	97.9	98.4	96.3	96.3	99.5			
Readmission Rate (%)	8.4%	10.5%	10.3%	10.5%	10.1%	10.2%	11%	10.4%	9.9%	10.6%		
Discharge Delay Average (days)	0.825	0.623	0.559	0.681	0.67	0.574	0.553	0.632	0.709	0.619	0.647	0.622

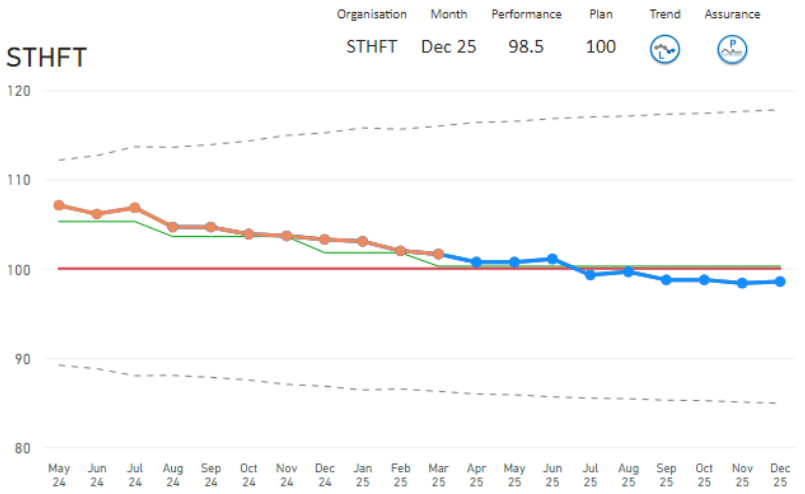
South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Summary Hospital-Level Mortality Indicator	100	100.7	101.1	99.3	99.6	98.7	98.7	98.4	98.5			
Readmission Rate (%)	8.4%	8.4%	9.1%	8.6%	8.4%	8.7%	8.6%	8.2%	8.7%	8.1%		
Discharge Delay Average (days)	0.825	0.626	0.594	0.617	0.601	0.688	0.671	0.594	0.635	0.738	0.726	0.746

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: Higher than average SHIMI in December 2025. STHFT: Improving.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: Coding audit work is underway focusing on diagnoses with higher mortality and coding depth (co-morbidities).
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee





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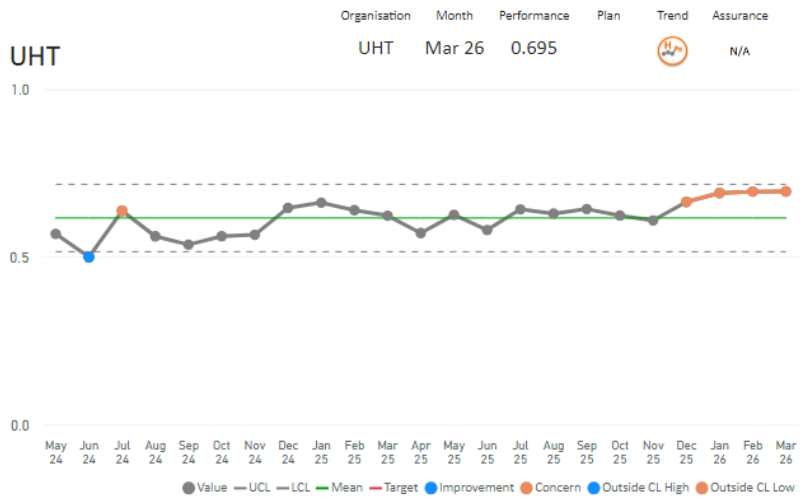
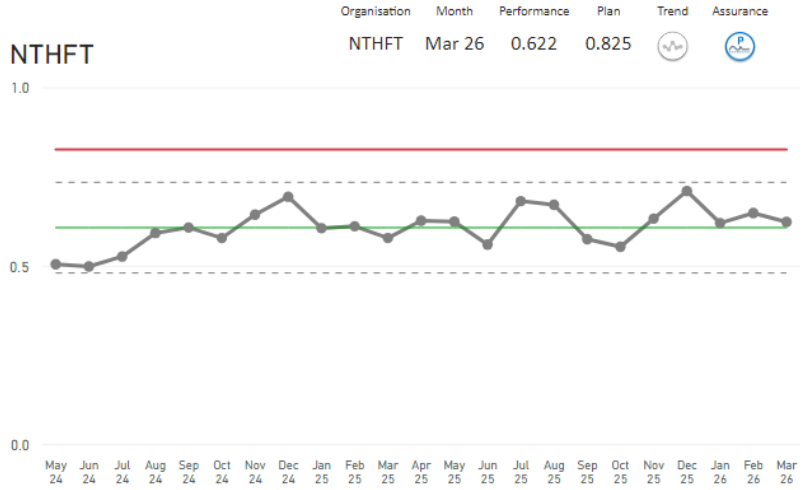
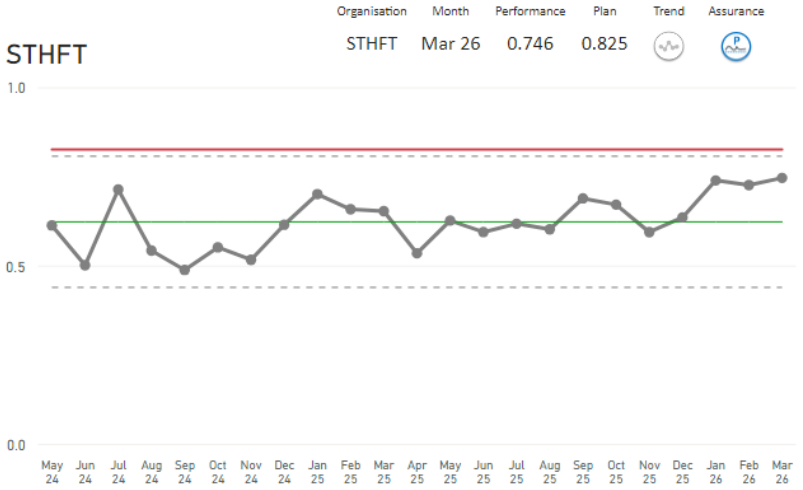
EFFECTIVE Discharge Delay Average (days)

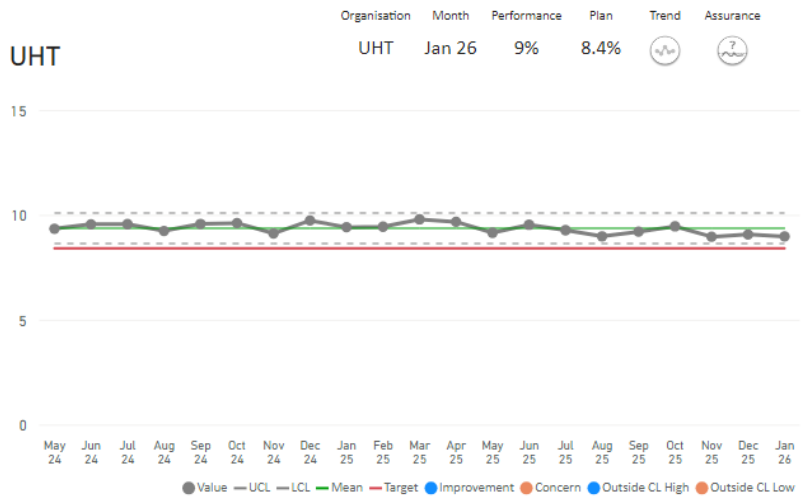




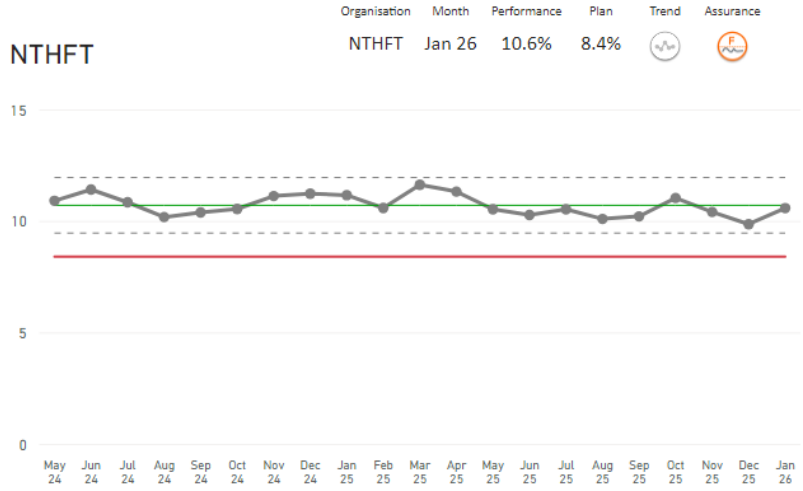


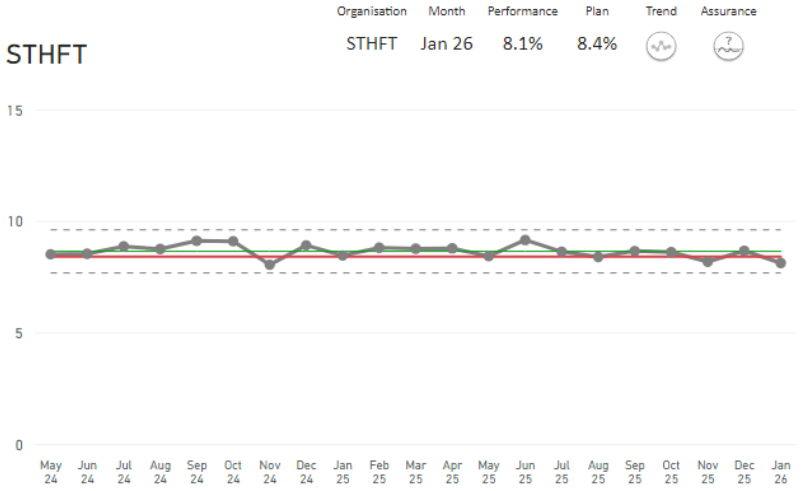
Metric: Average number of days between discharge ready date and discharge date, including zero-day length of stay.
Plan: No published standard, local plan to perform significantly better than national mean rate for 25/26.
Rationale: NHS Oversight Framework 25/26 core metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Assure.
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

EFFECTIVE Readmission Rate (%)



Metric: Percentage of patients readmitted within 30 days.
Plan: 2024/25 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 rate consistently higher than plan. STHFT: Advise.
Action taken: Highlight report presented at the Quality Oversight Group in March including COPD audit. Oversight of challenges, risks and improvement will be embedded into Quality and Performance Reviews.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee





RESPONSIVE DOMAIN SUMMARY

Executive lead: Russell Nightingale, Chief Delivery Officer **Accountable to: Resources Committee**

Urgent and emergency care

Ambulance handover performance compliance continued to improve at NTHFT in April, and handovers within 45 minutes are usually assured at >95% outside of peak winter demand. At STHFT, compliance remained within the expected performance variance although below plan.

Clinical teams at both Trusts improved their A&E 4-hour standard and 12-hour ED breach performance following heightened seasonal demand and acuity, NTHFT exceeded the agreed April trajectories for both standards. STHFT is tracking close to monthly plan for the A&E 4-hour standard .

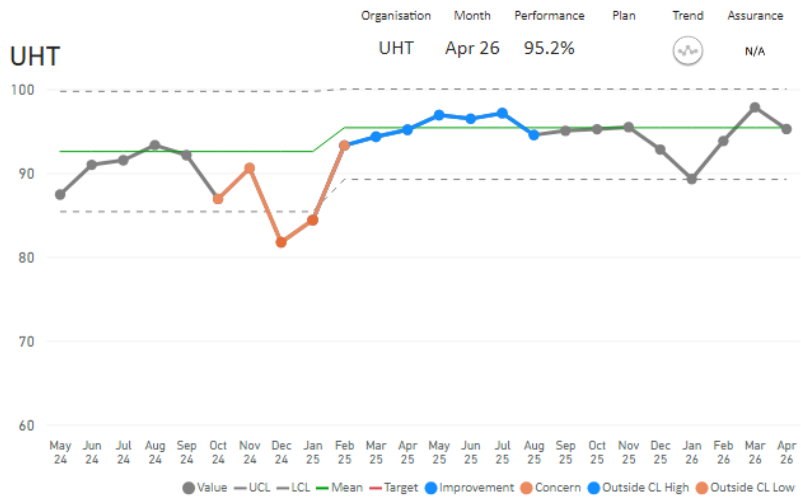
Above-standard performance in the community urgent 2-hour response reflects the continued focus on supporting urgent and emergency care pathways and caring for patients in the most appropriate setting. Work is ongoing with NEAS to reduce conveyance of care home residents, where an urgent community response is more appropriate. Service integration and 24-hour access to UCR Pathways remains a priority for UHT.

Elective operations cancelled on the day for non-medical reasons and not rebooked within 28 days has increased in April 2026 from the 5 or fewer per month at NTHFT throughout 25/26 . At STHFT this metric has stabilised after re-invigorating focus on re-booking through the Surgical Improvement Group and the UHT Elective Access Group.

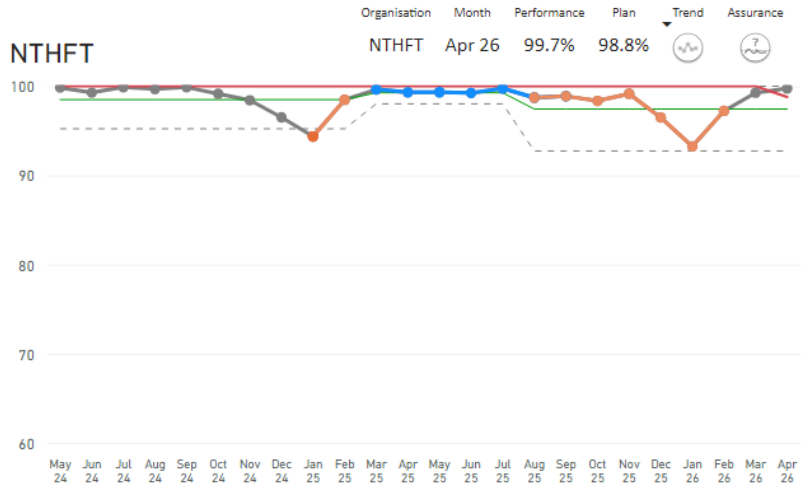
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
NEAS Handovers - Within 45 Mins (%)	98.8%	99.3%	99.2%	99.7%	98.7%	98.9%	98.4%	99.2%	96.5%	93.3%	97.2%	99.3%	99.7%
4-Hour A&E Standard	82.1%	86.4%	84.6%	84.9%	84.6%	83.4%	82%	82%	83.3%	80.4%	83%	86.2%	86.1%
12-hour ED breaches rate	1.6%	1.4%	3.2%	1.5%	1.4%	4.5%	6.4%	5.5%	6.9%	9.5%	5.7%	0.7%	1.1%
Community UCR 2hr Response Rate (%)	70%	75%	75%	76%	80%	76%	73%	75%	74%	75%	72%	74%	
Cancelled Ops - Not Rebooked Within 28 days	0	4	5	1	0	3	4	2	2	4	3	3	8

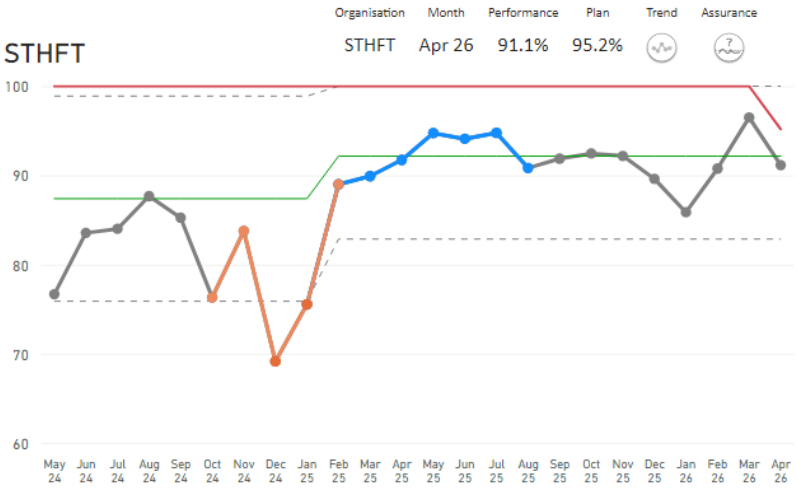
South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
NEAS Handovers - Within 45 Mins (%)	95.2%	94.7%	94.1%	94.8%	90.8%	91.9%	92.5%	92.2%	89.6%	85.9%	90.8%	96.5%	91.1%
4-Hour A&E Standard	79.5%	77%	76.6%	78.5%	78%	76.7%	77.3%	77.7%	78.5%	75.6%	77.6%	80%	78.7%
12-hour ED breaches rate	4.1%	2.8%	3.2%	2.7%	4.6%	5.6%	5.2%	5.5%	5.5%	8.4%	5.6%	2.3%	5.8%
Community UCR 2hr Response Rate (%)	70%	81%	78%	76%	77%	71%	76%	76%	77%	76%	76%	75%	
Cancelled Ops - Not Rebooked Within 28 days	0	6	11	10	10	9	16	10	16	20	13	15	11

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 (returned to previous levels of compliance). STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Handover SOPs, including escalation processes in place across UHT. Validation protocol standardised across UHT. Ambulance registration process changed at JCUH to avoid reception queues.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





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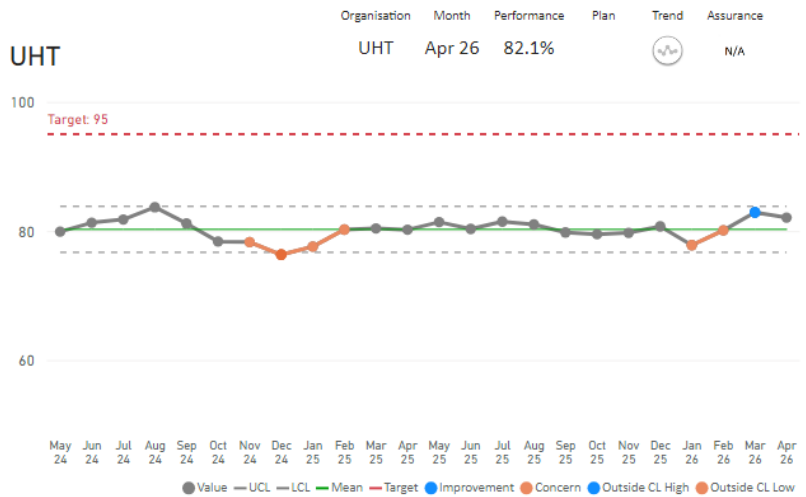
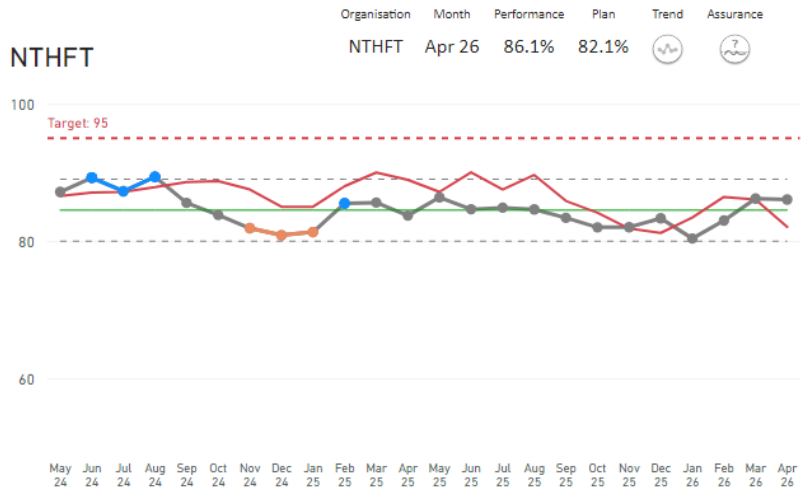
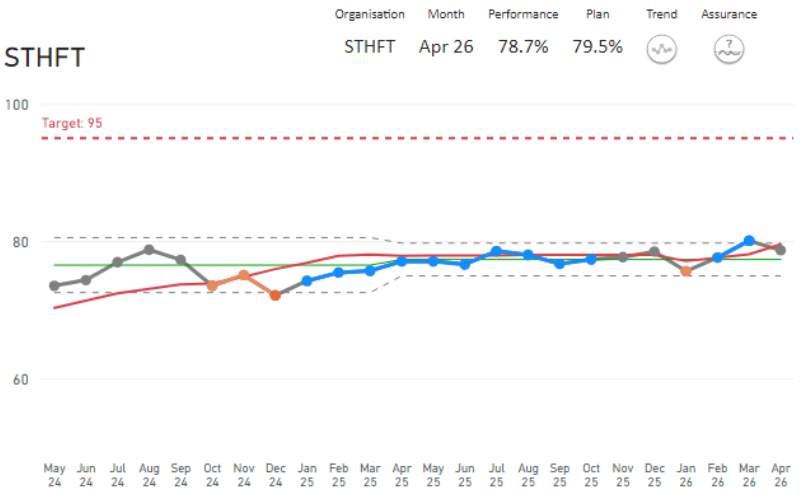
RESPONSIVE 4-Hour A&E Standard



Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%; recovery plan 82% by March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend (returned to previous levels of compliance).
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Urology ambulatory pilot underway, RTCS projects for Resus expansion, CYPED corridor, NT waiting area remodel, and E-triage underway.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



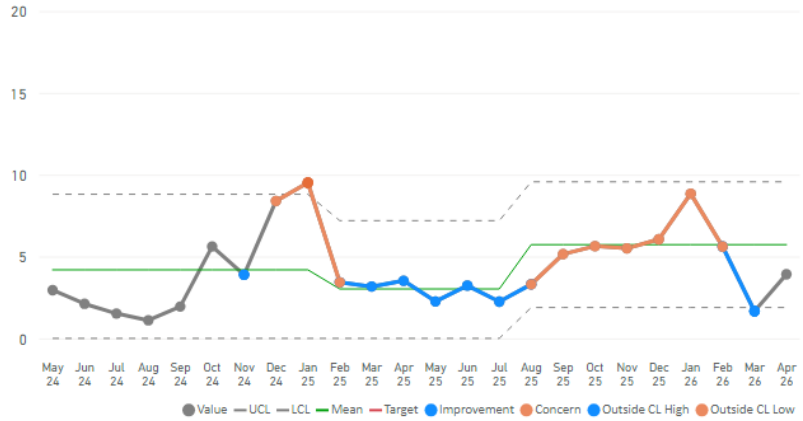


RESPONSIVE 12-hour ED breaches rate

Metric: Percentage of patients admitted or discharged from Type 1 Emergency Department after 12 hours.
Plan: Seasonalised recovery plan, for year-on-year improvement.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: GIRFT MH UEC standards review commenced. 12-hour workstreams with leads established
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

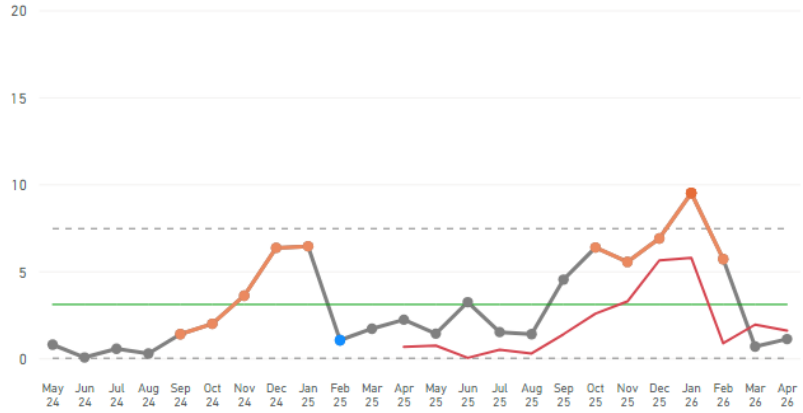
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	3.9%			N/A



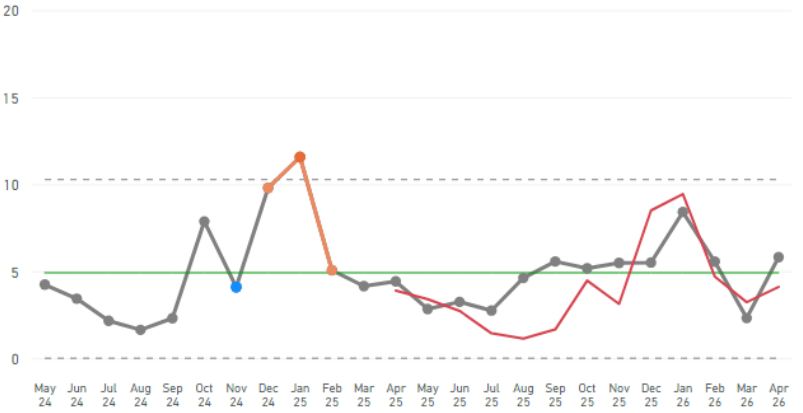
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	1.1%	1.6%		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	5.8%	4.1%		

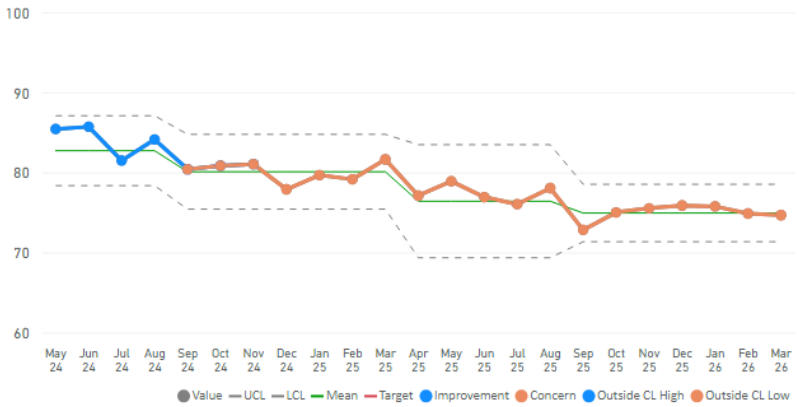


RESPONSIVE Community UCR 2hr Response Rate (%)

Metric: Urgent community response within 2-hours
Plan: 70% national standard.
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, one month in arrears. A consistency review of UCR reporting across NENC is planned.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Performance maintained above national standard**.** Clinical prioritisation of responses across UCR and Hospital@Home caseloads continues. A continued focus on clock stops will positively impact compliance with the 2-hour time frame.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

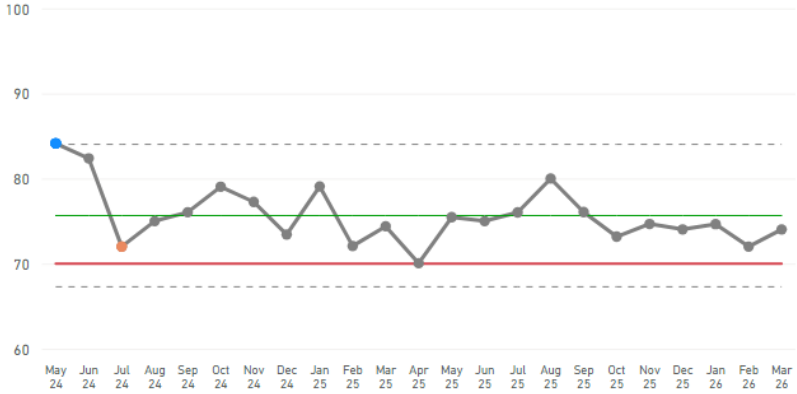
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Mar 26	75%			N/A



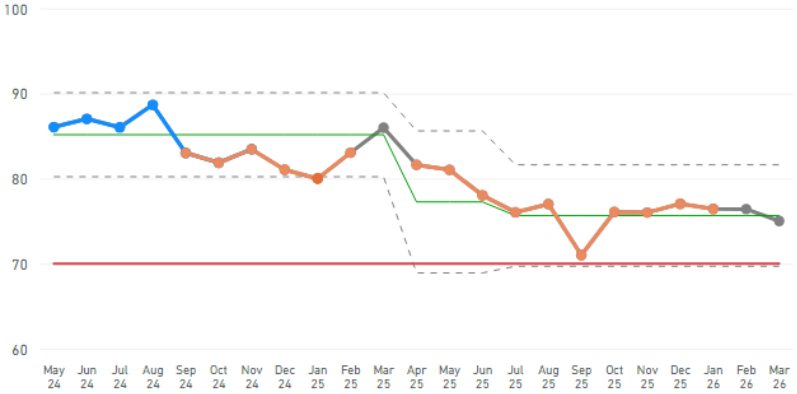
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Mar 26	74%	70%		

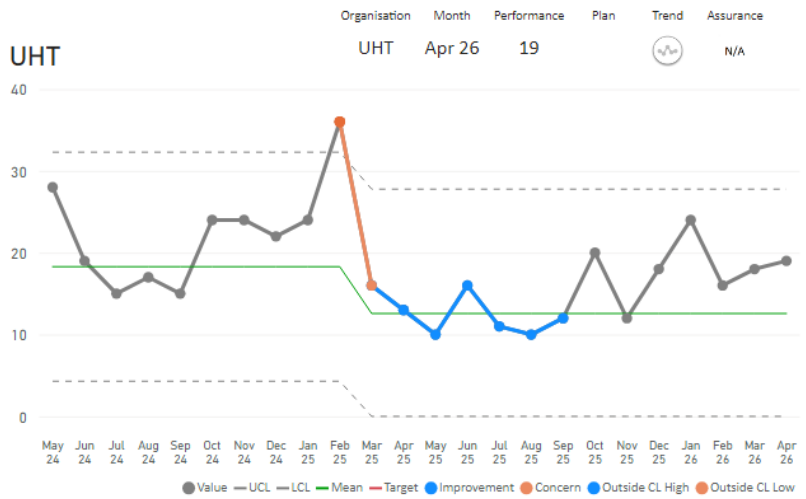


STHFT

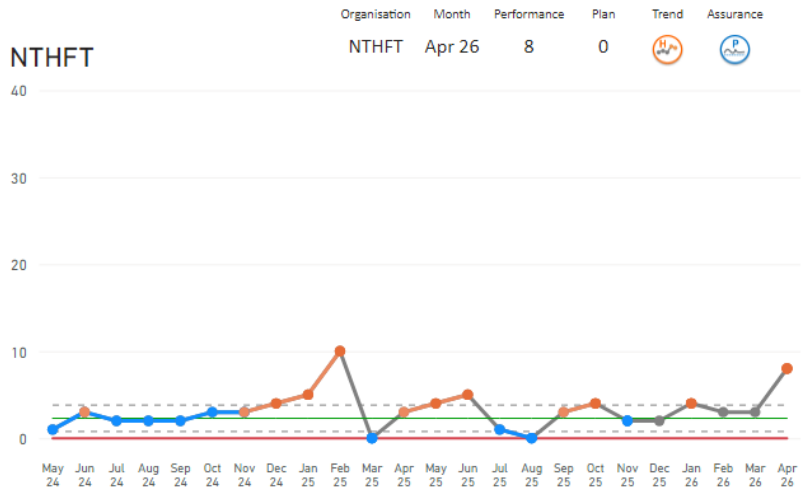
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Mar 26	75%	70%		

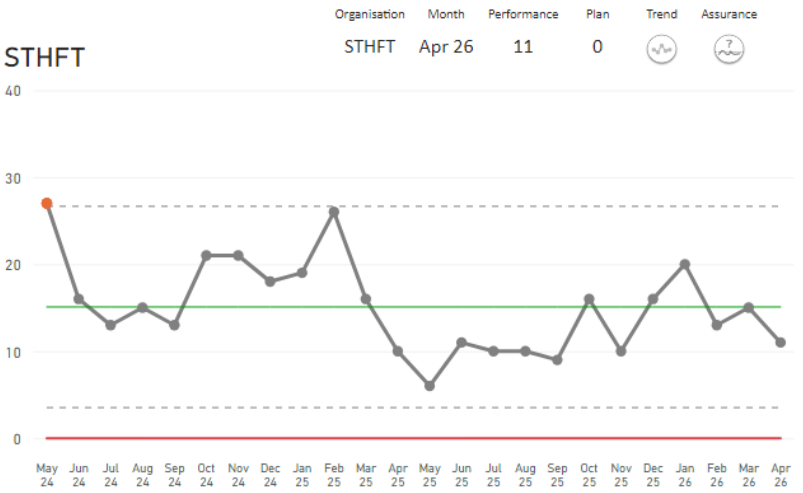


RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days



Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: high outlier in April. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Daily review of all cancellations is in place and services remain focussed and committed to reappointing patients within the timeframe. Renewed focus on rebooking is monitored via Surgical Improvement Group and the UHT Elective Access meetings. April performance was negatively impacted by industrial action.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





RESPONSIVE DOMAIN SUMMARY

Executive lead: Russell Nightingale, 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 with compliance reporting below plan for April. For the 31-day cancer standard, STHFT continue to focus on the patients waiting longest for subsequent treatments, for radiotherapy and managing constraints of capacity, with an approved business case to increase capacity.

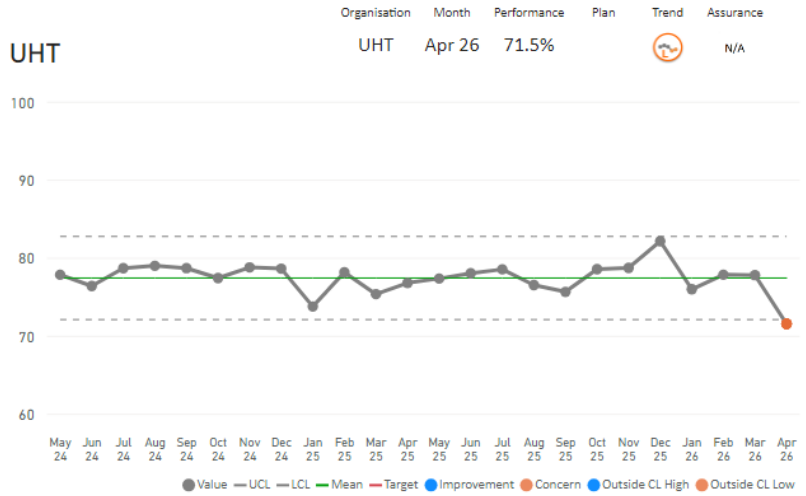
NTHFT 31-day and 62-day performance compliance has shown impacts of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025. Across UHT, tumour specific pathway improvements are driven by the clinically-led Cancer Improvement Groups with oversight from the Performance Recovery Oversight Group. Tiered support from NHS England continues.

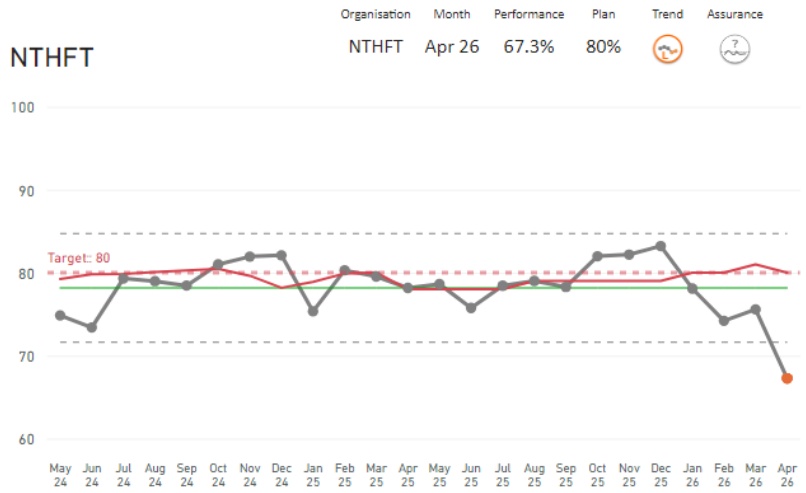
Elective recovery trajectories are supported by waiting list validation, clinic template review, additional capacity in targeted specialties with the greatest patient access/demand challenges. Patients with the longest waits are prioritised with NTHFT achieving the NHS operational standard for 52-week waits for the majority of months. For STHFT, 52-week waits are reducing although still exceed the planned trajectory. STHFT entered tiered support arrangements with NHS England in November 2025 with the aim of eliminating 65 week waits. At April month end, NTHFT had 7 patients, and STHFT 18 patients, waiting over 65 weeks.

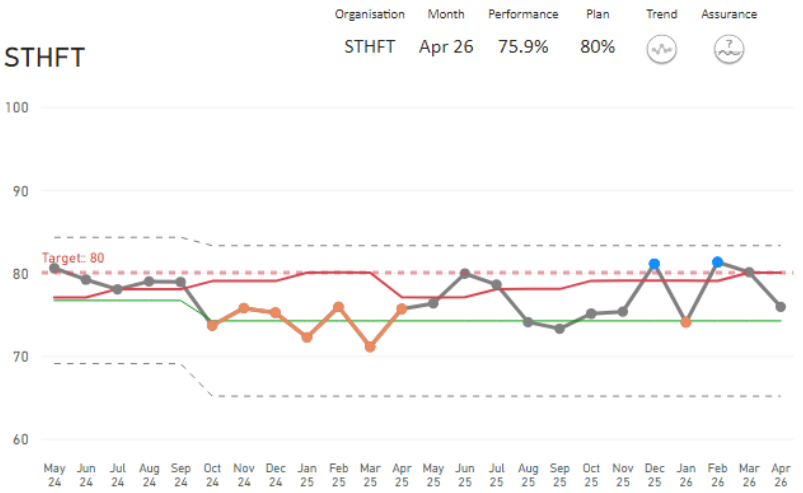
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Cancer Faster Diagnosis Standard (%)	80%	78.6%	75.7%	78.4%	79%	78.3%	82%	82.2%	83.2%	78.1%	74.2%	75.6%	67.3%
Cancer 31 Day Standard (%)	94.3%	94.8%	97.1%	92.5%	88.8%	92.4%	94.2%	93.3%	97.2%	92.7%	96.6%	97.8%	94.7%
Cancer 62 Day Standard (%)	52.3%	58%	56.7%	52.3%	51.7%	56.7%	61%	63%	62.1%	54.8%	52.9%	66.6%	58.3%
Diagnostic 6 Weeks Standard (%)	95.1%	96.3%	95.8%	96.6%	94.5%	96.1%	94.9%	95.5%	95%	95.5%	98.3%	97.3%	95.8%
RTT Incomplete Pathways (%)	71%	74.5%	73.9%	74.2%	72.7%	73.3%	73.8%	72.8%	71.3%	70.7%	70.1%	70.6%	72.4%
RTT 52 Week Waiters Rate	1%	1%	1.2%	0.9%	0.8%	0.7%	0.9%	0.8%	1%	1.1%	1.1%	1%	0.9%
Community Over 52 Week Waiters Rate	1.8%	1.5%	2.9%	3%	3.4%	3.2%	1.5%	3.1%	2.9%	1.7%	0.7%	0.3%	0.2%
Community 18 Week Compliance (%)	78%	80.3%	78.4%	80.4%	80.7%	78.3%	77.9%	72%	75%	75.1%	75.3%	76%	78.7%

South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Cancer Faster Diagnosis Standard (%)	80%	76.3%	79.9%	78.6%	74%	73.2%	75.1%	75.3%	81.1%	74%	81.3%	80.1%	75.9%
Cancer 31 Day Standard (%)	81.1%	82.8%	87.1%	86.1%	81.7%	83.9%	83.3%	82.5%	80.7%	77.1%	84.4%	81.6%	79.6%
Cancer 62 Day Standard (%)	68.7%	64.4%	62.3%	68.7%	66.8%	65.2%	65.7%	70.6%	69.4%	68.5%	71.5%	70.5%	68.3%
Diagnostic 6 Weeks Standard (%)	83.3%	83%	84.5%	86.9%	82.2%	85.4%	86.6%	85.7%	84.1%	85.7%	88%	88.5%	85%
RTT Incomplete Pathways (%)	62.6%	62.1%	62.1%	61.9%	61.1%	61.7%	62.1%	61.8%	61.9%	62.1%	63.1%	65.2%	65.6%
RTT 52 Week Waiters Rate	1.4%	2.8%	2.8%	2.7%	2.9%	2.7%	2.4%	2.2%	1.9%	1.8%	1.6%	1.2%	1.3%
Community Over 52 Week Waiters Rate	1.9%	2.3%	2.2%	2%	1.9%	1.9%	1.8%	2%	2.2%	2%	1.1%	2.1%	2.3%
Community 18 Week Compliance (%)	88.4%	90.8%	92.5%	91.9%	91.9%	92.7%	92.7%	92.8%	93.1%	93.7%	94.2%	89.9%	92.2%

RESPONSIVE **Cancer Faster Diagnosis Standard (%)**

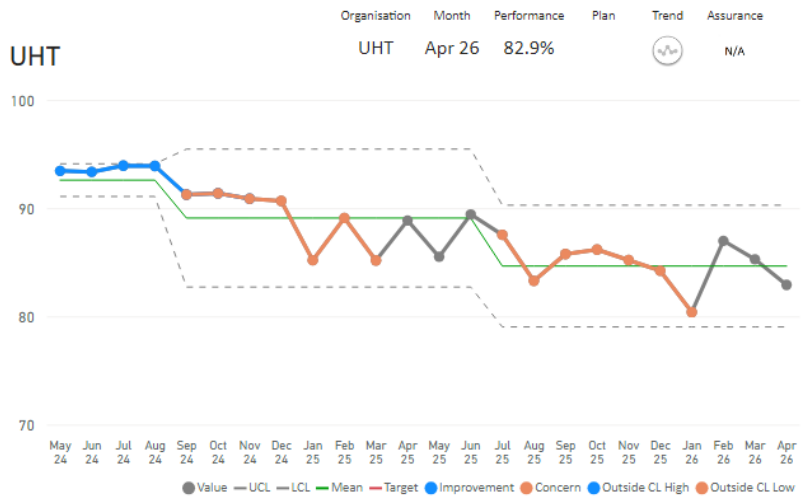




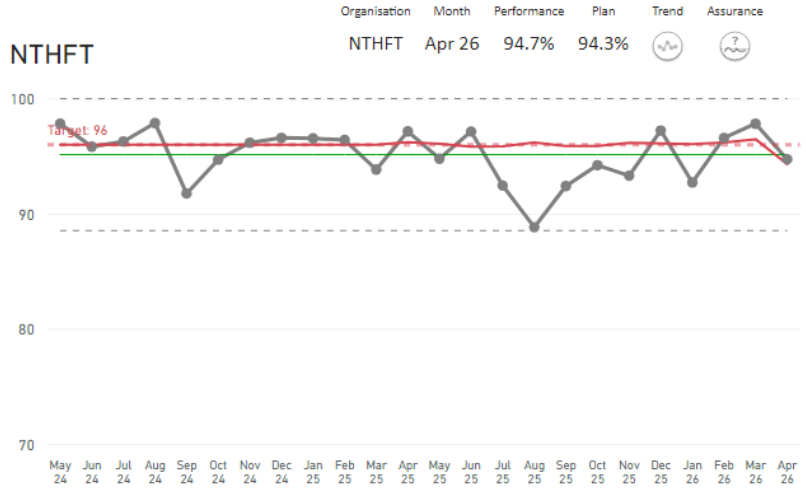


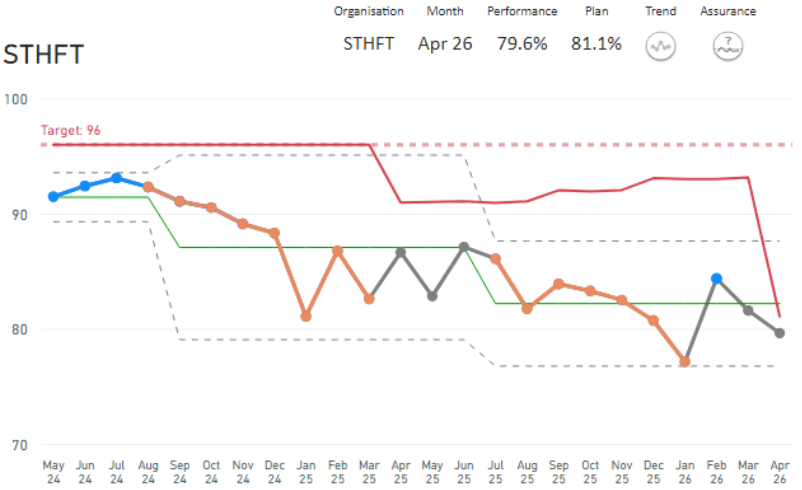
Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 80% (from April 2025). Agreed operational planning trajectories: NTHFT 80%, STHFT 80% by end March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Negative outlier in April, outside of expected variance. STHFT: No Trend.
Assurance: NTHFT: Alert . STHFT: Advise.
Action taken: UHT focus on compliance in Urology, respiratory and gastro-intestinal tumour groups. NTHFT FDS performance impacted by ongoing increase in breast pathway referrals, being address with additional capacity where possible. NTHFT Respiratory team have recently introduced a weekly clinical huddle covering recording of FDS, expediting diagnostics/OPA and results letters. Performance improvement expected over coming months.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE Cancer 31 Day Standard (%)

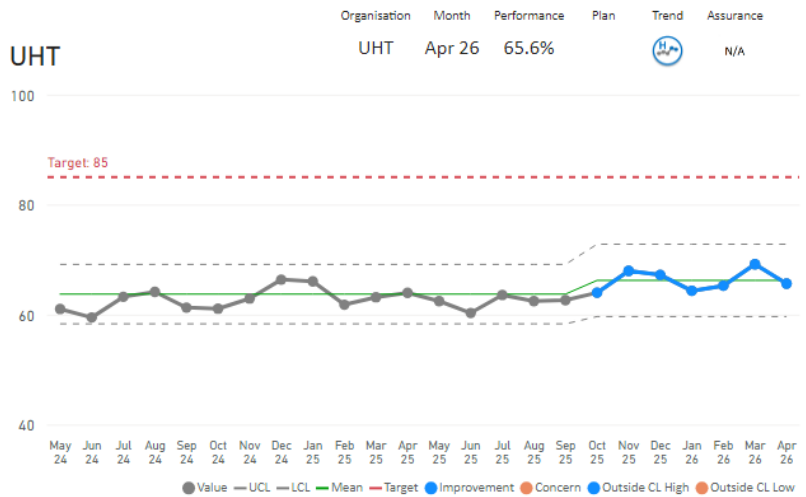


Metric: Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
Plan: NHS Constitution standard 96%. Agreed operational planning trajectories to 95.1% NTHFT, 92.1% STHFT by end March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend, new plan for recovery trajectory is within statistic range of performance.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Across UHT, breast pathway demand is challenging to compliance. STHFT focus is on the patients waiting longest for subsequent treatments for radiotherapy and managing constraints of capacity, with an approved business case to increase capacity by quarter 3 26/27.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

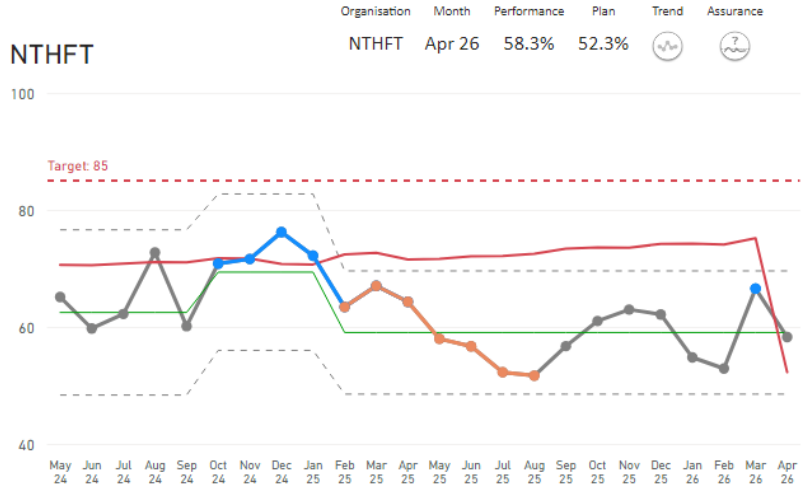


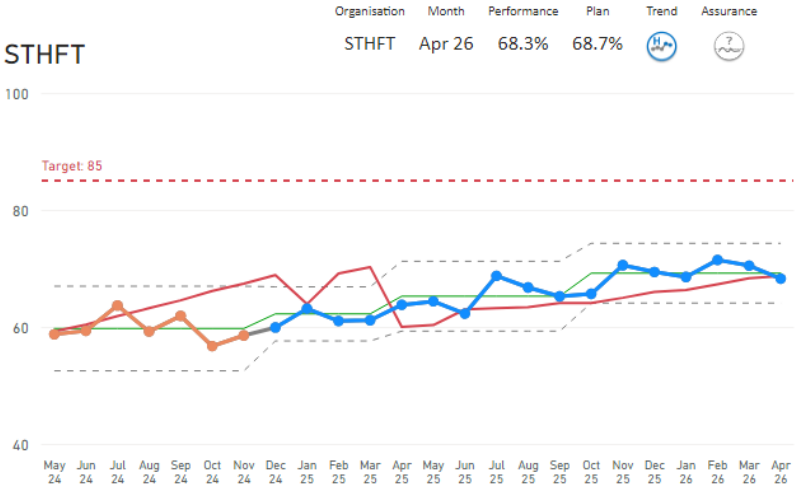


RESPONSIVE Cancer 62 Day Standard (%)



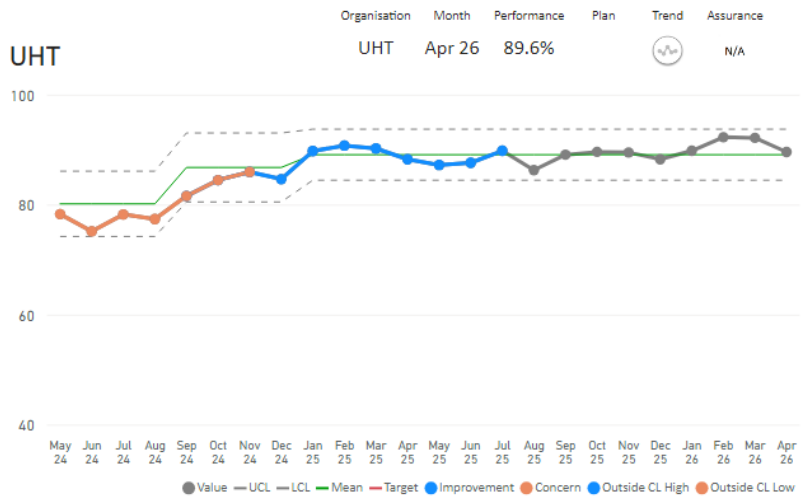
Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Operational planning trajectories: NTHFT 76.1%, STHFT 76.1% by March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: sustained improvement in performance.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Breast pathway demand is challenging to compliance. Both Trusts are in NHSE tiered support for cancer 62-day performance with focus on pathway recovery plans. Pathway changes implemented at STHFT have improved performance; UHT pathway improvement groups now established, to deliver specific recovery trajectories.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



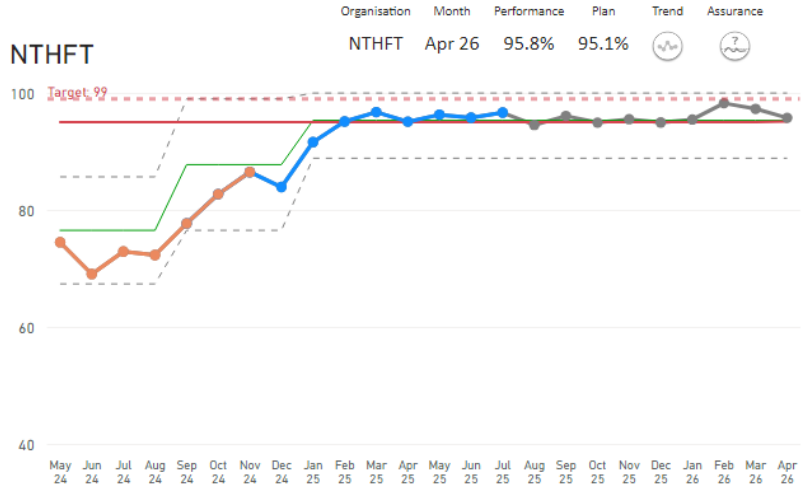


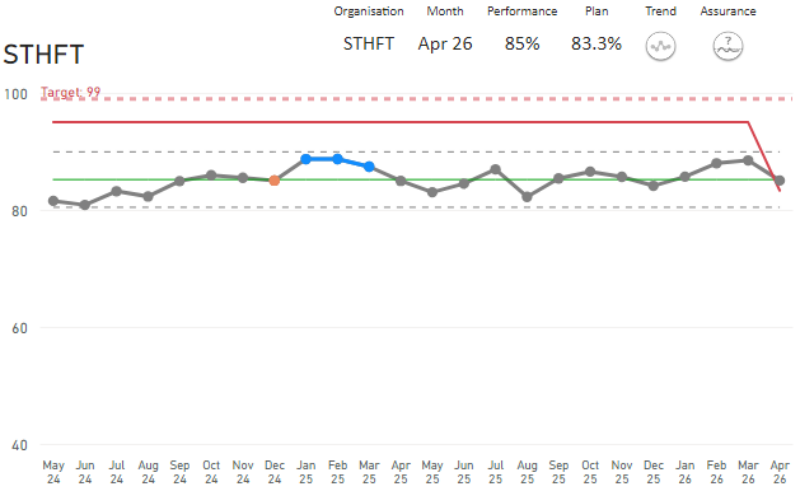
Caring Better Together

RESPONSIVE Diagnostic 6 Weeks Standard (%)



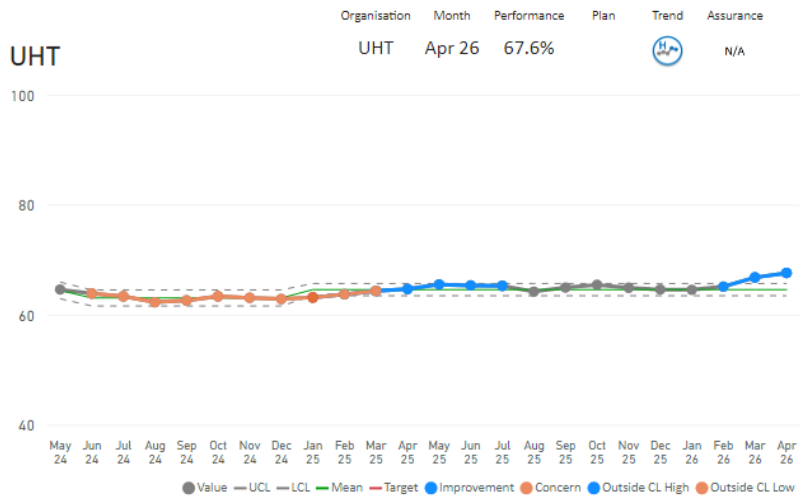
Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHS Constitution standard 99%; recovery plan NTHFT 3.5%, STHFT 10.3% by March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Improvement work underway in STHFT specialist services will show only incremental improvement over several months. Focus on optimising use of CDC capacity to support compliance with diagnostic, elective and cancer access targets.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



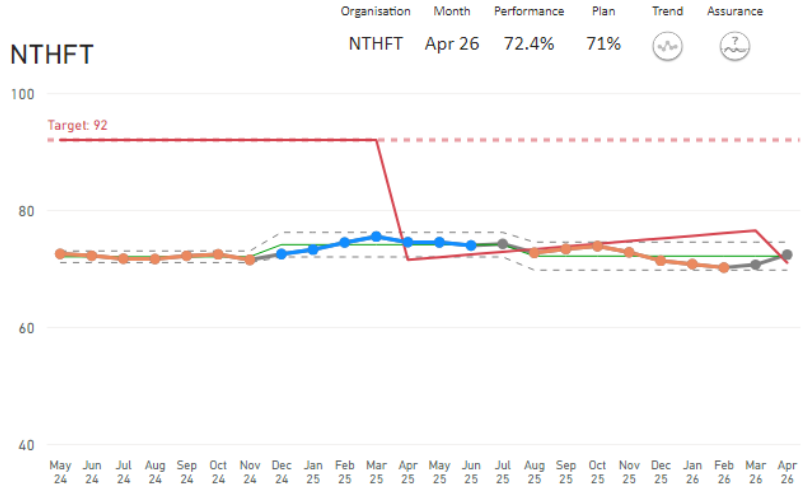


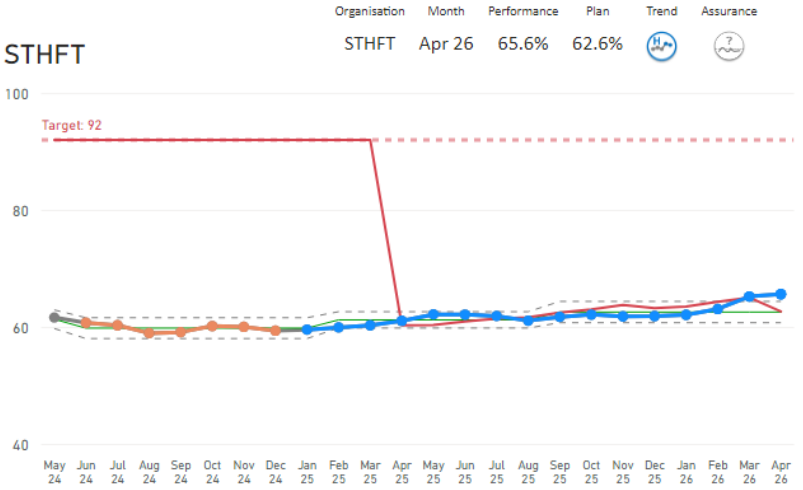
Caring Better Together

RESPONSIVE RTT Incomplete Pathways (%)

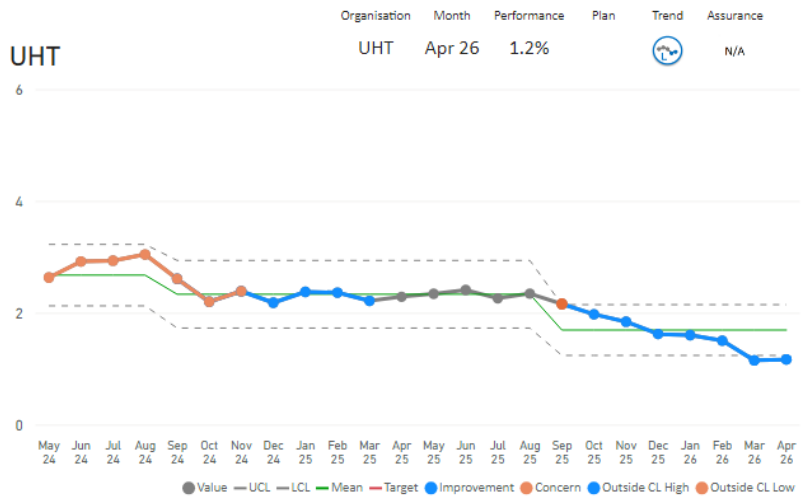


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%; recovery plan NTHFT 83.5%, STHFT 72.0% by March 2027.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Improvement trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks with a wider strategy of proactive mutual support. Weekly elective access meetings are in place to problem-solve barriers to improvement, with the focus on the longest waiters.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

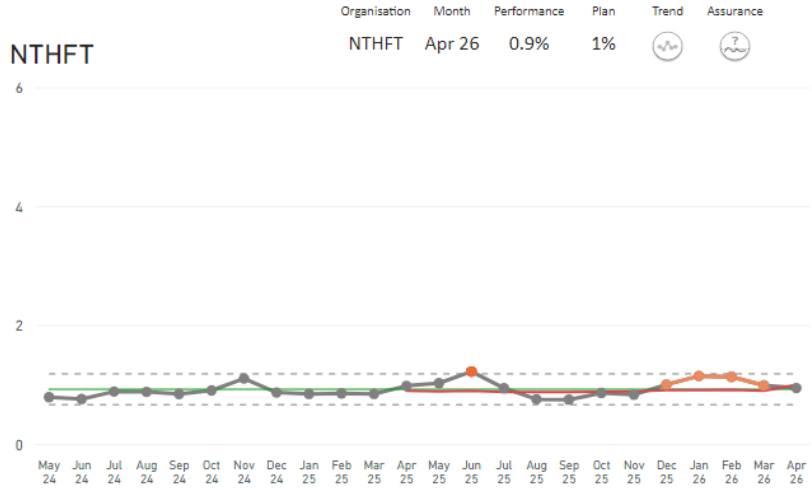


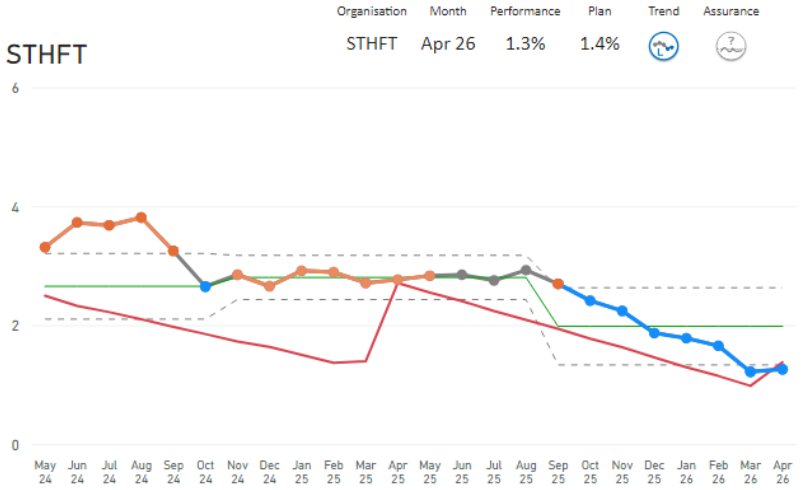


RESPONSIVE RTT 52 Week Waiters Rate

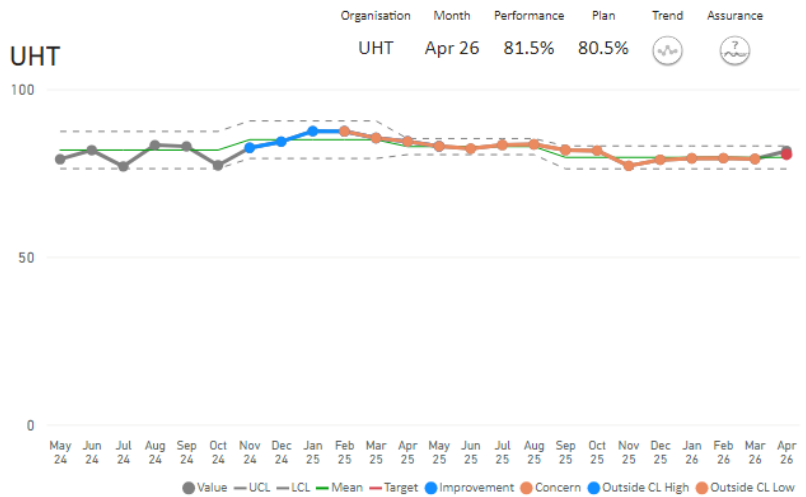


Metric: Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To maintain the number of 52-week waiters at less than 1% of the waiting list.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend, compliance returned within expected variance. STHFT: Improvement trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: The UHT Elective Access Group, with oversight from the Performance Recovery Oversight Group, scrutinise plans to eliminate 65 week waits and return to plan for 52 week waits. Services are utilising capacity more flexibly across UHT to improve patient access.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

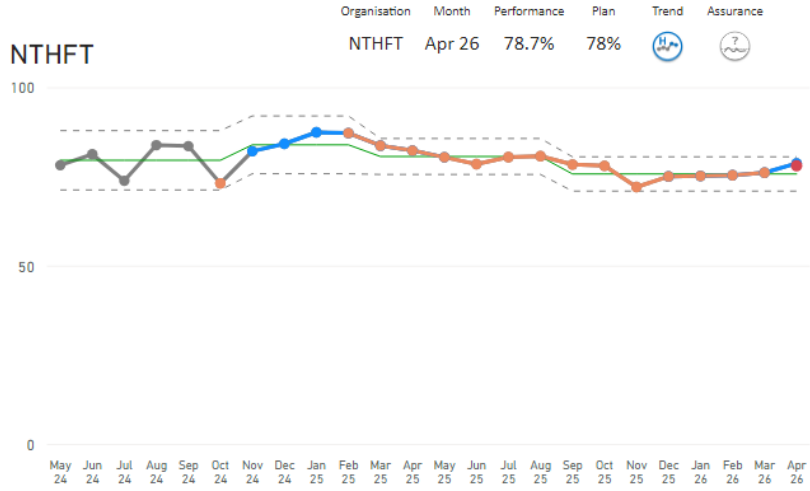


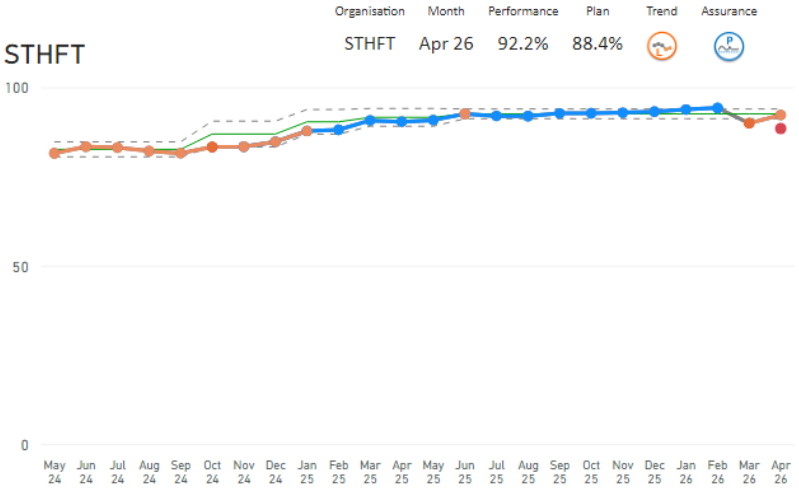


RESPONSIVE Community 18 Week Compliance (%)

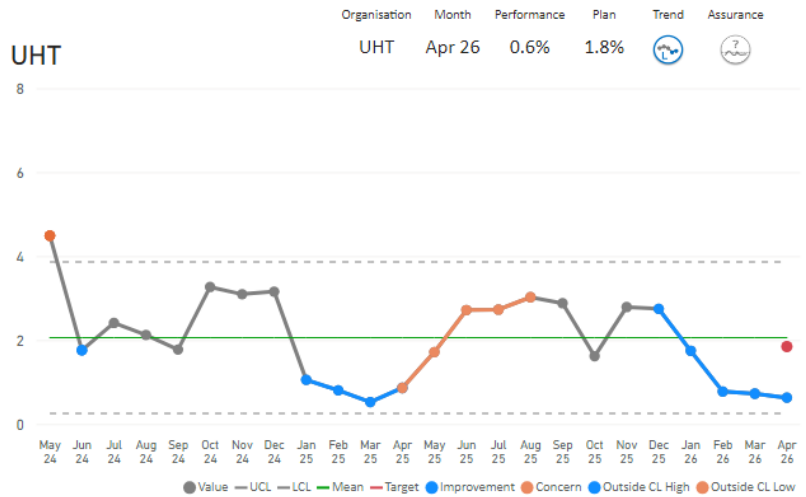


Metric: Community 18 Week Compliance(%)
Plan: Agreed operational planning trajectories: NTHFT 81.8%, STHFT 88.3% by March 2027
Rationale: NHS operational planning guidance
Data quality: Advisory, variation in reported position. further validation may be required.
Trend: NTHFT: positive, 5 consecutive months of improvement. STHFT: negative, March and April 2026 at the lower limits of expected performance.
Assurance: NTHFT: Advise. STHFT: Advise, compliance is assured above plan but lower than expected.
Action taken: Focused validation of reported position and bringing forward longest waiters. Capacity for paediatric therapy interventions, and specialist weight management, is being addressed with recovery plans in place.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

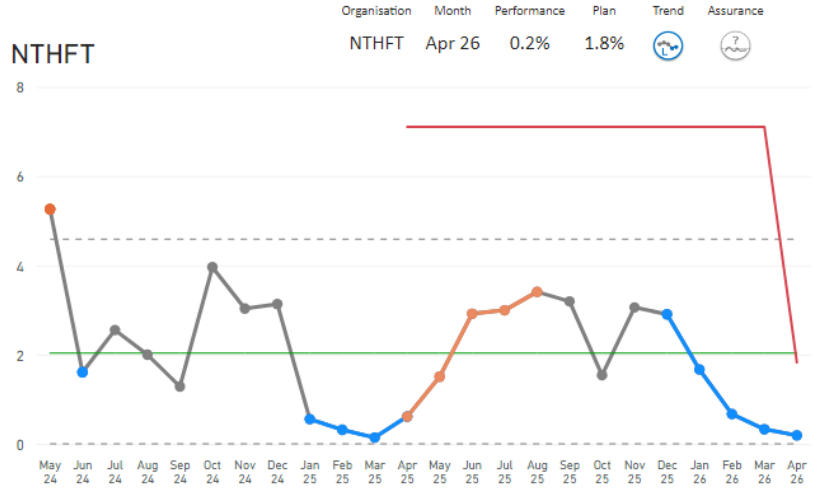


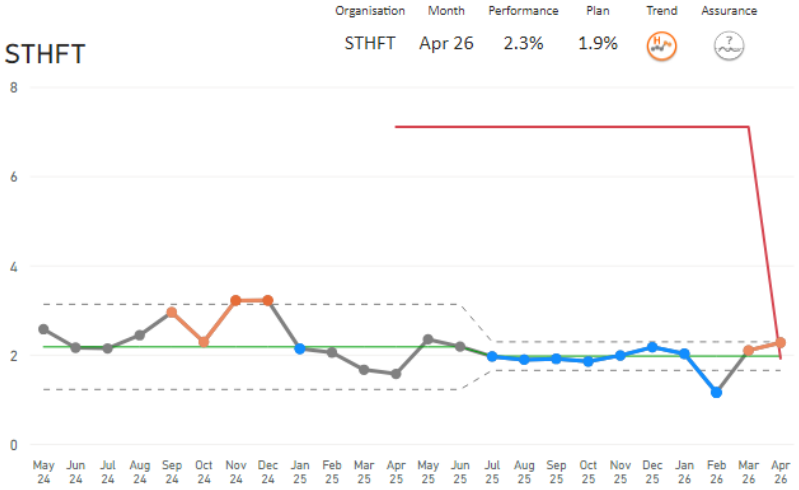


RESPONSIVE Community Over 52 Week Waiters Rate



Metric: Rate of community patients awaiting treatment who have waited more than 52 weeks from referral.
Plan: Agreed operational planning trajectories per Trust.
Rationale: NHS Oversight Framework metric.
Data quality: Advisory, variation in reported position. further validation may be required.
Trend: NTHFT :Improvement trend. STHFT: performance at the upper limit of expected variance April 2026.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Focused validation of reported position and bringing forward longest waiters. Capacity for paediatric therapy interventions, and specialist weight management, is being addressed with recovery plans in place.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





CARING DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

Learning from patient feedback is captured in a variety of ways but is recorded for analysis by patient experience surveys and complaints.

Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall as very good or good. For April 2026, NTHFT registered above plan in all five surveys. STHFT were above plan in four of the five surveys, maternity experience ratings recently show a decline against the 24/25 national average.
The focus remains on increasing response rates to FFT surveys to provide more assurance of that the information truly illustrates the experience of our patients. STHFT are using Healthcare Guardian (HG) for all surveys. NTHFT will transition from an external service provider to HG in the near future.

Timely responses to complainants remains a key priority. Acknowledgement of receipt of the complaint within 3 working days remained at 100% at NTHFT, an increase to 87.7% on the previous month at ST. At NTH 70.3% of complaints were closed within target and 45.3% at ST where improvements are being targeted.

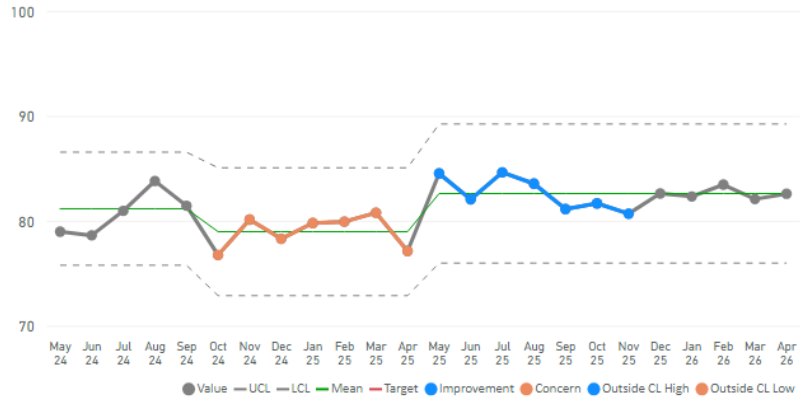
North Tees & Hartlepool NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
A&E Experience (%)	79%	87.2%	84.8%	84.9%	85.8%	82.3%	82.3%	79.7%	83%	85.1%	85.2%	83.2%	86%
Inpatient Experience (%)	95%	93.5%	95.4%	92.7%	93.4%	96.1%	95.8%	94.3%	94.4%	96.9%	92.1%	96.6%	96.3%
Maternity Experience (%)	92%	94.1%	84.8%	94.3%	96.2%	95%	93.8%	94.8%	95.3%	97.8%	96.8%	93.6%	91.5%
Outpatient Experience (%)	94%	95.5%	94.1%	94.2%	94.4%	94.1%	94.9%	94.7%	95.7%	94.9%	94.7%	94.8%	95.1%
Community Experience (%)	94%	97.7%	96%	94.5%	96%	93.4%	96.8%	96.3%	95.6%	96.1%	96.1%	95.8%	96.3%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	78.5%	65.9%	62%	73.6%	76.8%	73.5%	80.5%	69%	70.4%	69.2%	58.1%	70.3%

South Tees Hospitals NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
A&E Experience (%)	79%	84%	80.1%	84.4%	82.3%	80.4%	81.2%	81.4%	82.3%	80.2%	82.2%	81.4%	80.2%
Inpatient Experience (%)	95%	95.1%	97.8%	98.2%	99.3%	99.3%	95.9%	95.6%	95.6%	94.9%	95%	95.7%	94.9%
Maternity Experience (%)	92%	93.8%	93.2%	89%	91.2%	91.3%	96.6%	91.5%	89.9%	87.8%	86.1%	83.2%	87.8%
Outpatient Experience (%)	94%	95.9%	96.3%	95.8%	95.7%	96%	95.3%	96.6%	93.8%	94.5%	94.6%	94.5%	94.5%
Community Experience (%)	94%	100%	100%	100%	100%	100%	100%	96.8%	98.2%	97.3%	97.6%	97.6%	97.3%
Feedback Acknowledged in 3 Days (%)	100%	98.3%	99.1%	100%	97.1%	100%	98.4%	95.1%	98.5%	97.7%	95%	80.8%	87.7%
Complaints Closed Within Target (%)	80%	62.6%	65.7%	53.3%	54.9%	48.3%	52.4%	32%	48.1%	59.1%	41.8%	32.6%	45.3%

CARING A&E Experience (%)

UHT

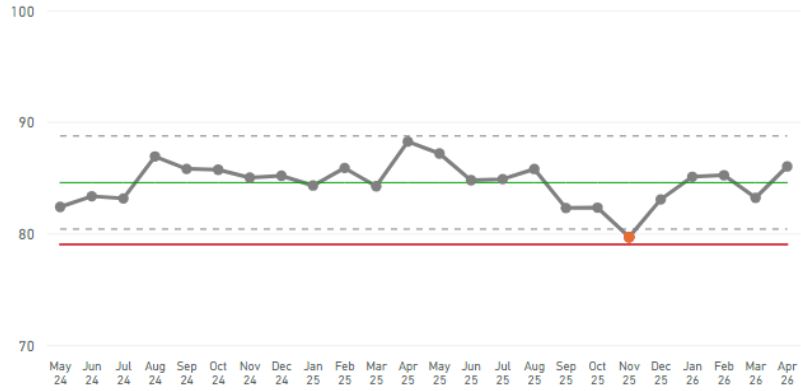
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	82.6%			N/A



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 25/26.
Rationale: NHS contract metric.
Data quality: Assured (manual and digital systems).
Response rates: NTHFT 5%, STHFT 8%.
Trend: NTHFT: No trend, above plan but with low response rates. STHFT: No trend Improved performance since May 2025 now stabilised but increased response rates would provide more assurance.
Assurance: NTHFT: Assure, consistently exceeds national average. STHFT: Advise.
Action taken: A&E waiting times continue to be the main theme noted in the survey comments. Actions to improve 4-hour standard performance.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

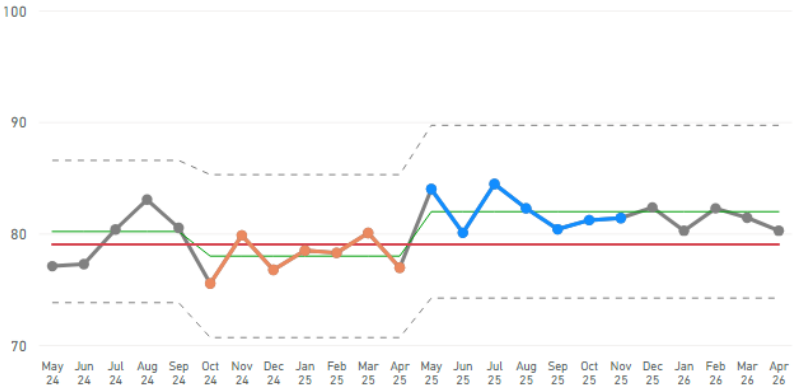
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	86%	79%		

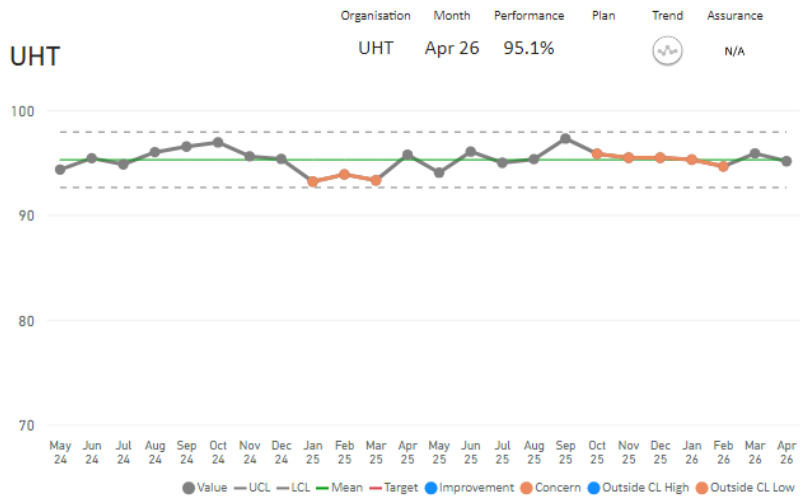


STHFT

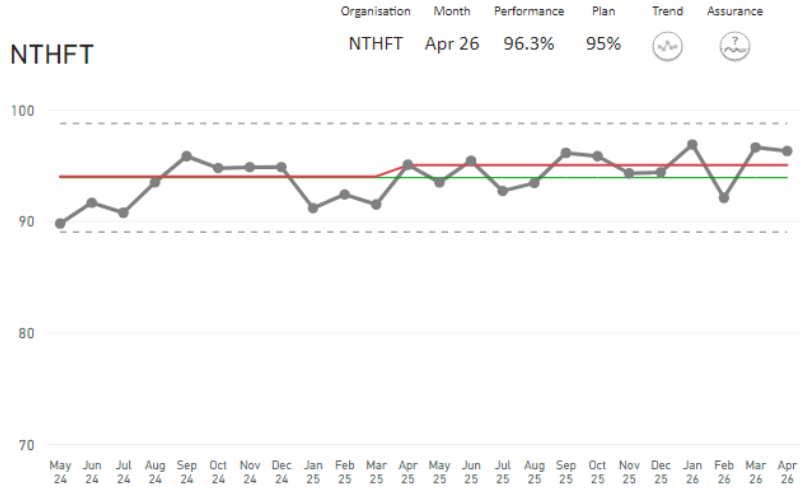
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	80.2%	79%		

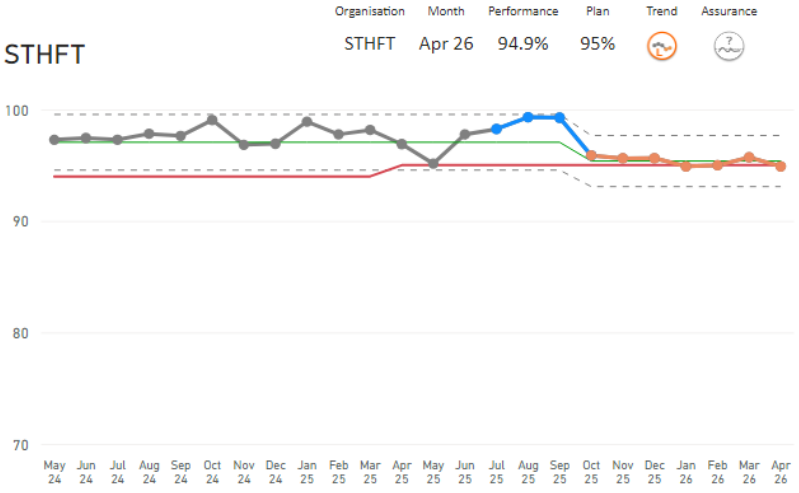


CARING Inpatient Experience (%)

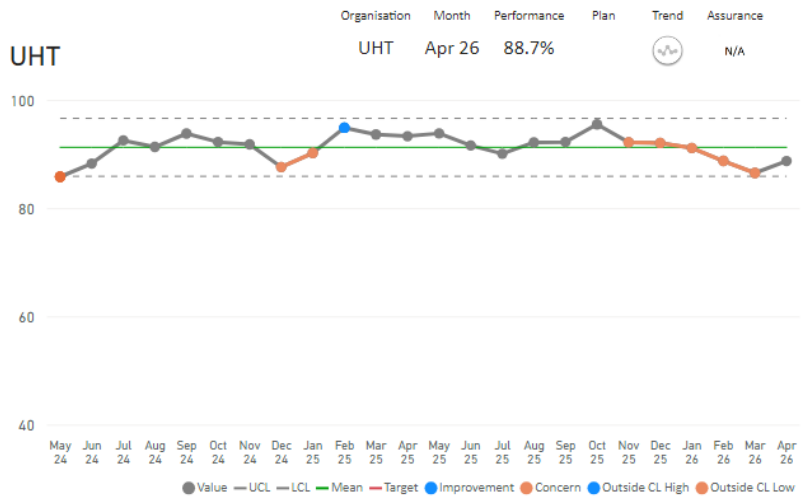


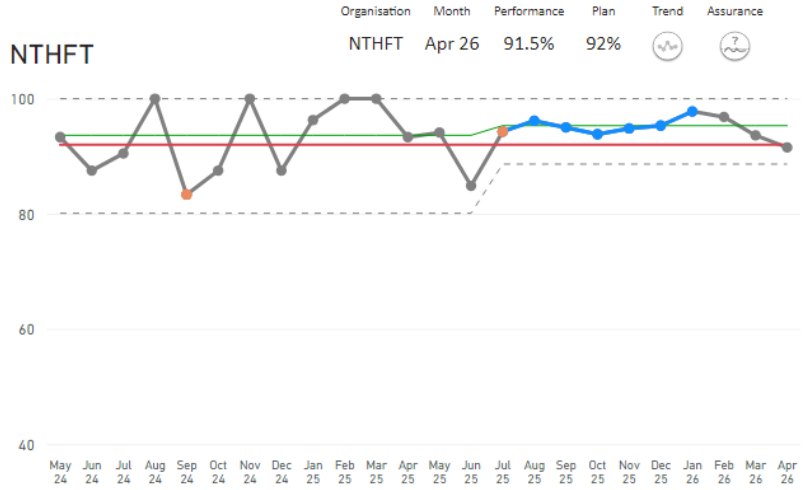
Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 25/26.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 11%, STHFT 20%.
Trend: NTHFT: performance is above plan but based on low response rates. STHFT: deteriorating over recent months,
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Continue to promote engagement with Friends and Family Test, particularly at NTHFT site. STHFT has transitioned from Meridian to HG, but performance is just above plan. NTHFT: plan to transition to HG.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

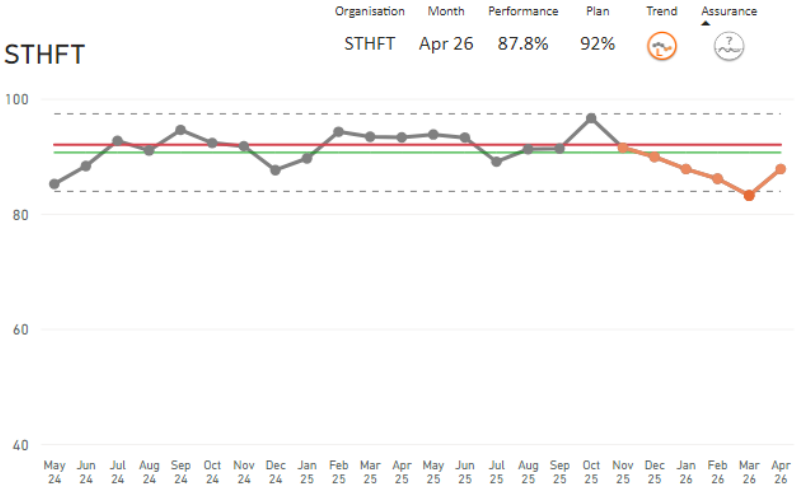




CARING Maternity Experience (%)

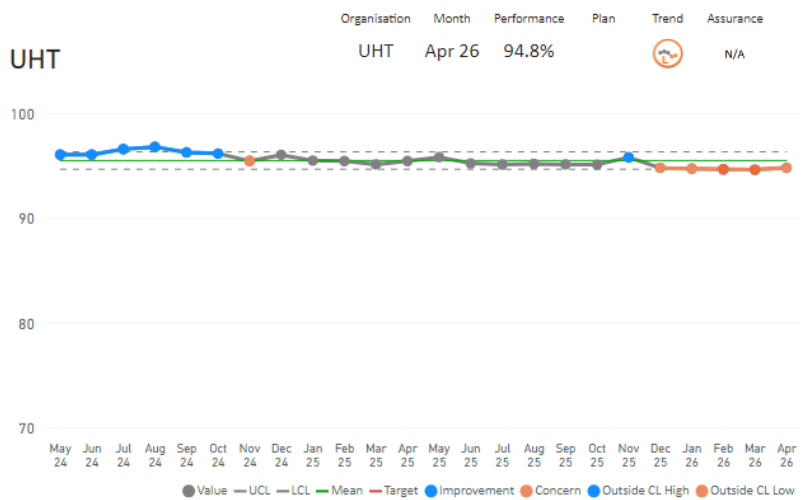




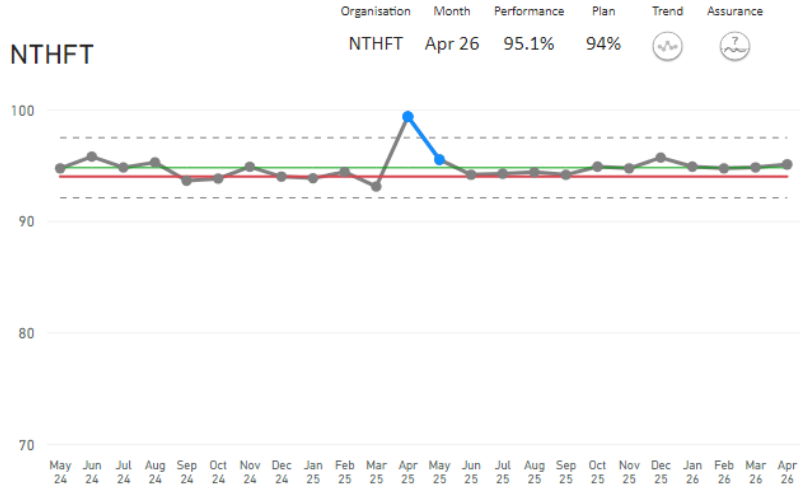


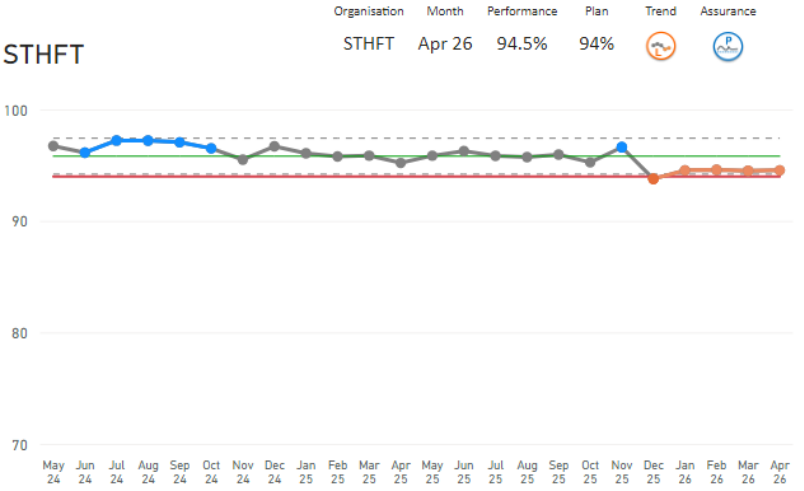
Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 25/26.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can low, reported figure is Birth only.
Response rates: NTHFT 25%, STHFT 14%.
Trend: NTHFT: No Trend. STHFT: Deteriorating trend which is below plan and based on low sample size.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Continue to promote engagement with Friends and Family Test, particularly at STHFT. STHFT has transitioned from Meridian to HG. NTHFT: plan to transition to Healthcare Guardian.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Outpatient Experience (%)

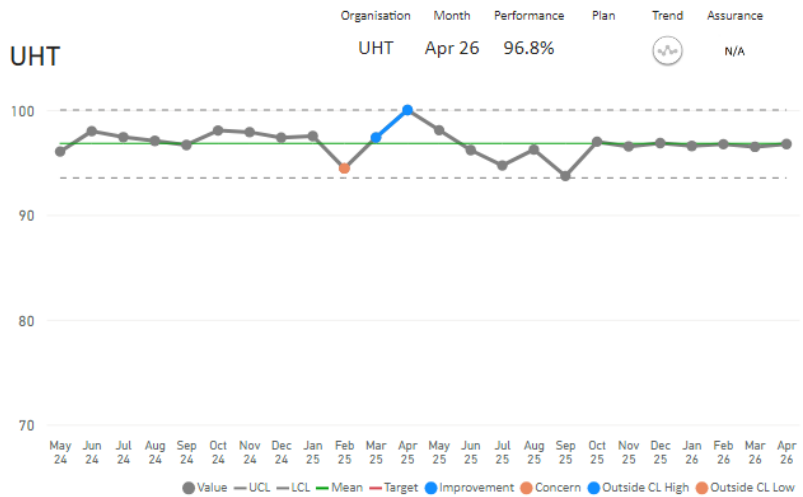


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 25/26.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 19%, STHFT 19%.
Trend: NTHFT: No trend. STHFT: Reduced performance since December 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Continue to promote engagement with Friends and Family Test, particularly at STHFT. STHFT has transitioned from Meridian to HG. NTHFT: plan to transition to HG.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

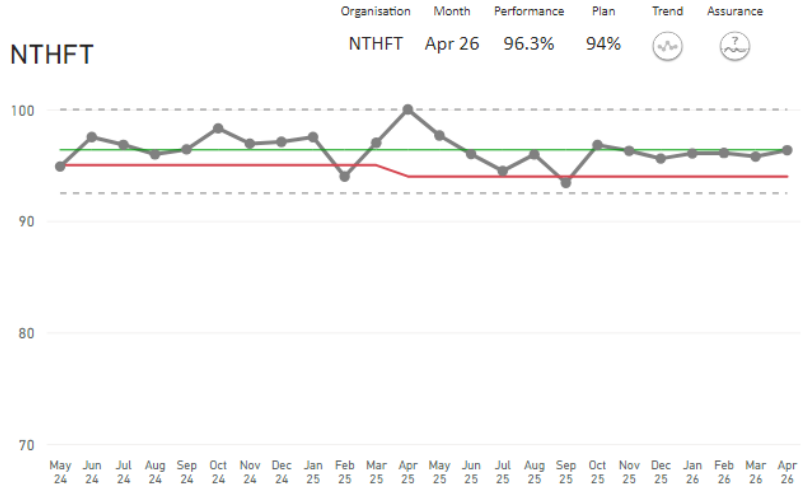


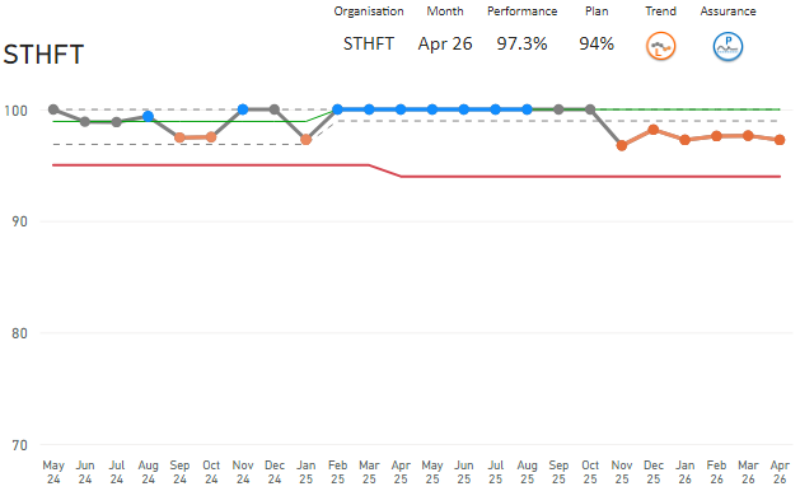


CARING Community Experience (%)

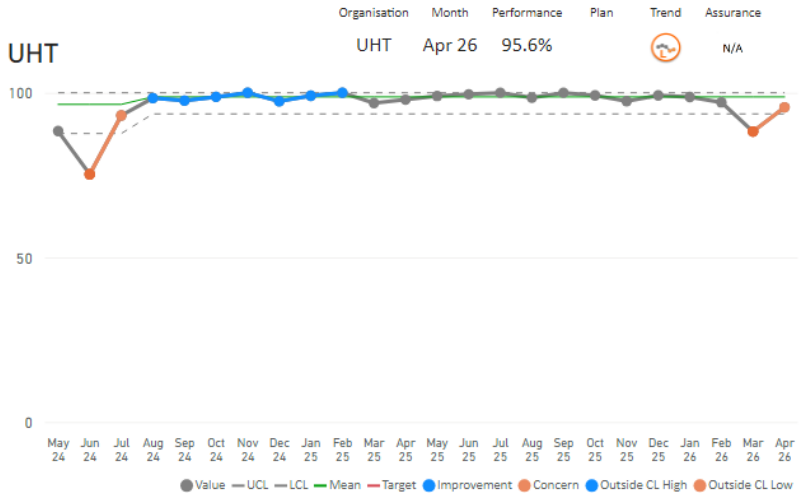


Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 25/26.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 7%, STHFT 7%.
Trend: NTHFT: Consistently above plan but with low response rates. STHFT: Consistently above plan but with reduced performance since November 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Action planned at both NTHFT and STHFT to improve response rates in community services.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

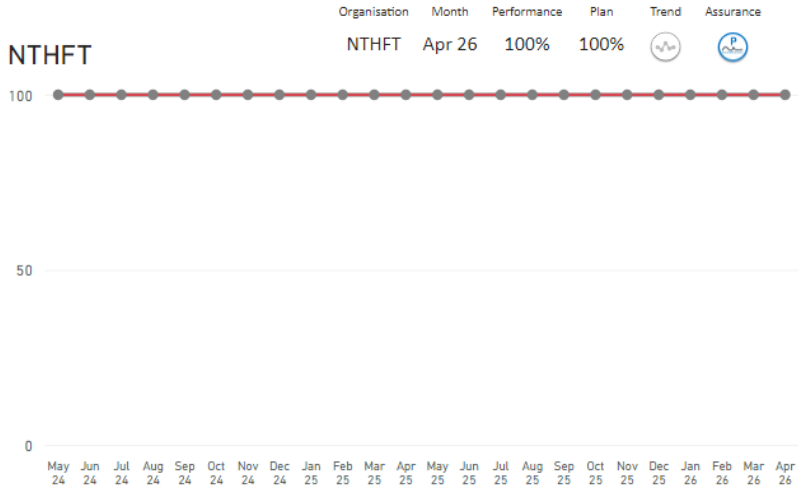


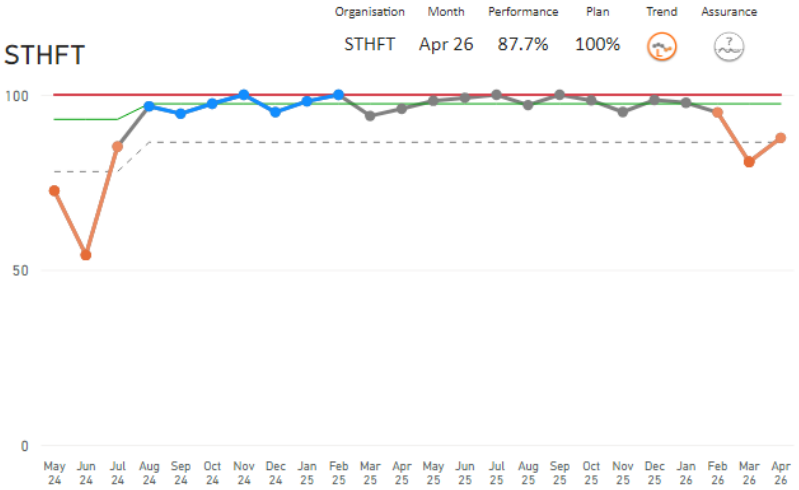


CARING Feedback Acknowledged in 3 Days (%)

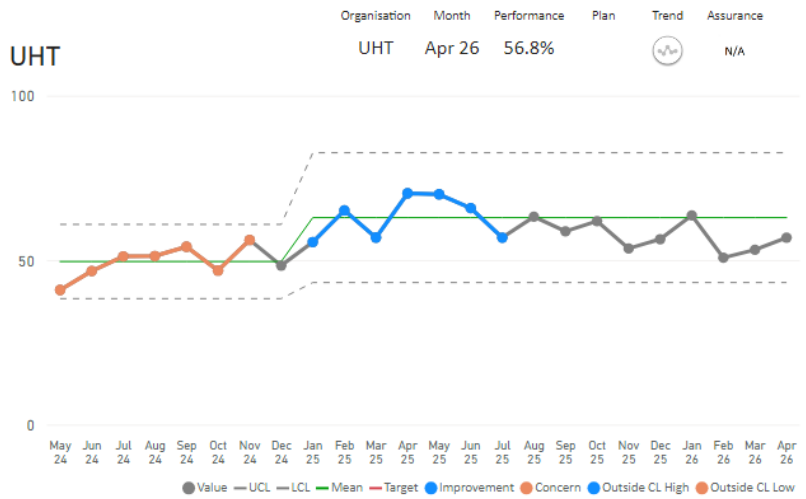


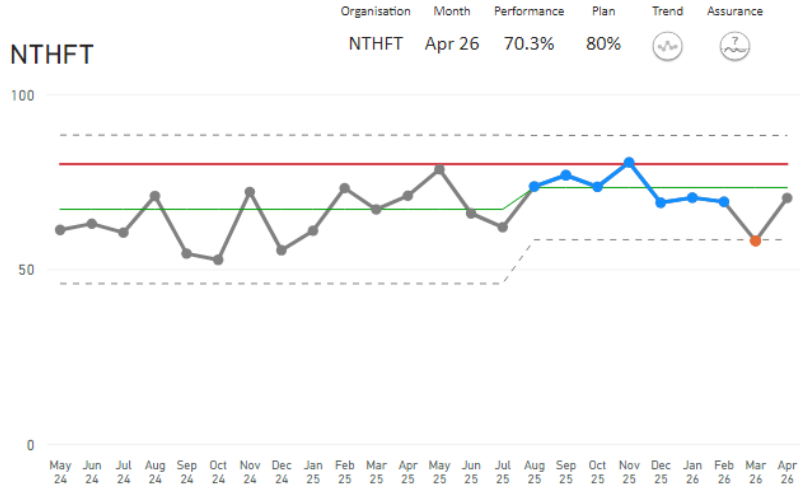
Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend, consistently achieves target. STHFT: Significant reduction in performance from March 2026.
Assurance: NTHFT: Assure. STHFT: Alert.
Action taken: Work on aligning processes across UHT is underway to ensure the 3 working day target is met consistently.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

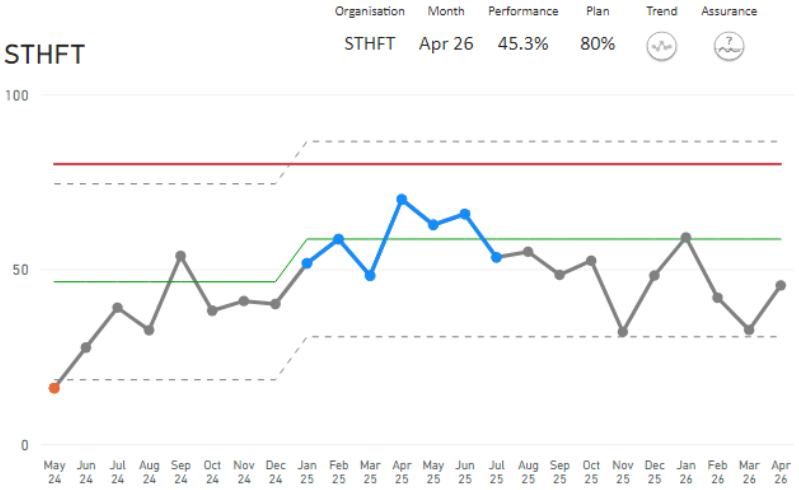




CARING Complaints Closed Within Target (%)







Metric: Percentage of complaints closed in agreed timeframe.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. STHFT data definitions refreshed this month for consistency.
Trend: NTHFT: No trend. STHFT: No trend, performance remains below plan.
Assurance: NTHFT: Advise STHFT: Advise, plan is within range of performance variation.
Action taken: NTHFT: HG reporting functionality to be improved to allow increased performance monitoring within CSUs. STHFT: Intensive review of processes are underway. Improvement targets to be agreed with each CSU.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

WELL LED DOMAIN SUMMARY

Executive leads: Rachael Metcalf, Chief People Officer
Chris Hand, Chief Finance Officer

Accountable to: People Committee
Resources Committee

Staff turnover is assured within plan across UHT. A vacancy freeze and executive vacancy approval process is in place across UHT. Voluntary Redundancy (VR) scheme underway to support whole time equivalent (wte) reduction targets.

Sickness absence continues to be a priority; an absence reduction action plan is in development for CSUs and corporate teams to achieve a 1% reduction by March 2027. People clinics established to support managers reduce absence in their areas of responsibility.

Revised, streamlined and standardised appraisal documentation has been agreed and implementation underway. BI dashboard to incorporate appraisal data to allow managers target areas for improvement..

The Mandatory Learning Oversight Group monitors adherence to mandatory training targets. Deep dive underway on resuscitation topics.

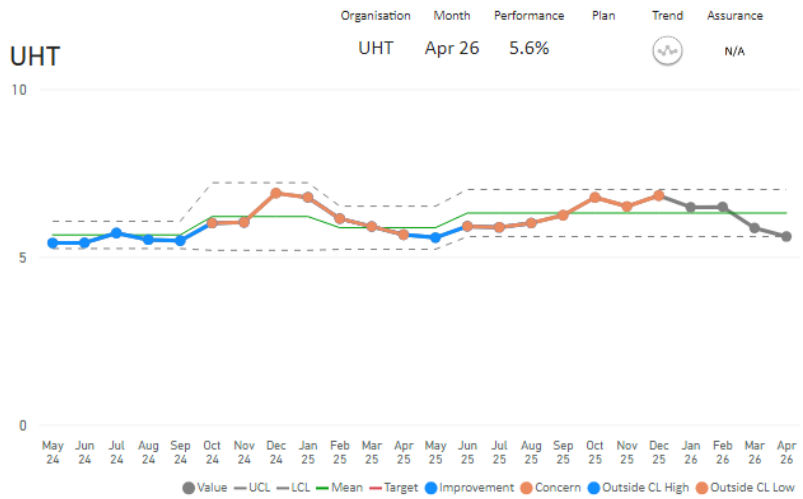
NTHFT position is reported to be on plan and is a deficit of £0.245m and STHFT position is reported to be on plan and is a deficit of £1.750m.

Sickness Absence (%)	4%	5.3%	5.8%	5.9%	5.9%	6.1%	6.3%	6.1%	6.7%	6.4%	6.5%	6.2%	5.8%
Staff Turnover (%)	10%	7.6%	7.4%	7.4%	7.6%	7.5%	7.6%	7.7%	7.6%	7.7%	7.7%	7.6%	7.5%
Annual Appraisal (%)	85%	88.5%	88.5%	88.6%	87.9%	88.1%	87.9%	87.5%	86.5%	85.4%	85.6%	85.3%	85.7%
Mandatory Training (%)	90%	88.9%	89.4%	89.8%	90.2%	90%	89.5%	89.1%	89.5%	88.8%	88.5%	87.9%	88.6%
Cumulative YTD Financial Position (£'millions)	-£0.245	£0.28	£0.644	£0.416	£0.833	£0.85	£0.693	£0.389	£0.601	£0.176	£0.542	£3.28	-£0.245

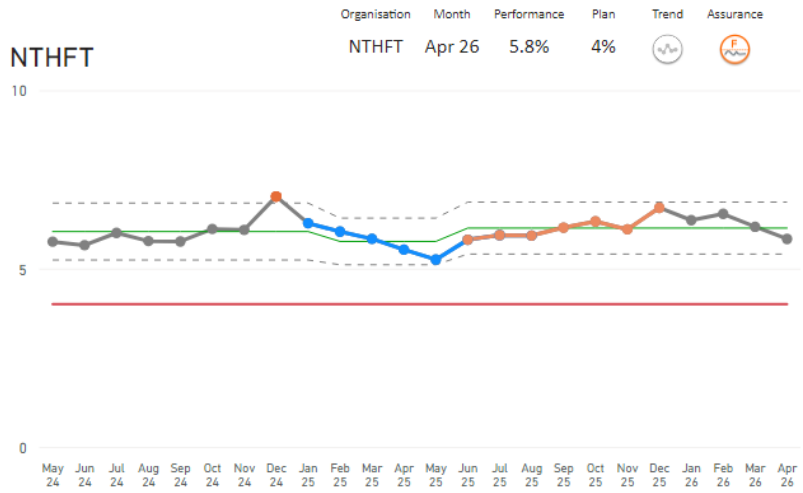
South Tees NHS FT	Plan	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Sickness Absence (%)	4%	5.7%	6%	5.9%	6%	6.3%	7%	6.7%	6.9%	6.5%	6.5%	5.7%	5.5%
Staff Turnover (%)	10%	6.6%	6.5%	6.5%	6.8%	6.7%	6%	6.8%	6.8%	6.8%	6.8%	6.8%	7%
Annual Appraisal (%)	85%	83.1%	84%	83.1%	83.5%	83.3%	82.9%	81.6%	81.1%	78.2%	74.9%	73.3%	73.2%
Mandatory Training (%)	90%	85.7%	85.7%	86.2%	85.9%	84.7%	84.8%	84.7%	84.6%	83.7%	83.7%	82.6%	82.3%
Cumulative YTD Financial Position (£'millions)	-£1.75	-£3.467	-£7.009	-£4.503	-£5.725	-£6.232	-£6.813	-£7.596	-£9.293	-£10.066	-£10.198	-£4.138	-£1.75

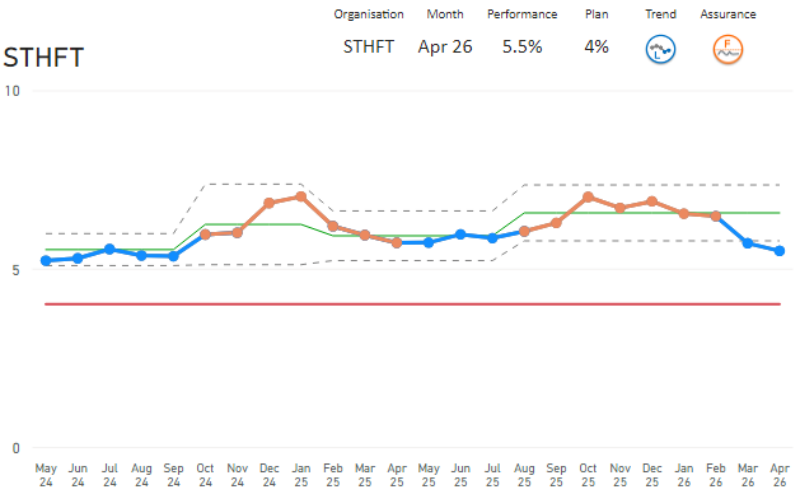
Caring Better Together

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: Positive April 2026 performance following a period of deterioration.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: UHT audits recommendations received and will feed into the overall absence action planning.
People assurance clinics established.14 absence related dismissals in May 26.
Executive lead: Chief People Officer
Accountable to: People Committee

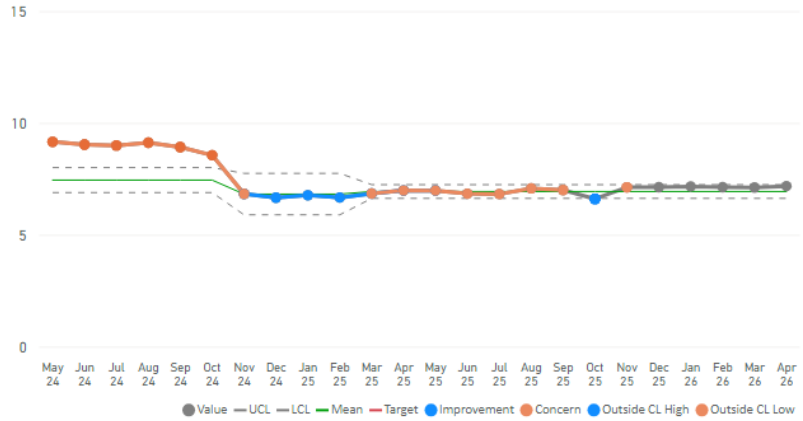




WELL LED Staff Turnover (%)

UHT

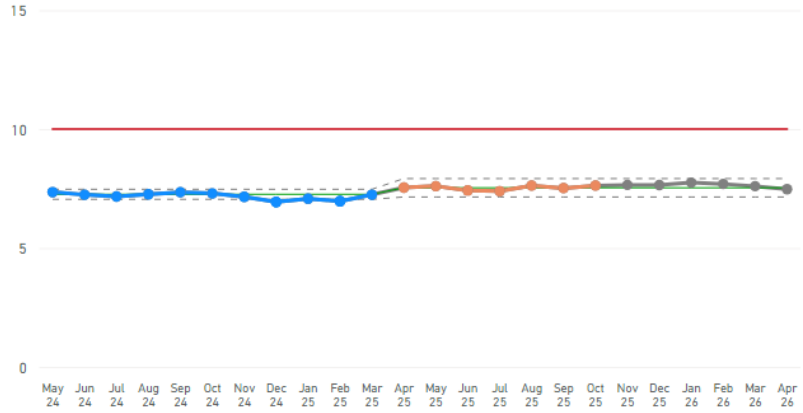
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	7.2%			N/A



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: Turnover remains stable across UHT. Deep dive has identified HCAs as an area of focus. Work underway to attract staff into these roles from local communities.
Executive lead: Chief People Officer
Accountable to: People Committee

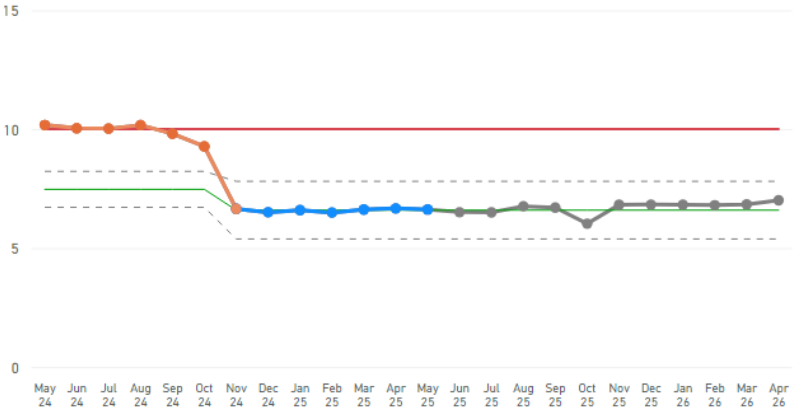
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	7.5%	10%		

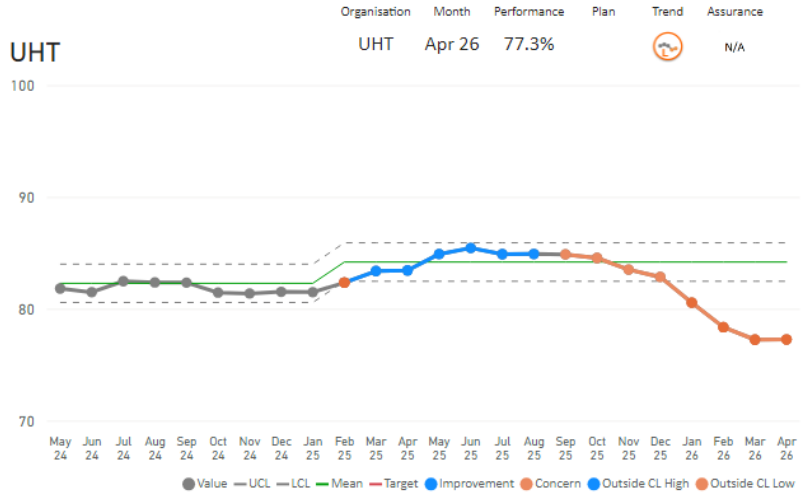


STHFT

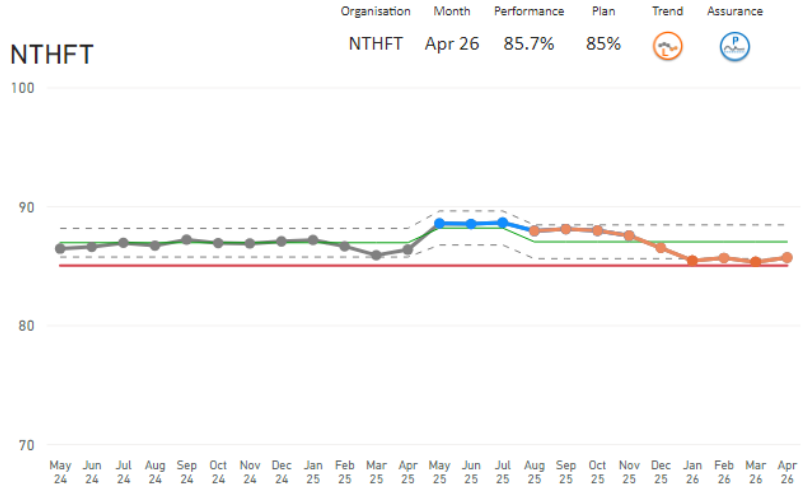
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	7%	10%		

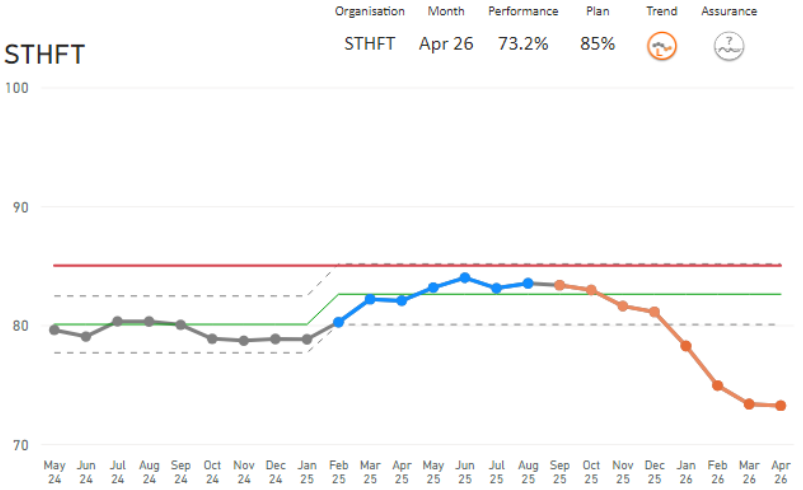


WELL LED Annual Appraisal (%)

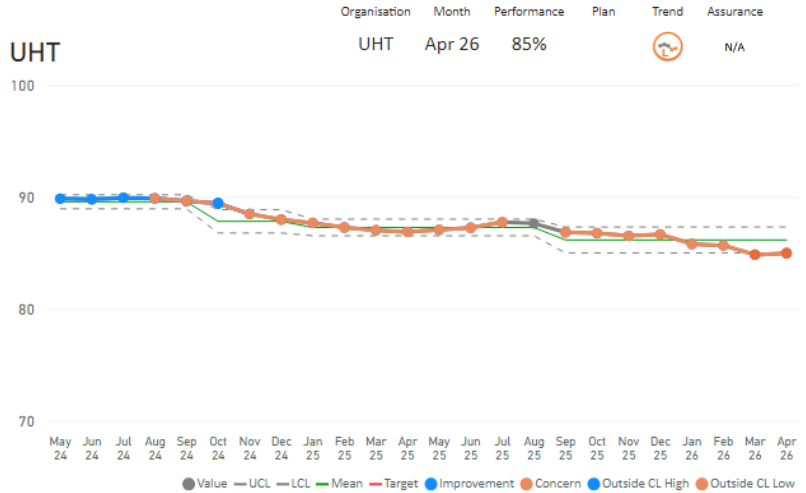


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Deteriorating trend but remaining above plan. STHFT: Deteriorating trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Revised appraisal documentation agreed with staff side and implementation for managers ongoing. BI dashboard will incorporate detailed appraisal data to support managers target areas of improvement.
Executive lead: Chief People Officer
Accountable to: People Committee

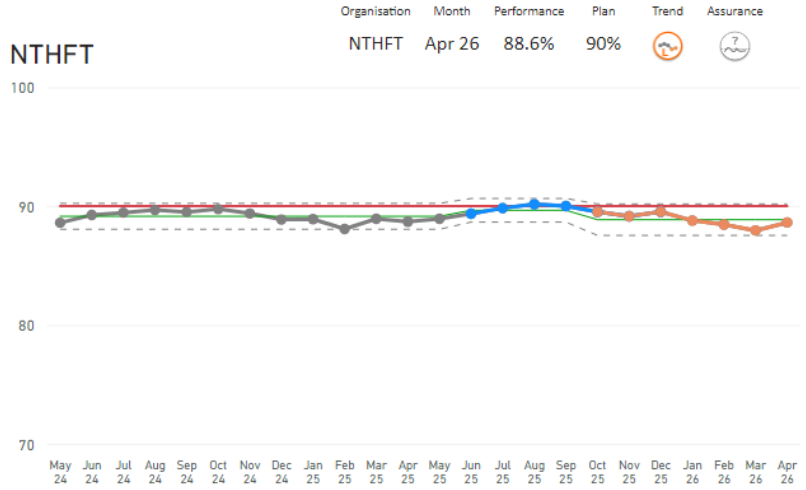


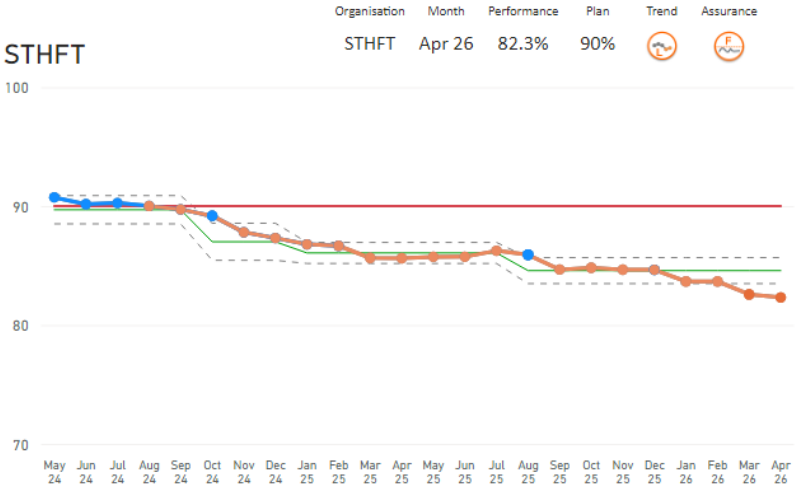


WELL LED Mandatory Training (%)



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: Deteriorating trend for 7 months. STHFT: Deteriorating long term trend, planned compliance not within range of current performance.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: Mandatory Learning Oversight Group overseeing alignment to national core framework and reform. Deep dive into resuscitation compliance underway. BI dashboard developed to support managers target areas of improvement.
Executive lead: Chief People Officer
Accountable to: People Committee



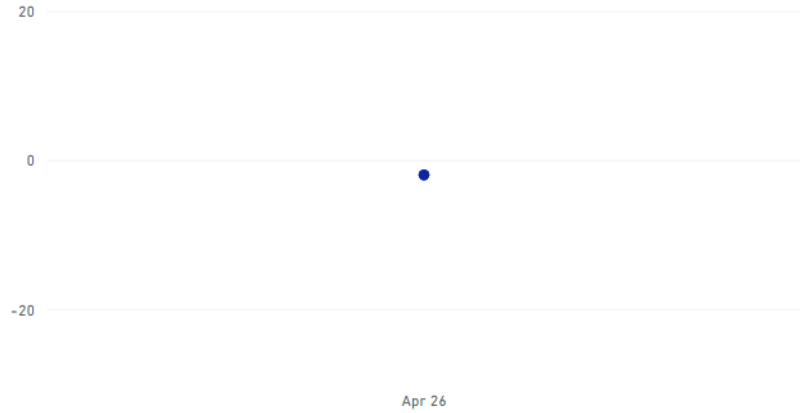


WELL LED Cumulative YTD Financial Position (£'millions)

Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with NHSE. Both NTHFT and STHFT are required to deliver a break-even plan for 2026/27.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: At Month 1, NTHFT position is reported to be on plan and is a deficit of £0.245m and STHFT position is reported to be on plan and is a deficit of £1.750m. Both trusts are forecasting to be on plan at the 31st March 2027.
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

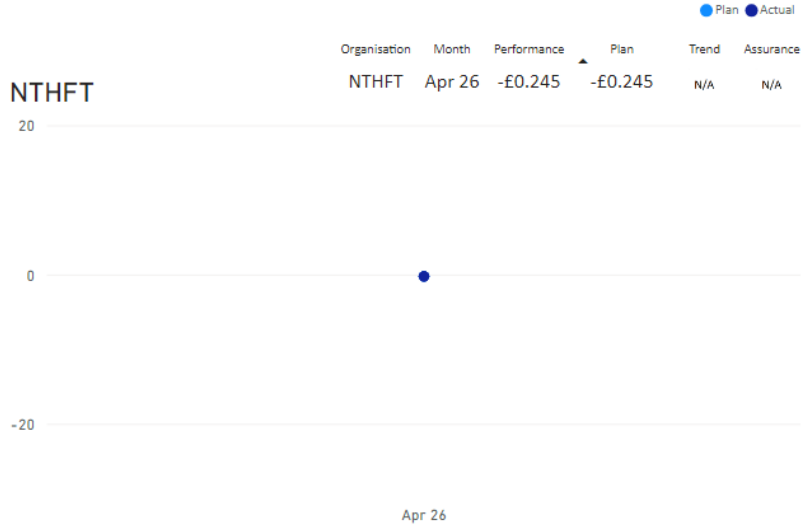
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Apr 26	-£1.995	-£1.995	N/A	N/A



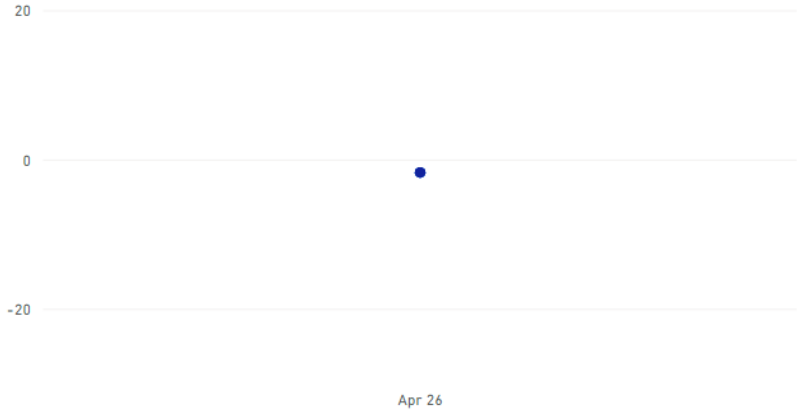
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Apr 26	-£0.245	-£0.245	N/A	N/A



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Apr 26	-£1.75	-£1.75	N/A	N/A



Caring Better Together

Regulation and Compliance

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 report received and due to be reviewed at the UHT Regulation and Compliance Group.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Sept 2022	Sept 2022	Sept 2022	Sept 2022	Sept 2022	Sept 2022

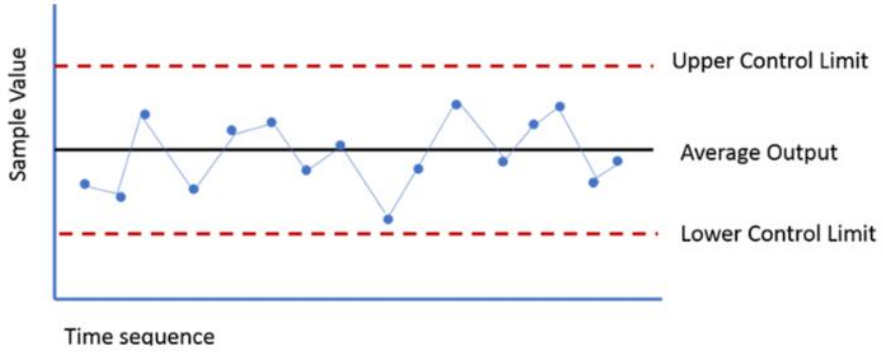
South Tees Hospitals NHS Foundation Trust has an overall rating of Good. Since the 2023 CQC inspection 11 Must Do and 15 Should Do actions have been completed. The remaining 2 Must Do and 5 Should Do actions have seen significant progress in assurance on Resuscitation and Safeguarding training in ED, and improvements in SDR compliance across the Friarage Hospital and Community Services. These actions are monitored by the Regulation and Compliance Group.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Good	Good	Good	Good
May 2023	May 2023	May 2023	May 2023	May 2023	May 2023

CQC assessment ratings per hospital site and service can be found on the CQC website.

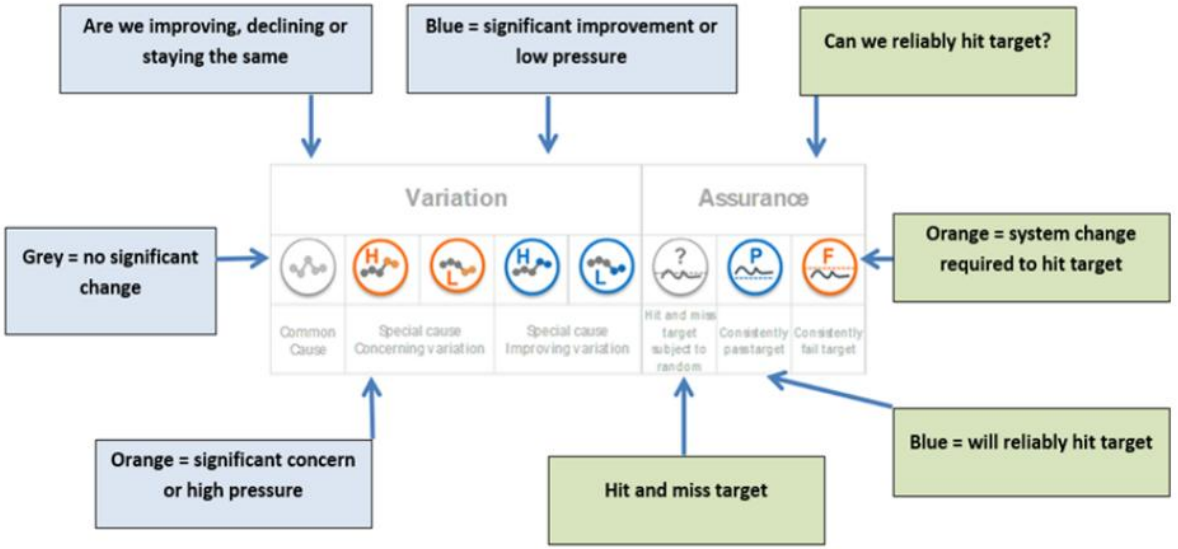
OVERVIEW SPC CHARTS

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

NHS
University Hospitals Tees

Thank you

Caring
Better
Together

University Hospitals Tees

Board Committee Terms of Reference Update

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 4.4

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Company Secretary

Action required: Approval

Delegation status: Jointly delegated item to Group Board

Previously presented to: Quality Committee, People Committee, Resources Committee, Academic Committee, Audit 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.

Following the annual effectiveness review, there were a number of minor changes in respect of the Board Committees Terms of Reference. The updated Terms of Reference were presented to each of the Committees during April and May 2026 for agreement.

The changes included a name change to Resources Committee, now known as Resources & Performance Committee to reflect the remit of the Committee moving forward and Audit and Risk Committee now known as Audit Committee (ST) removing the specific duties in relation to risk management.

One change applied to all the Committee Terms of Reference with the exception of the Audit Committees, was the insertion of narrative in respect of escalation and information sharing between individual Committees and the Board:

Information Sharing Between Committees
Each Committee shall share with the Board and with other Committees such information, insights and outputs as may be relevant to their respective remits. Chairs of Committees are responsible for ensuring material issues, risks, decisions and recommendations are communicated in a timely and transparent manner to avoid duplication, promote alignment and support informed decision-making across the Board. Where matters span multiple Committees, Chairs may agree joint consideration, cross-attendance at meetings or coordinated reporting to ensure effective oversight.

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 Terms of Reference define the purpose, scope and structure of the Committee. They set out the duties, which have been delegated to it by the Board with expected outcomes, along with the membership for each Committee.

Ongoing monitoring of the Terms of Reference are undertaken by the Committee in terms of attendance at meetings monthly and annually through the Committee effectiveness review to ensure they remain fit for purpose.

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 ratify the updated Terms of Reference for Quality Committee, People Committee, Resources and Performance Committee, Academic Committee, Audit Committee (NT) and Audit Committee (ST);
- To note the updated Terms of Reference were approved at the individual Committees on 27 April 2026, 28 April 2026, 29 April 2026, and 21 May 2026 respectively.

University Hospitals Tees

Quality Assurance Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the University Hospitals Tees (UHT) Board in April 2024. The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the Quality Assurance Committee to form a single UHT Assurance Quality Committee.

The terms of reference (ToR), which form part of the UHT Governance Framework, set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

To gain assurance the appropriate governance systems, structures and processes are in place to ensure delivery of high quality, safe, effective and patient-centred care in all of the services provided by the parties.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties, and agreed organisational strategic and operational plans.

4. Role and responsibilities

The responsibilities of the committee will be authorised by the UHT Board. It is expected that the committee will:

Each Committee shall share with the Board and with other Committees such information, insights and outputs as may be relevant to their respective remits. Chairs of Committees are responsible for ensuring material issues, risks, decisions and recommendations are communicated in a timely and transparent manner to avoid duplication, promote alignment and support informed decision-making across the Board. Where matters span multiple Committees, Chairs may agree joint consideration, cross-attendance at meetings or coordinated reporting to ensure effective oversight.

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the quality and safety risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks;
- Refer any potential people or resource risks identified by the Committee to the appropriate

committee

- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;
- Provide the Audit Committees of the UHT Board and the UHT Board; with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

Specific Responsibilities:

- Be assured that there are robust processes in place for the effective management of quality, including safety, experience and clinical effectiveness.
- Approve the quality priorities and receive regular updates on their delivery on behalf of the UHT Board.
- Approve the Annual Quality Accounts as delegated by the UHT Board and ensure publication in line with national requirements.
- Receive assurance on delivery of key statutory requirements and performance indicators in relation to quality, safety, experience and clinical effectiveness.
- Review and monitor those risks on the board assurance framework and corporate risk register which relate to quality, and high-risk operational risks which could impact on care. Ensure the UHT Board is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and review compliance with all statutory and regulatory requirements, ensure this is adhered to, and improvements are sustained.
- Receive assurance that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by the parties.
- Receive assurance that Duty of Candour (DoC), patient safety incident response framework (PSIRF) incidents requiring investigation (PSII), never events, safety alerts and claims are embedded, in order to disseminate and share learning.
- Receive assurance that effective and transparent processes are in place to monitor mortality and learning from death's metrics. (including coronial inquests).
- To receive assurance that robust and effective arrangements are in place for Infection Prevention and Control, Safeguarding, Health and Safety, Health Inequalities and Mental Health.
- To oversee the development and implementation of the Patient Experience and Involvement Strategy, the collection and use of patient reported experience, including national surveys, and feedback from complaints, in order to disseminate and share learning.
- Have oversight of and approve the terms of reference and work programmes for the clinical governance and groups reporting into the Committee (e.g., quality groups, infection prevention and control, local maternity and neonatal system, safeguarding).
- Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
- Receive assurance on the robustness of the arrangement's compliance with statutory responsibilities for health and safety management i.e. Security, decontamination, water

safety, fire and medical devices to ensure a safe environment.

- Receive assurance on maternity services across the UHT.
- Receive assurance on clinical effectiveness, including the triangulation of data from Clinical Audit, NICE and GIRFT.

5. Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.
Create sub-groups / task and finish groups	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups / task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference – but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.
Escalation of risk	If the Committee is not satisfied by the assurance provided it will escalate this to the Board through the escalation report

6. Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal assurance committee of the UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the UHT Board.

7. Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the UHT Board after each meeting and provide a report on assurances received, key actions taken with regard to quality, experience, clinical effectiveness and safety issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the UHT Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

8. Committee meetings

8.1. Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non-Executive Member will be nominated to Chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another Non-Executive Member of the Committee will be responsible for deciding the appropriate course of action.
Membership	Non-Executive Director – Chair Non-Executive Director – Vice Chair Non-Executive Director Lead Executive – Chief Nurse Group Executive Member – Chief Medical Officer In attendance – Deputy Director of Quality, Deputy Director of Safety, Medical Director, Nurse Director, Associate Medical Director Quality & Safety, subject specific experts as appropriate

Composition/ quoracy	Description of expectations
Member deputies	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.
Quoracy and Procedure for Inquoracy	The Committee has no decision making authority unless there are two Non-Executive Directors and one Executive Director present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

8.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee shall normally meet 10 times a year on a monthly basis and will not meet in August or December. The time in August and December may be used as a development session or opportunity for horizon scanning. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
Open vs closed	All Committee meetings will be held in private and be closed. .

8.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the parties. Members of, and those attending, the Committee shall behave in accordance with the parties constitution, standing orders, and standards of business conduct and the Code of Conduct and Accountability policy and Declarations of Interest policy

8.4 Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meeting, with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee provided by the company Secretary.	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions. Produce the chairs escalation report and grade all reports with a level of assurance
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members.

9. Revision History

Version	Date	Approved by	Review	Type of changes
V1	April 2024	Group Board	Annually	Developed
V2	August 2025	Group Board	Annually	
V3	April 2026			

Review date: April 2026

University Hospitals Tees

Resources and Performance Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the UHT Board in April 2024. The Group is known as University Hospitals Tees (UHT). The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the Resources Committees to form a single UHT Resources and Performance Committee.

The terms of reference (ToR), which form part of the Governance Framework, set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

2.1 Purpose

To gain assurance the appropriate governance systems, structures and processes are in place to ensure effective and efficient use of resources in all of the services provided by UHT including its subsidiary companies . UHT has a clear ambition to do things differently by working collaboratively as a Group, and in doing so delivering real benefits for our patients, staff and the wider population served by both Trusts.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties and agreed organisational strategic and operational plans.

3. Roles and responsibilities

The responsibilities of the Committee will be authorised by the Board. It is expected that the Committee will gain assurance in respect of:

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the resources risks and ensure the effectiveness and implementation of controls for resources risks and actions to mitigate these risks;
- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;
- Provide the Audit Committee of the UHT Board and the UHT Board; with assurance on the

effectiveness of management of the principal risks relating to the Committee's purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

Specific Responsibilities:

Planning, Performance and Compliance

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include:

- oversight of the Integrated Performance Report reflecting the position of the UHT Board in regard to performance and recovery objectives aligned to the annual planning round.
- Monitoring key performance, financial, activity and workforce plans over the short, medium and long term, including annual targets (including revenue and capital budgets) for approval by the UHT Board on an annual basis prior to the start of each financial year
- ensuring that all delivery requirements and remedial actions with regard to performance, planning and recovery objectives, give due cognisance to the regulatory requirements of financial performance and effective budget management.
- well founded governance processes for the overall delivery of performance, supported by sub governance processes for each key performance objective.
- clear overview of the annual planning round and the and the alignment to the delivery of the internal Business Planning process, monitoring and reviewing progress against plan, taking decisions to recover areas of underperformance, providing assurance to the UHT Board and escalating as required.
- Ensure operational efficiencies are delivered in line with the requirement to provide viable, clinically sustainable services, fit for the future

Digital Strategy

- To provide oversight and review on the development, implementation and delivery of the Digital, Cyber and I&TS strategies; and to monitor progress against and risks associated with the strategies, including any associated improvement plans
- Oversight of the Information Governance/Data Security agenda including the Data Security and Protection Toolkit submission and external audits in order to gain assurance on compliance with the legislative requirements.
- Gain assurance that information governance has been considered in all decisions and that this can be evidenced, receiving exception reports for non-compliance.
- Regularly review cyber resilience and security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime.
- Ensuring the UHT Board undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Estates Strategy

- The Committee shall have responsibility for the oversight of the Capital Programme (including individual Business Cases for Capital Investment) and the review of the Estates Strategy and plans relating to Estate development (including the acquisition and disposal of property), and for making recommendations to the UHT Board as appropriate on any issue within its terms of reference.

Procurement Strategy

- To review the UHT Board procurement strategy and policies on a regular basis and to make recommendations to the UHT Board.
- To consider any significant variations to the existing procurement methodology as set out in the UHT Board Standing Orders and Standing Financial Instructions.
- To understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change.

Resource Management

- Full oversight of the monthly financial position of the UHT Board, including ICP/ICS implications/risks/opportunities of system working.
- Regular updates regarding the efficiency, sustainability and the financial control environment and framework, as well capital programme and scrutiny of investment decisions.
- Provide rigorous scrutiny of cost improvement programmes for current and future years, and challenge processes where necessary, ensuring actions are implemented to achieve CIP targets without compromising on quality and to ensure that proposed financial initiatives are rated according to their potential impact on quality.
- Oversight of the adequacy of the financial and demand estimates, forecasts and plans, looking forward over the period as required by NHS England annually, five yearly or longer, depending on the investment.
- Oversight of the adequacy of any external financing arrangements to ensure that they are both adequate in provision and offer value for money for the UHT Board.
- Ensure there is congruence between the future plans and aspirations of the UHT Board, and the availability of adequate resources to support the plan.
- Business Case Investments - ensuring that these support the delivery of the corporate objectives, include the benefits and are linked to the strategic direction and annual plans.
- Receive and scrutinise post implementation reviews on business case and capital investment schemes including benefits realisation
- Seek reports and assurances from sub-committees, directors and managers as appropriate, concentrating the over-arching systems of resource planning, integrated governance, risk management and internal control, together with indicators of their effectiveness
- Receive and consider major Investment Plans for the UHT Board and maintain an oversight of the investments, ensuring compliance with the Strategic Direction and Annual Plans.
- Review and approve or make a recommendation to the UHT Board on recurring or non-recurring revenue schemes that will result in costs that are over those in line with each UHT Board Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.

Sustainability

- Review the Green Plan of the UHT Board which sets out the aim to achieve carbon neutral for energy emissions by 2030 which can be accomplished by creating a fully sustainable estate, utilising alternative, renewable power sources and making the most of innovation.
- Monitor routinely the actions to deliver this aim including receiving reports on
  - Working collaboratively
  - Resources
  - Procurement and raw materials
  - Waste
  - People
  - Journeys
  - Green spaces

Transformation

- Receive regular updates on key issues and progress against plans for strategic transformational change initiatives, improvement programmes, service redesign etc.
- Oversee the implementation of national transformation plans within clinical service areas, including GIRFT, HED, Model Hospital, and Carter. This will include cost improvement and other productivity improvement programmes.

Information Sharing Between Committees

- Each Committee shall share with the Board and with other Committees such information, insights and outputs as may be relevant to their respective remits.
- Chairs of Committees are responsible for ensuring material issues, risks, decisions and recommendations are communicated in a timely and transparent manner to avoid duplication, promote alignment and support informed decision-making across the Board.
- Where matters span multiple Committees, Chairs may agree joint consideration, cross-attendance at meetings or coordinated reporting to ensure effective oversight.

The Committee will agree progress reporting and information requirements relating to its remit on behalf of the UHT Board and will oversee the resulting performance intelligence.

3.1 Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.
Create sub-groups/sub-committees	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups/task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference– but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.

3.2 Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the UHT Board.

3.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the UHT Board after each meeting and provide a report on assurances received, key actions taken with regard to use of resource issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the UHT Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.

Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

4. Committee meetings

4.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations

Membership	Non Executive Director – Chair Non Executive Director – Vice Chair Non Executive Director Lead Executive – Chief Finance Officer Executive Members In attendance - Deputy Director of Finance, Chief Operating Officer and subject specific (as per cycle of business) – Procurement, Digital, Estates, Resource Management, Business Intelligence, Transformation, Service Improvement
	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.
Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are 2 Non Executive Directors and 1 Executive Director present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

4.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee shall normally on a monthly basis. One month the meeting will be face to face and the following month the meeting will be held virtual with a reduced membership and risk based approach to the agenda. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
	Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
Open vs closed	All Committee meetings will be held in private and be closed

4.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the UHT Board. Members of, and those attending, the Committee shall behave in accordance with the UHT Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

5. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the UHT Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

6. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Group Board	Annually	Development
V2	April 2025	Group Board	Annually	Changes to those in attendance and NED reduction
V3	April 2026			Changes to those in attendance

Review date: April 2026

University Hospitals Tees

People Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the UHT Board in April 2024. The Group is known as University Hospitals Tees (UHT). The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the People Committee to form a single UHT People Committee.

The terms of reference (ToR), which form part of the UHT Governance Framework , set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

To gain assurance that the appropriate governance systems, structures and processes are in place to ensure delivery of effective people, workforce and organisational development strategies in all of the services provided by UHT . University Hospitals Tees has a clear ambition to do things differently by working collaboratively as a Group, and in doing so delivering real benefits for our patients, staff and the wider population served by both Trusts.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties, and agreed organisational strategic and operational plans.

4. Roles and responsibilities

The responsibilities of the Committee will be authorised by the Board. It is expected that the Committee will gain assurance by:

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks;
- Refer any potential risks to patient safety or quality identified by the Committee to the UHT Quality Committee;
- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;

- Provide the Audit Committee of the UHT Board and the UHT Board; with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

People Strategy

- Provide assurance that the UHT People Strategy is aligned to the national workforce agenda reflecting the NHS People Strategy and People Promise
- Obtain assurance and monitor delivery of the People Plan through the associated activity/implementation plan.

People Values

- Evaluate the impact of work to promote the People values of the UHT Board and of the NHS Constitution and the People Plan
- Review and monitor progress against the NHS National Staff Survey with a particular focus on Staff Engagement and Health and Wellbeing.
- Monitor progress against the Freedom to Speak Up strategy and themes arising from speaking up. To provide assurance that the organization promotes a culture where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.
- Gain assurance from the Guardian of Safe Working on practice relating to doctors working hours
- Oversee and monitor the effectiveness of the Leadership Development programmes in place to support all leaders, evaluating to inform further improvements.

Equality, Diversity and Inclusion

- Oversee the employment related equality, diversity and inclusion agenda, receiving regular reports and assurance from the relevant groups.
- Monitor the legal and regulatory requirements in relation to the workforce, to include diversity and inclusion such as WRES, WDES and Gender Pay Gap.

Use of resources

- Provide assurance to the Board of the effective use of its Human Resource through workforce planning and re-design strategies, succession planning and the monitoring of pay costs (including agency spend/usage)
- Monitor plans to improve productivity of permanent and temporary staff, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices.
- Consider and monitor the coherence and pace of strategic plans to secure transformational change, service redesign and pathways of care; new and innovative ways of working; use of tools and technology; opportunities for changing practices and skills across traditional professional boundaries; joint working with partners both in health and social care and other sectors; and the value of apprenticeships

Education and training

- Oversight of current and future educational and training needs to ensure they support the strategic objectives of the UHT Board in the context of the wider health and care system.
- .Ensure plans are developed to sustain and promote a culture of developing a pipeline of trainees/apprenticeships as part of the workforce of the future.
- Assess relationships with academic institutions to ensure a supportive and aspirational plan for workforce development.

Health & Safety Security management – violence and aggression

- Ensuring the Violence Prevention and Reduction Strategy is monitored and reviewed regularly.
- Review the Equality Quality Impact assessment to ensure that inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced.
- Evaluate and assess the Violence Prevention and Reduction Programme, sharing the findings with the Board on a 6 monthly basis.

Performance and Progress Reporting

- Consider and recommend to the Board the key people and workforce performance metrics and targets for the Trust.
- Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. Assist the UHT Board in its assurances and consistent use of data and intelligence, by working closely with the Audit, UHT Quality, and UHT Resources Committees.

Information Sharing Between Committees

- Each Committee shall share with the Board and with other Committees such information, insights and outputs as may be relevant to their respective remits.
- Chairs of Committees are responsible for ensuring material issues, risks, decisions and recommendations are communicated in a timely and transparent manner to avoid duplication, promote alignment and support informed decision-making across the Board.
- Where matters span multiple Committees, Chairs may agree joint consideration, cross-attendance at meetings or coordinated reporting to ensure effective oversight.

5. Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.

Create sub-groups/sub-committees	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups/task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference– but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.

6. Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation

The Committee is a formal committee of the UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these terms of reference as determined by the UHT Board.

7. Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the UHT Board after each meeting and provide a report on assurances received, key actions taken with regard to people issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description

Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the UHT Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

8. Committee meetings

a. Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations

Membership	Non Executive Director – Chair Non Executive Director – Vice Chair Non Executive Director Lead Executive – Chief People Officer UHT Executive Member In attendance – 4 x Deputy Directors; Associate Medical Director – People, subject specific officers
	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.
Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are 2 Non Executive Directors and 1 Executive Director present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

b. Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description

Meeting frequency	The Committee shall normally meet 10 times a year on a monthly basis and will not meet in August and December. The time in August and December may be used as a development session or opportunity for horizon scanning. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
Open vs closed	All Committee meetings will be held in private and be closed

c. Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the UHT Board. Members of, and those attending, the Committee shall behave in accordance with the UHT Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

9. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the UHT Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

10. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Group Board	Annually	
V2	April 2025	Group Board	Annually	Changes to number of NEDs and those in attendance
V3	April 2026			No changes

Review date: April 2026

University Hospitals Tees

Academic Committee

Terms of Reference

Table of Contents

1. Introduction

North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the Group Board in April 2024. The Group is known as University Hospitals Tees (UHT). The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2. Establishment

The Group Board has agreed to establish a single Committee to be known as the Academic Committee.

The terms of reference (ToR), which form part of the Group Governance Framework, set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the Group Board.

The committee will have a shared remit with the People Committee to seek assurance that the appropriate education and training provision is in place to deliver our workforce plan, with focus on non-workplace training.

The Committee will have a shared remit with the Resource Committee to seek assurance that resources across research, education and innovation are being effectively managed

The committee is a non-executive member chaired committee of the Group Board, and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

The purpose of the Academic Committee is to lead on behalf of the Group Board; the acquisition and scrutiny of assurances concerning;

(i) Positioning of the Group in partnership with the Universities of Newcastle, Sunderland, Teesside and Hull York Medical School and other academic organisations as a leading global academic, research and innovation institution and as a catalyst for commercial opportunities that may emerge;
(ii) Oversight of medical undergraduate and postgraduate education and training, NMAHP training, and supporting the development of advanced specialty practice
(iii) Assurance regarding quality and appropriate use of educational funding
(iv) Support Teesside University's aspiration to develop a local medical school and continued development of its School of Health.
(v) Compete for and win research grants or funds that underpin the Group Board's long-term clinical and strategic aspirations;
(vi) Patient benefit from research participation and utilisation;
(vii) Linking research participation to quality and service improvement
(viii) Having oversight of commercial opportunities that arise from research and innovation programmes, as well as related business-engagement activities that seek to exploit Trust-owned resources
(ix) Ensuring good governance and risk management of research and innovation activities in the Trust.

4. Roles and responsibilities

The responsibilities of the Academic Committee will be:

4.1 To provide oversight and scrutiny to the Research & Innovation Board Assurance Framework and escalate assurance concerns to the Board. This also includes the responsibility to review the Board Assurance Framework at the beginning of each year and propose a risk appetite for R&I to the Board for formal approval.

4.2 To be assured of the development and implementation of strategies to promote the Group as a global hub for research and innovation and to establish conditions for increasing participation in research, promoting and supporting innovation and continuing development opportunities.

4.3 Provide assurance of the establishment of partnerships with higher education institutes, industry, NHS organisations, and charities across the UK and internationally to increase participation in research, clinical innovation pathways and continuing development opportunities.

4.4 Provide assurance regarding optimal access and use of NHS Education funding

4.5 Provide assurance of the proactive development of commercial opportunities that may arise from research and innovation activities and from the networks that develop with partners and other organisations through the course of that work. When necessary, be underpinned by external advice and expertise to explore and exploit commercial opportunities.

4.6 Provide assurance of the process and review of the performance management for the delivery of the Research and Innovation Strategy and progress of the defined key performance indicators.

4.7 Provide assurance of the financial management, performance and governance of Education, Research and Innovation activity, which enable the Committee to consider the risks involved in the Group's business and how they are controlled and monitored by management.

4.8 Provide assurance that opportunities to develop the education, research and clinical innovation portfolios are aligned with the Group Board's strategy and that high quality bids are submitted.

4.9 Provide assurance that the research and teaching workforce is developed and replenished in sufficient numbers to meet the Group's long-term strategic and clinical aspirations.

4.10 Provide assurance on the development and implementation of highly effective controls for education, research and innovation governance, including the management of risks, ensuring appropriate controls are in place, reporting to other Group Board committees as appropriate.

4.11 Provide assurance on the rapid resolution of any significant weaknesses found in the Group's research and innovation endeavours by reviewing decisions to halt research and innovation activity and apply whatever learning is necessary to: (i) ensure safe, high-quality compliance of research and innovation practices at all times; and (ii) the success fulfilment of research obligations to which the Group is committed. Ensure material concerns are addressed to the satisfaction of all concerned and properly declared to the Group Board.

4.12 Provide assurance that the synergies between the Group's research and innovation activity and work of local authority partners are being maximised including through the development of strategic partnerships, funding opportunities and programmes.

4.13 Provide assurance of communication plans and activities about LA partnerships to key internal and external groups, championing the investment objectives and benefits of the planned workstreams, ensuring alignment with the overall group strategic development plan.

4.14 Provide assurance to the Chairs of Audit Committees confirming the effectiveness of the Committee and fulfilment of its objective, and to the effect that the Committee has disclosed to the Audit Chairs all significant deficiencies and material weaknesses in the design or operation of internal controls which could adversely affect the Group's ability to achieve research, innovation, education, or training objectives.

4.15 To consider, within its agenda, material issues communicated to it by the Audit Committees arising from the work of the Internal Audit function relating to matters which fall within the scope of the objective and responsibilities of the Committee. The Committee shall provide feedback on its review of such referred internal audit work, in particular as to any shortcomings perceived in the scope or adequacy of the work. Additionally, the Committee shall respond to any other matters of an internal audit nature that are referred to it by the Audit Committees as appropriate.

4.16 The Committee shall review annually the Committee's terms of reference and its own effectiveness and recommend to the Group Board any necessary changes arising therefrom.

4.17 To report to the Group Board on matters set out in these terms of reference and how the Committee has discharged its responsibilities.

4.18 The Chair of the Committee shall provide an annual letter of assurance to the Chair of Audit Committee confirming the effectiveness of the Committee and fulfilment of its objective, and to the effect that the Committee has reported to the Group Board financial or operational performance which could adversely affect achievement of corporate objectives.

4.19 To undertake or consider on behalf of the Group Chair or the Group Board such other related tasks or topics as the Group Chair or the Group Board may from to time entrust to the Committee.

4.20 Where there is a perceived overlap of responsibilities between other assurance Committees of the Group Board, the respective Committee Chair shall have the discretion to agree the most appropriate Committee to fulfil any obligation. To support this, information will be shared (and reported to more than one Committee).

Information Sharing Between Committees

Each Committee shall share with the Board and with other Committees such information, insights and outputs as may be relevant to their respective remits. Chairs of Committees are responsible for ensuring material issues, risks, decisions and recommendations are communicated in a timely and transparent manner to avoid duplication, promote alignment and support informed decision-making across the Board. Where matters span multiple Committees, Chairs may agree joint consideration, cross-attendance at meetings or coordinated reporting to ensure effective oversight

5. Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.
Create sub-groups / task and finish groups	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups / task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference – but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.
Escalation of risk	If the Committee is not satisfied by the assurance provided it will escalate this to the Board through the escalation report

6. Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal assurance committee of the Group Board. The Group Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the Group Board.

7. Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the Group Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the Group Board after each meeting and provide a report on assurances received, key actions taken with regard to quality, experience, clinical effectiveness and safety issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers beforehand.

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the Group Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Group Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the Group Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

8. Committee meetings

8.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

The Committee will normally meet 4 times a year, with no committee meetings taking place in August or December. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the Group Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the Group Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non-Executive Member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another Non-Executive member of the Committee will be responsible for deciding the appropriate course of action.
Membership	Non-Executive Director – Chair Non-Executive Director – Vice Chair Lead Executive – Group Chief Medical Officer Group Executive Members – Group Chief Nursing Officer,/Group Chief Strategy Officer In attendance - Director of Research; Director of Innovation; Director of Medical Education; Director of Pharmacy Additional Members: Newcastle University Academic Lead and Teesside University Academic Lead
Member deputies	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part ofthe quoracy.

Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Group meetings to provide advice or support particular discussion(s). In addition to the core membership the Committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are two Non-Executive Directors and one Executive Director present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

8.2 Frequency and formats

This section on Group meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee shall normally meet 4 times a year on a quarterly basis. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

Open vs closed	All Committee meetings will be held in private and be closed

8.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the Group Board. Members of, and those attending, the Committee shall behave in accordance with the Constitutions, standing orders, and standards of business conduct and the Code of Conduct and Accountability policy and Declarations of Interest policy.

8.4 Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.

Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the Group Board. Take forward action points between meetings and monitor progress against those actions. Produce the Chair's Log for assurance to the Group Board.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for Committee members.

9 Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.1	June 2025	Group Board	Annually	First approval
V2	June 2026			

Review date: March 2027

University Hospitals Tees

Audit Committee
North Tees & Hartlepool NHS Trust

Terms of Reference

1. Introduction

The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1 The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives.

2.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board of Directors to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. Roles and responsibilities

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self certifications
- the policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

As part of its integrated approach, the Committee will have effective relationships with other Trust Board Committees to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors of Directors. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governing the appointment permit

- discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy

- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertake outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality Committee, Academic Committee the Resource Committee and People Committee.

3.5 Counter Fraud

The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's requirements and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

3.6 System for raising concerns

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionally and independently, and in line with the relevant policies.

3.7 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit).

3.8 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements

- significant adjustments resulting from the audit
- Letters of representation
- Qualitative aspects of financial reporting

3.9 Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons test.

The Committee shall satisfy itself that the organisations' policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4.1 Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.

4.2 Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the North Tees & Hartlepool NHS Foundation Trust Board. The Board has delegated authority to the Committee as set out in in the terms of reference and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the Board.

4.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the North Tees & Hartlepool NHS Foundation Trust Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, key actions taken with regard to use of resource issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

5. Committee meetings

5.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations
Membership	Non Executive Director – 3 including the Chair of the Committee
Attendees and procedure for absence	The Chief Finance Officer, and the Company Secretary, shall normally attend meetings. Representatives of the external auditor and internal audit will attend. The Counter fraud specialist will attend a minimum of two committee meetings a year. Only members of the Committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit and risk committee. The Accountable (or Accounting Officer) should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. Representatives from other organisations (for example, NHSCFA) and other individuals may be invited to attend on occasion, by invitation.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are 2 Non Executive Directors present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

5.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee will meet five times a year additional meetings may be arranged as required. The chair of the committee, board, Accounting (or Accountable) Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting
Open vs closed	All Committee meetings will be held in private and be closed

5.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the Board. Members of, and those attending, the Committee shall behave in accordance with the Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

6. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

7. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Board	Annually	
V2.0	13/5/25	Board	Annually	
V2	14/5/26			

Review date: September 2027

University Hospitals Tees

Audit Committee
South Tees Hospitals NHS Trust

Terms of Reference

1. Introduction

The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1 The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives.

2.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board of Directors to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. Roles and responsibilities

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self certifications
- the policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

As part of its integrated approach, the Committee will have effective relationships with other Trust Board Committees to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors of Directors. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governing the appointment permit

- discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy

- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertake outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Assurance Committee the Resource Committee and People Committee.

3.5 Counter Fraud

The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's requirements and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

3.6 System for raising concerns

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionally and independently, and in line with the relevant policies.

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The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit).

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The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements

- significant adjustments resulting from the audit
- Letters of representation
- Qualitative aspects of financial reporting

3.9 Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons test.

The Committee shall satisfy itself that the organisations' policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4.1 Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.

4.2 Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the South Tees Hospitals NHS Foundation Trust Board. The Board has delegated authority to the Committee as set out in in the terms of reference and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the Board.

4.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the South Tees Hospitals NHS Foundation Trust Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, key actions taken with regard to use of resource issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

5. Committee meetings

5.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. All meetings will be closed and held in private.

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Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations
Membership	Non Executive Director – 3 including the Chair of the Committee
Attendees and procedure for absence	The Chief Finance Officer, and the Company Secretary, shall normally attend meetings. Representatives of the external auditor and internal audit will attend. The Counter fraud specialist will attend a minimum of two committee meetings a year. Only members of the Committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit and risk committee. The Accountable (or Accounting Officer) should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. Representatives from other organisations (for example, NHSCFA) and other individuals may be invited to attend on occasion, by invitation.

Composition/ quoracy	Description of expectations
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5.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee will meet five times a year additional meetings may be arranged as required. The chair of the committee, board, Accounting (or Accountable) Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting
Open vs closed	All Committee meetings will be held in private and be closed

5.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the Board. Members of, and those attending, the Committee shall behave in accordance with the Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

6. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
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Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

7. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Board	Annually	
V2.0	13/5/25	Board	Annually	
V2	14/5/26			

Review date: September 2027

University Hospitals Tees

Modern Slavery and Human Trafficking Statement - STHFT

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 5.1

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

Action required: Approval

Delegation status: Matter reserved to Unitary Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF 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.

To present the Modern Slavery and Human Trafficking Statement for 2026/27 to the Board of Directors for approval, in line with requirements of section 54 (1) of the Modern Slavery Act 2015.

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps the Trust and its subsidiary company: South Tees Healthcare Management Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within the business, subsidiary companies or supply chain during the year ending 31 March 2027.

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 Modern Slavery Act 2015 introduced changes in UK law, focused on increasing transparency in supply chains. Specifically, large businesses are now required to disclose the steps they have taken to ensure their business and supply chains are free from modern slavery, that is, slavery, servitude, forced and compulsory labour and human trafficking.

Commercial organisations that supply goods or services and have a minimum turnover of £36 million are required to produce a 'slavery and human trafficking statement' each financial year. This should set out the steps taken to ensure modern slavery is not taking place in the organisation's own business and its supply chains.

The Trust supports and has zero tolerance for slavery and human trafficking and is fully aware of its responsibilities towards service users, employees and local communities. There is an expectation that all the companies it does business with share and adhere to the same ethical values. The Trust has in place due diligence and internal policies and procedures that assess supplier risk in relation to the potential for modern slavery or human trafficking. It also operates a number of policies which support it in conducting business in an ethical manner, including recruitment and selection; equal opportunities and diversity; safeguarding; freedom to speak up; procurement; standards of business conduct; grievance and counter fraud, bribery and corruption.

The appended statement has been developed with input from a number of key stakeholders.

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 statement requires approval at Board level, following which it will be published in a prominent place on the organisation's website and that of its subsidiary companies.

Recommendations:

The Board of Directors are asked to approve the Modern Slavery and Human Trafficking Statement for 2026/27.

Slavery and Human Trafficking Statement 2026/27

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that South Tees Hospitals NHS Foundation Trust and its subsidiary company: South Tees Healthcare Management Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business, subsidiary companies or supply chain during the year ending 31 March 2027.

Due to the scope of our business, South Tees Hospitals NHS Foundation Trust recognises that it may be at risk of modern slavery, which encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

About the organisation

South Tees Hospitals NHS Foundation Trust provides more than 37 specialities to 1.5 million patients across Teesside, North Yorkshire and beyond. Care is delivered from two main acute hospital sites, James Cook University Hospital and the Friarage Hospital in Northallerton, in addition to a number of community facilities across the area including Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and the Friary Community Hospital.

We provide a large number of specialist services – delivering world-class cancer, cardiothoracic, spinal, cochlear implant, neurosciences, gynaecology vascular and urology care for patients across our region.

Together with our three primary care hospital wards and local community NHS teams, we provide care closer to home for patients from Hawes to East Cleveland and everywhere in between.

With more than 10,000 staff, we are the largest employer in Teesside and North Yorkshire.

The Trust's Commitment

The Trust supports and is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect all the companies we do business with to share the same ethical values.

We also have an impartial Freedom to Speak up Guardian who supports staff to raise any concerns.

Due Diligence

We are committed to ensuring that:

- There is no modern slavery or human trafficking in our supply chains or in any part of our business and this includes our subsidiary South Tees Healthcare Management Limited;
- Employment with the Trust and our suppliers is entirely voluntary;
- Our workplaces, and those of our subsidiaries and suppliers, are safe, healthy and free from discrimination or harassment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation, or any other characteristic that is protected by law;
- Corruption, in all its forms including extortion and bribery is prohibited;
- We have a number of policies which support us in conducting business in an ethical manner, including:
    - Recruitment and Selection Policy
    - Equal Opportunities and Diversity Policy
    - Adult Safeguarding Policy
    - Safeguarding Children Policy
    - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
    - Standards of Business Conduct Policy
    - Procurement Policy
    - Resolution Policy
    - Counter fraud, Bribery and Corruption Policy

All policies are reviewed to ensure they are working effectively every 3 years or earlier if relevant laws change or new evidence or guidance becomes available and they are available on the Trust's website www.southtees.nhs.uk.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain, the Trust and its subsidiary companies operates and adheres to a robust recruitment process including compliance with the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references) and employ agency staff (where appropriate) from agencies on approved frameworks so that we are assured that pre-employment clearance has been obtained to safeguard against human trafficking or individuals being forced to work against their will. If there is not an available worker from a framework agency, this is escalated to senior managers and local pre-employment checks, including the right to work in the UK, are sought.

We adhere to the principles inherent within both our safeguarding children and adult's policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the Modern Slavery Network and the Vulnerable, Exploited, Missing, Trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

Our purchasing and procurement is governed by the new Procurement Act 2023, the NHS 'Supplier Code of Conduct' and standard NHS Terms & Conditions. The Procurement Act, which came into force in February 2025, strengthens the approach to tackle modern slavery in public procurement by introducing mandatory exclusion grounds and broader discretionary grounds for excluding suppliers. This means for suppliers found to be involved in modern slavery practices or connected to individuals convicted of such offences are more easily excluded from bidding on public contracts.

High value contracts are effectively managed and relationships built with suppliers through frameworks, which have been negotiated under the NHS Standard Terms and Conditions of Contract with anti-slavery and human trafficking policies and processes in place. All of our suppliers must comply with the provisions of the UK Modern Slavery Act (2015).

The Trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply.

Training

Advice and training about modern slavery and human trafficking, including how to identify and respond to concerns and how to report suspected cases of modern slavery, is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads.

We also provide additional, targeted training for members of staff who are likely to identify modern slavery concerns in the course of their work. If required, bespoke training is provided to teams who identify a need for further information and support.

Our performance indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if: no reports are received from our staff, the public or law enforcement agencies to indicate that modern slavery practices have been identified.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at the Board of Directors meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

Approval for this statement

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Derek Bell
Chair

Stacey Hunter
Chief Executive

June 2026

University Hospitals Tees

Documents executed under Seal - STHFT

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 5.2

Report author: Jackie White, Director of Corporate Affairs & Co Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs & Co Secretary

Action required: Information

Delegation status: Matter reserved to Unitary Board

Previously presented to:

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 NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required and a report of all sealing to be made to the Board of 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.

Seal No	Document	Signed and Sealed by
2026/010	Transfer of Title (TPI) and Deed of Indemnity for purchase of six residential plots, Hartburn Grange, Yarm Back Lane, Stockton on Tees, TS21 1AU. Value (1.4m) 1. Taylor Wimpey UK Limited (Seller) 2. North Tees and Hartlepool NHS Foundation Trust	Signed by: Stacey Hunter, CE Chris Hand, CFO Sealed by both trusts 31 March 2026
2026/011	Supplemental Agreement to a concession agreement dated 16 August 1999 in variation V08888	Stacey Hunter, CE Chris Hand, CFO Sealed 1 April 2026
2026/012	Members Agreement and Deed of Adherence in relation to North Tees and Hartlepool Solutions LLP appointing STHFT as a member to replace Northumbria Healthcare Facilities Management Limited. Transaction effective 31 March 2026 1. North Tees and Hartlepool NHS Foundation Trust 2. South Tees Hospitals NHS Foundation Trust 3. North Tees and Hartlepool Solutions LLP Deed of Adherence:	Signed 31 March 2026 by: Stacey Hunter, CE Chris Hand, CFO Retrospectively sealed by both trusts on 7 May 2026

	1. South Tees Hospitals NHS Foundation Trust 2. Northumbria Healthcare Facilities Management Limited 3. North Tees and Hartlepool NHS Foundation Trust 4. North Tees and Hartlepool Solutions LLP	
2026/013	Letter of Indemnity: Capital Works Variations V0915, V0916 and V0917 – MTHW (Medium Temperature Hot Water) to LTHW (Low Temperature Hot Water) Conversion Scheme Between: 1. South Tees Hospitals NHS Foundation Trust 2. Endeavour SCH Plc	Signed by: Stacey Hunter, CE Chris Hand, CFO Sealed 18 June 2026

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 documents were signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board of Directors are asked to note the documents executed under seal.

NHS
University Hospitals Tees

Audit Committee – South Tees

21 May 2026

Connecting to: Unitary Board of Directors

Chair of Committee: Ken Readshaw

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.

Registers reviewed. Progress in terms of coverage from 2024/25 position, but too many staff still choosing not to complete conflicts of interest and gifts and hospitality declarations. Agreed a 3rd email follow up and escalation processes instigated for a update in 6 months time. Overseen via Management Group.

Internal audit

Progress on implementing overdue outstanding actions has stalled. This exposes the organisation to risk. Resource being reallocated to increase oversight within Corporate Affairs.

Internal audit report on complaints received – High risk. There are weaknesses which need to be addressed via the action plan. Report to be considered in Management Team and QAC.

Internal audit report on Procurement – High risk. Contract management continues to be high risk and little has changed since the 2020 internal audit. The head of procurement

attended the meeting and explained the new processes to address the issues identified. New ways of working have been made possible by the group mode which will improve practice in this area. Management Team to review and audit to be considered by Resources & Performance Committee.

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

Terms of reference reviewed and aligned with North Tees & Hartlepool audit committee. Committee effectiveness report discussed

Draft annual reports and filings reviewed

Provider licence declaration approved

Good progress on external audit process. No issues at this stage

Internal audit

Internal audit report on healthcare acquired infections – Medium risk. Progress has been made in this area and some good practice identified. Report to be reviewed in Management Team and QAC.

Consideration was given to running the audit committees in common for part of the agenda, however it was decided not to do so at this stage. External audit advised that they had experience of a group that ran audit committees in common and encountered governance problems as it was not always clear which statutory organisation was getting the assurance from the agenda item

Recommendations:

The Board of Directors are asked to note the update.

NHS
University Hospitals Tees

Audit Committee – South Tees

19 June 2026

Connecting to: Unitary Board of Directors

Chair of Committee: Ken Readshaw

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.

External audit opinion - The significant weakness around value for money remains due to the 25/6 agreed deficit position.

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.

External audit

The audit completion report and auditors annual report were presented. The audit opinion is expected to be unqualified.

Caring Better Together

Internal audit

The internal audit annual report was presented. The head of internal audit opinion is reasonable/moderate assurance. This is an improvement on last year although the decision was finely balanced. The strength of BAF and risk management processes was a factor in the improved opinion.

Governance

The financial statements were approved

The annual governance statement was approved

The audit committee annual report was approved

The annual report was approved

For each of the four items above delegated authority was given to CH and KR to approve any minor changes required prior to submission.

Recommendations:

The Board of Directors are asked to note the update.

University Hospitals Tees

Modern Slavery and Human Trafficking Statement - NTHFT

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 6.1

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

Action required: Approval

Delegation status: Matter reserved to Unitary Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF 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.

To present the Modern Slavery and Human Trafficking Statement for 2026/27 to the Board of Directors for approval, in line with requirements of section 54 (1) of the Modern Slavery Act 2015.

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps the Trust and its subsidiary companies: North Tees and Hartlepool Solutions Limited Liability Partnership and Optimus Health Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within the business, subsidiary companies or supply chain during the year ending 31 March 2027.

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 Modern Slavery Act 2015 introduced changes in UK law, focused on increasing transparency in supply chains. Specifically, large businesses are now required to disclose the steps they have taken to ensure their business and supply chains are free from modern slavery, that is, slavery, servitude, forced and compulsory labour and human trafficking.

Commercial organisations that supply goods or services and have a minimum turnover of £36 million are required to produce a 'slavery and human trafficking statement' each financial year. This should set out the steps taken to ensure modern slavery is not taking place in the organisation's own business and its supply chains.

The Trust supports and has zero tolerance for slavery and human trafficking and is fully aware of its responsibilities towards service users, employees and local communities. There is an expectation that all the companies it does business with share and adhere to the same ethical values. The Trust has in place due diligence and internal policies and procedures that assess supplier risk in relation to the potential for modern slavery or human trafficking. It also operates a number of policies which support it in conducting business in an ethical manner, including recruitment and selection; equal opportunities and diversity; safeguarding; freedom to speak up; procurement; standards of business conduct; grievance and counter fraud, bribery and corruption.

The appended statement has been developed with input from a number of key stakeholders

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 statement requires approval at Board level, following which it will be published in a prominent place on the organisation's website and that of its subsidiary companies.

Recommendations:

The Board of Directors are asked to approve the Modern Slavery and Human Trafficking Statement for 2026/27.

Slavery and Human Trafficking Statement 2026/27

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that North Tees and Hartlepool NHS Foundation Trust and its subsidiary companies: North Tees and Hartlepool Solutions Limited Liability Partnership (NTH Solutions LLP) and Optimus Health Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business, subsidiary companies or supply chain during the year ending 31 March 2027.

Due to the scope of our business, North Tees and Hartlepool NHS Foundation Trust recognises that it may be at risk of modern slavery, which encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

About the organisation

North Tees and Hartlepool NHS Foundation Trust provides integrated hospital and community health services to a population of around 400,000 people in Stockton-on-Tees, Hartlepool and East Durham, including Sedgefield, Peterlee and Easington. Care is delivered from two main acute hospital sites, the University Hospital of Hartlepool and the University Hospital of North Tees in Stockton-on-Tees and a number of community facilities across the area including Peterlee Community Hospital and the One Life Centre, Hartlepool. The Trust provides bowel and breast screening services, as well as community dental services to a wider population in Teesside and Durham and employs approximately 5,500 medical, nursing, allied health professionals, clinical and non-clinical support staff with a total annual turnover of around £365 million.

The strategic objectives of the organisation are:

- Putting our population first
- Valuing People
- Transforming our services
- Health and Wellbeing

The Trust's Commitment

The Trust supports and is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect all the companies we do business with to share the same ethical values.

We also have an impartial Freedom to Speak up Guardian who supports staff to raise any concerns.

Due Diligence

We are committed to ensuring that:

- There is no modern slavery or human trafficking in our supply chains or in any part of our business and this includes our subsidiaries NTH Solutions LLP and Optimus Health Limited;
- Employment with the Trust and our suppliers is entirely voluntary;
- Our workplaces, and those of our subsidiaries and suppliers, are safe, healthy and free from discrimination or harassment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation, or any other characteristic that is protected by law;
- Corruption, in all its forms including extortion and bribery is prohibited;
- We have a number of policies which support us in conducting business in an ethical manner, including:
    - Recruitment and Selection Policy
    - Equal Opportunities and Diversity Policy
    - Adult Safeguarding Policy
    - Safeguarding Children Policy
    - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
    - Standards of Business Conduct Policy
    - Procurement Policy
    - Resolution Policy
    - Counter fraud, Bribery and Corruption Policy

All policies are reviewed to ensure they are working effectively every 3 years or earlier if relevant laws change or new evidence or guidance becomes available and they are available on the Trust's website www.nth.nhs.uk.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain, the Trust and its subsidiary companies operates and adheres to a robust recruitment process including compliance with the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references) and employ agency staff (where appropriate) from agencies on approved frameworks so that we are assured that pre-employment clearance has been obtained to safeguard against human trafficking or individuals being forced to work against their will. If there is not an available worker from a framework agency, this is escalated to senior managers and local pre-employment checks, including the right to work in the UK, are sought.

We adhere to the principles inherent within both our safeguarding children and adult's policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the Modern Slavery Network and the Vulnerable, Exploited, Missing, Trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

Our purchasing and procurement is governed by the new Procurement Act 2023, the NHS 'Supplier Code of Conduct' and standard NHS Terms & Conditions. The Procurement Act, which came into force in February 2025, strengthens the approach to tackle modern slavery in public procurement by introducing mandatory exclusion grounds and broader discretionary grounds for excluding suppliers. This means for suppliers found to be involved in modern slavery practices or connected to individuals convicted of such offences are more easily excluded from bidding on public contracts.

High value contracts are effectively managed and relationships built with suppliers through frameworks, which have been negotiated under the NHS Standard Terms and Conditions of Contract with anti-slavery and human trafficking policies and processes in place. All of our suppliers must comply with the provisions of the UK Modern Slavery Act (2015).

The Trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply.

Training

Advice and training about modern slavery and human trafficking, including how to identify and respond to concerns and how to report suspected cases of modern slavery, is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads.

We also provide additional, targeted training for members of staff who are likely to identify modern slavery concerns in the course of their work. If required, bespoke training is provided to teams who identify a need for further information and support.

Our performance indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if: no reports are received from our staff, the public or law enforcement agencies to indicate that modern slavery practices have been identified.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at the Board of Directors meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

Approval for this statement

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Derek Bell
Chair

Stacey Hunter
Chief Executive

June 2026

University Hospitals Tees

Documents executed under Seal - NTHFT

Meeting date: 2 July 2026

Reporting to: Board of Directors

Agenda item No: 6.2

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs & Co Secretary

Action required: Information

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 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 NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required and a report of all sealing to be made to the Board of 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.

Transfer of Title (TPI) and Deed of Indemnity for purchase of six residential plots, Hartburn Grange, Yarm Back Lane, Stockton on Tees, TS21 1AU. Value £1.4m 1. Taylor Wimpey UK Limited (Seller) 2. North Tees and Hartlepool NHS Foundation Trust	Signed by: Stacey Hunter, CE Chris Hand, CFO Sealed by both Trusts on 31 March 2026
Members Agreement and Deed of Adherence in relation to North Tees and Hartlepool Solutions LLP appointing STHFT as a member to replace Northumbria Healthcare Facilities Management Limited. Transaction effective 31 March 2026 1. North Tees and Hartlepool NHS Foundation Trust 2. South Tees Hospitals NHS Foundation Trust 3. North Tees and Hartlepool Solutions LLP Deed of Adherence: 1. South Tees Hospitals NHS Foundation Trust 2. Northumbria Healthcare Facilities Management Limited 3. North Tees and Hartlepool NHS Foundation Trust 4. North Tees and Hartlepool Solutions LLP	Signed 31 March 2026 by: Stacey Hunter, CE Chris Hand, CFO Retrospectively sealed by both trusts on 7 May 2026

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 document was signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board of Directors are to note the documents executed under seal.

NHS
University Hospitals Tees

Audit Committee – North Tees & Hartlepool

21 May 2026

Connecting to: Unitary Board of Directors

Chair of Committee: Ken Readshaw

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.

Registers reviewed. Progress in terms of coverage from 2024/25 position, but too many staff still choosing not to complete conflicts of interest and gifts and hospitality declarations. Agreed a 3rd email follow up and escalation processes instigated for a update in 6 months time. Overseen via Management Group.

Internal audit report on healthcare acquired infections – Reasonable assurance (Please note that Reasonable assurance is the second worse rating and aligns with High risk in the South Tees internal audit lexicon). As this report includes a high risk finding quality committee have been alerted. This will be considered in Management Group and QAC.

Caring Better Together

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

Terms of reference reviewed and aligned with South Tees audit committee. Committee effectiveness report discussed

Draft annual reports and filings reviewed

Provider licence declaration approved

Good progress on external audit process. No issues at this stage

Following the annual meetings with committee chairs and subsequent discussion at board a debate on negative and no assurance reporting took place. It was agreed that routes for committee chairs to report negative and no assurance should be developed, and the company secretary will do this.

Internal audit

The internal audit plan was approved

Recommendations:

The Board of Directors are asked to note the update.

NHS
University Hospitals Tees

Audit Committee - North Tees and Hartlepool

19 and 25 June 2026

Connecting to: Unitary Board of Directors

Chair of Committee: Ken Readshaw

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.

External audit - The audit completion report and auditors annual report were presented. The audit opinion is expected to be unqualified.

Internal audit - The internal audit annual report was presented. The head of internal audit opinion is good assurance. This is an the same as last year although the decision was finely balanced. The strength of BAF and risk management processes was a factor in maintaining the good assurance opinion.

Governance

The financial statements were approved

The annual governance statement was approved

The audit committee annual report was approved

The annual report was approved

For each of the four items above delegated authority was given to CH and CW to approve any minor changes required prior to submission.

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.

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 update on the annual filings as delegated to the Audit Committee.