NHS
University Hospitals Tees

Board of Directors Meeting

Thursday, 7 May 2026 at 13:00

Boardroom, 4th floor North Wing, University Hospital of North Tees

Caring Better Together

University Hospitals Tees

MEETING OF THE BOARD OF DIRECTORS
TO BE HELD IN PUBLIC
ON THURSDAY, 7 MAY 2026 AT 1:00PM
BOARDROOM, 4TH FLOOR, NORTH WING,
UNIVERSITY HOSPITAL NORTH TEES

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
1. CHAIR'S BUSINESS					
1.1	Welcome and Introductions	Information	Chair	Verbal	13:00
1.2	Apologies for Absence	Information	Chair	Verbal	13:00
1.3	Quorum and Declarations of Interest	Information	Chair	ENC	13:00
1.4	Minutes of the last meeting held on 5 March 2026	Approval	Chair	ENC	13:00
1.5	Matters Arising and Action Log	Information	Chair	ENC	13:05
1.6	Chair's Report	Information	Chair	ENC	13:10
1.7	Chief Executive's Report	Information	Chief Executive	ENC	13:20
1.8	UHT Management Team Chairs Log: 19 March & 23 April 2026	Information	Chief Executive	ENC	13:35
1.9	Board Assurance Framework	Assurance	Director of Assurance & Deputy MD	ENC	13:40
2. QUALITY AND SAFETY					
2.1	Quality Committee Chairs Log: 23 March & 27 April 2026	Assurance	Chair of Committee	ENC	13:50
2.2	Perinatal Quality and Safety Report Quarter 4: 2025/26	Assurance	Director of Midwifery	ENC	14:00

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

	ITEM	PURPOSE	LEAD	FORMAT	TIME
2.3	Perinatal Staffing Report Quarter 4: 2025/26	Assurance	Director of Midwifery	ENC	14:10
3. PEOPLE					
3.1	People Committee Chairs Log: 24 March & 28 April 2026	Assurance	Chair of Committee	ENC	14:20
3.2	Academic Committee Chairs Log: 19 March 2026	Assurance	Chair of Committee	ENC	14:30
3.3	NHS Staff Survey Overview 2025	Assurance	Deputy Director Education & Learning	ENC	14:40
3.4	Freedom to Speak Up End of Year Report: 2025/26	Assurance	FTSU Guardians	ENC	14:50
3.5	Nurse Safer Staffing Report	Assurance	Chief Nursing Officer	ENC	15:00
COMFORT BREAK 15:10 – 15:20					
4. FINANCE & PERFORMANCE					
4.1	Resources Committee Chairs Log: 25 March & 29 April 2026	Assurance	Chair of Committee	ENC	15:20
4.2	Finance Report Month 12: 2025/26	Assurance	Chief Finance Officer	ENC	15:30
4.3	Integrated Performance Report	Assurance	Managing Director	ENC	15:40
5. WELL LED					
5.1	Fit and Proper Person Framework Report: 2025/26	Approval	Director of Assurance & Deputy MD	ENC	15:50
6. SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
6.1	Going Concern Annual Accounts 2025/26	Approval	Chief Finance Officer	ENC	15:55

	ITEM	PURPOSE	LEAD	FORMAT	TIME
6.2	Audit & Risk Committee Chairs Log: 19 March 2026	Assurance	Chair of Committee	ENC	16:00
6.3	Audit & Risk Committee and Audit Committee Committee in Common Chairs Logs: 19 March & 24 March 2026	Assurance	Chair of Committee	ENC	16:05
7. NORTH TEES AND HARTLEPOOL NHS TRUST UNITARY BOARD					
7.1	Going Concern Annual Accounts 2025/26	Approval	Chief Finance Officer	ENC	16:10
7.2	Audit Committee Chairs Log: 19 March 2026	Assurance	Chair of Committee	ENC	16:15
7.3	Audit & Risk Committee and Audit Committee Committee in Common Chairs Logs: 19 March & 24 March 2026	Assurance	Chair of Committee	ENC	16:20
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Board of Directors will take place on Thursday 2 July 2026 in the Boardroom, James Cook University Hospital				

University Hospitals Tees

Register of members interests

Meeting date: 7 May 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.

UHT Board of Directors Register of Interests

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 2026	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
				Non-Executive Director, Leazes Homes
				Member of the Karbon Group Audit and Risk Committee, Karbon Homes
				Independent Member of the Audit and Risk Committee, Cumberland Council
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 Foundation 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
		14 August 2025	Ongoing	Director of Optimus Health Limited – Company Number 07415246
		1 October 2025	Ongoing	Chair on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		31 March 2026	Ongoing	Director of Seaton Delaval Sports Property Limited
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
			Ongoing	Wife is employed at South Tees NHS FT
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

Board Member	Position	Relevant Dates From	to	Declaration Details
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
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
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

Minutes of a meeting of the University Hospitals Tees Board held in Public at 1:00pm on Thursday, 5 March 2026 in Rooms 3&4 STRIVE, Friarage Hospital, Northallerton

Present:
Ali Wilson, Vice Chair/Non-Executive Director (Chair)
Ann Baxter, Vice Chair/Non-Executive Director & Maternity Champion
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, Chief Delivery Officer
Rachael Metcalf, Chief People Officer
Mike Stewart, Chief Medical Officer
Emma Nunez, Chief Nursing Officer & Maternity Champion

Directors – non-voting:
Steve Taylor, Director of Estates
Ken Anderson, Chief Information & Technology Officer
Ruth Dalton, Director of Communications
Stuart Irvine, Director of Risk, Assurance & Compliance
Jackie White, Director of Corporate Affairs/Company Secretary

In Attendance:
Sarah Hutt, Assistant Company Secretary (note taker)
Katie Tait, Chief Executive Officer, Horatio's Garden (item 1.1 only)
Hannah Lyonette, KPMG (observer)
Steph Worn, Director of Midwifery (Shadow Board observer)
Michelle Watson, Deputy Chief Operating Officer – Community (Shadow Board observer)

GB25/232 Horatio's Garden

Katie Tait, Chief Executive Officer of Horatio's Garden Charity shared the plans to install a garden at the James Cook University Hospital (JCUH) to support the rehabilitation of spinal injury patients, outlining the background to how and why the charity was first established, the benefits of the gardens and an overview of the other gardens already in existence across the UK. The garden for JCUH would be a courtyard garden with planning permission now granted. The cost for the garden was £1.67m, with £1.48m currently raised and further activities planned to raise the remaining funds so that construction could commence. It was noted that the Charity funded the cost of a gardener to maintain the garden, with other ongoing fundraising activities undertaken to support funds.

The presentation was well received with board members commending the work of the Charity and asking a wide range of questions.

The Chair thanked Katie for coming along to share the valuable work of Horatio's Garden and the plans for the garden at JCUH, which were very exciting.

GB25/233 Welcome and Introductions

The Chair welcomed members to the meeting, noting that Steph Worn, Director of Midwifery and Michelle Watson, Deputy Chief Operating Officer – Community, were participants in the recently established Shadow Board programme and were attending the meeting as observers. In addition, Celia Weldon, newly appointed Non-Executive Director was welcomed and Hannah Lyonette, KPMG, who was observing the meeting as part of the Continuous Improvement programme.

A formal thanks was placed on record to Ann Baxter, Non-Executive Director & Maternity Champion who would be stepping down on 31 March 2026 for her contribution to the Board and organisation during her period of office.

GB25/234 Apologies for Absence

Apologies for absence were reported from Professor Derek Bell, Chair, Professor Chris Day, Non-Executive Director and Alison Fellows, Non-Executive Director.

Resolved: that, the verbal update be noted.

GB25/235 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.

GB25/236 Minutes of the last meeting held on, 8 January 2026

The minutes of the last meeting held on, 8 January 2026 were accepted as a true and accurate record subject to a minor amendment.

Resolved: that, the minutes of the meeting held on, 8 January 2026 be confirmed as a true and accurate record subject to a minor amendment.

GB25/237 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.

Neil Atkinson, Chief Delivery Officer suggested that a proposal be brought to a future meeting regarding the Integrated Performance Report (IPR) being aligned to the UHT strategic objectives going forward instead of the Care Quality Commission (CQC) domains.

Resolved:
(i) that, the verbal update be noted; and
(ii) that, a proposal be brought to a future meeting regarding the alignment of the IPR against UHT strategic objectives rather than the CQC domains.

GB25/238 Chair's Report

The Chair presented the key points of the Chair's Report that included national, regional and local

matters.

- An induction event for newly elected Governors took place on 14 January 2026, which was well received, the evolving health landscape and the future role of Governors was discussed. Thanks to those involved.
- Thank-you to Angela Warnes, Lead Governor and Out of Area Governor for North Tees and Hartlepool NHS Foundation Trust (NTHFT) Council of Governors who had stepped down for her valuable contribution and support to the Trust and wider organisation during her term of office.
- The Board had been involved in the significant work around the development and submission of the organisation's annual planning arrangements and financial plan for 2026/27 onwards, including the establishment of a task and finish group and two Board Seminars on 4 December 2025 and 5 February 2026.
- A new Chief Delivery Officer, Russell Nightingale had been appointed and would commence in role in May 2026.
- A piece of artwork by acclaimed artist Mackenzie Thorpe was recently officially unveiled at the organisation. The artwork had been commissioned by Alice and Michael Miles to support families experiencing the loss of a baby, following the loss of their own son, Angelo.
- The first meeting of the Shadow Board chaired by Ann Baxter, Non-Executive Director had taken place on 3 March 2026, a total of 13 colleagues had been selected to take part in the aspirant programme. A number of board papers from the agenda for this board meeting had been chosen to be reviewed by individual Shadow Board members with their observations to be presented to the Shadow Board and the feedback to be shared with the Board. The papers selected for review included the Month 10: 2025/26 Finance Report and EPRR Annual Report 2025. Participants were invited to attend the public board meeting to observe and triangulate the discussion held at the Shadow Board on the chosen reports. The feedback on the reports would be shared at the respective agenda item. It was highlighted that a new chair for the Shadow Board would be appointed, as Ann Baxter, Non-Executive was stepping down on 31 March 2026.

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

GB25/239 Chief Executive's Report

Stacey Hunter, Chief Executive highlighted the key points of the Chief Executive's Report, noting some of the items under Advise were included in other reports on the agenda.

- Following the submission of the annual planning requirements and medium-term financial plan on 12 February 2026 which had been agreed by the Board, the organisation had been asked to review whether there was further scope to improve compliance against specific areas in the plan, which had been considered in detail at an extra ordinary meeting of the Board of Directors on 27 February 2026 prior to a revised submission being made on 2 March 2026. It was noted that improvements were reported in respect of RTT and cancer performance standards over the three-year plan and an improved financial position. The Chief Executive highlighted that following a call earlier that day with NHSE, organisation's plans which were not fully compliant with the Medium-Term Planning Framework were not being accepted and further review was expected.
- There was an issue with the supply of bone cement from the supplier Heraeus Medical used in knee replacements and other join replacements, with production temporarily halted at its main site, which could affect supply for 2 months. It was noted that business continuity plans had been put in place to manage day to day / emergency supplies, however, since the time of the report a further two suppliers had committed to provide sufficient supplies, which would support continuation of the elective programme.
- There had been a requirement for providers to complete a Board Capability Assessment against the six domains from the Insightful Provider Board framework – strategy, culture, leadership, quality and delivery etc. The response for each trust was agreed with the Board prior to

submission. Confirmation had been received that the rating for both trusts was amber green, reflecting strong governance foundations and increasing board maturity, with some further developed required in other areas. A consolidated improvement plan was being developed to address the development areas and ensure continued progress across the organisation.

The Chair sought an update regarding the Return to Constitutional Standards (RTCS) Capital bids that had been submitted. It was noted that the outcome was still unknown and the Chief Executive reported that it was likely more information would be requested from the national committee regarding the bids.

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

GB25/240 Chair's Log – UHT Management Team Meeting 22 January and 19 February 2026

The Chief Executive presented the Chair's Logs for the meetings of the UHT Management Team held on 22 January and 19 February 2026 for noting and provided an update regarding the Quarter 4 elective access sprints committed to for South Tees Hospitals NHS Foundation Trust (STHFT) to receive additional funding to support priorities in relation to delivery of the agreed recovery trajectory for RTT. Good progress had been made, however, at present were 1.5% short of the committed 5% improvement, with a continued focus maintained, prompting a brief discussion regarding the expectation placed upon organisations to respond quickly and be able to deliver whilst recognising that with the financial reset taking place across the NHS, the challenging ask on providers would continue.

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

GB25/241 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) to the period 31 December 2025.

For NTHFT:

- 30 strategic risks
- 9 strategic risks outside the approved risk appetite, with 6 red/high risks
- No change to risk appetite
- 6 timescale extension requests

For STHFT:

- 31 strategic risks
- 11 strategic risks outside the approved risk appetite, 7 red/high risks
- No change to risk appetite
- 3 timescale extension requests

The single UHT Risk Management Policy would be updated following the formation of the Clinical Service Units (CSUs) and would include the revised BAF reporting arrangements. This would be completed by 31 March 2026.

A Board Development session was scheduled to review the risk appetite for 2026/27, which would further strengthen the standardisation and consistency achieved during 2025/26, with the aim to transition towards reporting a single BAF reflective of each trust. It was noted that the internal audit on the BAF and Risk Management processes had commenced and was expected to be concluded by 31 March 2026.

Emma Nunez, Chief Nursing Officer provided an update regarding the operational risk scoring 25 on the STHFT Risk Register in relation to Neuroscience Services, which had been added to the Register when the Service had temporarily been stopped. There had been an upgrade to equipment and the Service had partially re-commenced with a view that it would be fully operational again by the end of March.

Ken Readshaw, Non-Executive Director & Chair of Audit & Risk Committee commended the reduction of the current risk score in relation to the Digital strategic risk 3 following completion of a number of actions relating to the PwC DSPT audit.

Matt Neligan, Deputy Chief Executive & Chief Strategy Officer sought clarity regarding the alignment of the BAF during 2026/27 to reflect the Continuous Improvement (CI) programme, which was confirmed would be undertaken as part of the annual refresh exercise.

David Redpath, Non-Executive Director sought assurance regarding whether the Board needed to be aware of any actions being taken in relation to cyber security following recent tensions in the Middle East that had escalated into cyber-attacks targeting various healthcare tech providers. Ken Anderson, Chief Information and Technology Officer confirmed a communication was going to be issued to remind staff of the risks, things to look out for and associated actions to ensure systems remained protected.

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

GB25/242 Quality Committee Chairs Logs 26 January and 23 February 2026

Fay Scullion, Non-Executive Director presented the Quality Committee (QAC) Chairs Logs for the meetings held on 26 January and 23 February 2026 highlighting the key points.

For January, under Alert, the Corridor Care and 72 Hours of the Acutely Unwell Adult Care Report was reviewed and highlighted that there were differences across the estate regarding corridor care being facilitated. It was noted that 15 standards had been developed to support the first 72 hours of care and whilst the organisation was striving to deliver good practice against the standards, more work was required to provide assurance. Work was ongoing to mitigate risks, noting a number of challenges were being faced.

From an Advise perspective, the Cancer Quality Report demonstrated a marked improvement in the Prostate pathway and a task and finish group had been established for Urology to support improvements across the pathways. However, it was noted that due to non-compliance against a number of the cancer targets, resulting in additional scrutiny as part of the tiering process, the Report was also highlighted under Alert.

For Assure, the Quality Accounts were 2025/26 were on-track to be published by the 30 June 2026 deadline.

In respect of the February meeting, under Alert an update was provided regarding the Pathology Service Accreditation Suspension and associated action plan. A priority action team approach had been implemented with weekly task and finish groups established. The impact to staff was highlighted, acknowledging that Pathology Services were entering into a period of significant change alongside undertaking the necessary work to regain accreditation.

STHFT were non-compliant against Maternity Incentive Scheme (MIS) Year 7 safety action 8 in relation to training uptake, reporting 88% compliance against a threshold of 90%. Immediate action had been taken and revised compliance of 96% was reported. NHS Resolution had advised they would support a recommendation to upgrade the outcome to full compliance. Notification of a decision regarding this and any financial impact was still awaited.

In Quarter 3, there was a reported increase of 15.5% in complaints received at stages 1-5 and a significant increase of 16% for stage 1 complaints. This remained an area of Alert for the Committee and an update was provided regarding the actions being taken, noting a standardisation of the policy and processes across the two trusts, highlighting that during the process of standardisation a further increase may be seen prior to any reductions. Weekly oversight remained in place.

The Integrated Performance Report (IPR) continued to highlight a rise in infection rates across the organisation, an update regarding the focused actions being taken was provided, with the Infection Prevention Control (IPC) team targeting specific hot-spot areas and ensuring patients being admitted

were tested. The IPC dashboard was now in place to assist monitoring and oversight and it had been requested that in addition to the quarterly IPC Report, a monthly top-level report was presented. It was noted that estate challenges at NTHFT continued to impact the provision of dedicated decant facilities.

In relation to Advise, due to resource issues within the Mortality Review team, there were significant delays in the learning from deaths (LFD) reviews being undertaken, however, it was noted that the Summary Hospital-level Mortality Indicator (SHMI) values were 'as expected' for both trusts.

For Assure, it was positive to note that there had been an increase in the number of reported organ donations across both trusts, it was also highlighted that following a site visit during the Council of Governors meeting held at STHFT, there was positive feedback regarding the service and perceived culture within the team.

Miriam Davidson, Non-Executive Director & Maternity Champion highlighted that the interim findings had been published following the independent investigation into maternity and neonatal services led by Baroness Valerie Amos, which identified six main areas of concern: capacity pressures, culture & leadership, racism, lack of accountability, poor estate conditions and staffing levels. A National Maternity and Neonatal Taskforce had been established to implement changes and locally, the organisation would review the information. It was noted that both trusts had Maternity Voice Partnership Chairs, who were assisting with seeking the views of service users in order to help shape the maternity services across University Hospitals Tees (UHT) going forward.

Stacey Hunter, Chief Executive reported that a letter had been received from Sarah-Jane Marsh, National Priority Programme Director, Urgent and Emergency Care, NHS England regarding corridor care following work undertaken with the Corridor Care Coalition and setting out a number of actions. A review of the actions would be undertaken and any material findings would be reported to Board in advance of the next meeting. It was noted that the Quality Committee had already received a report on Corridor Care which would be triangulated with the letter. A copy of the letter would be circulated to the Board for information.

Ann Baxter, Non-Executive Director provided challenge regarding the month-on-month alert in respect of IPC and sought to understand whether the Quality Assurance Committee were assured that sufficient actions were being taken, prompting discussion with a number of factors outlined. The reporting of infections had improved and the antimicrobial stewardship measures introduced were having a positive impact. However, it was highlighted, that there was a continuing increase in the number of patients coming into hospital with infections rather than being hospital acquired and there were variations across the trusts regarding screening protocols. In addition, there were operational and estates challenges to manage including the redeployment of staff to meet safe staffing requirements, which could increase the risk of spreading infections, as well as not having decant facilities at NTHFT to facilitate the deep cleaning of affected areas. Mike Stewart, Chief Medical Officer suggested a development session be arranged regarding IPC. Ken Readshaw, Non-Executive Director agreed this would be a good opportunity to also review the risk appetite in relation to quality.

Resolved:
(i) that, the content of the report be noted;
(ii) that, the letter from Sarah-Jane Marsh, National Priority Programme Director, Urgent and Emergency Care regarding corridor care be circulated to the Board for information; and
(iii) that, a board development deep dive session be arranged regarding IPC.

GB25/243 Perinatal Quality and Safety Report Quarter 3: 2025/26

Steph Worn, Director of Midwifery presented the Perinatal Quality and Safety Report Quarter 3: 2025/26 and highlighted the key points.

Under Alert, NHS Resolution Maternity Incentive Scheme (MIS) year 7, STHFT declared non-compliance for safety action 8 in relation to the uptake of training for midwifery staff, reporting at 88% against the threshold of 90% within the reporting period. However, action was taken immediately and

the position rectified with a revised compliance rate of 96% by January 2026. As this was a marginal difference, NHS Resolution had informed an upgrade to full compliance would be considered, accounting for compliance with all other safety actions. The outcome to this was awaited and it was unknown what financial impact there would be for STHFT. Both sites were working together to share resources in respect of training.

For Advise, NTHFT was reporting an improvement in its crude stillbirth rate as well as an increase in breast feeding rates. For STHFT, there was a marginal increase in crude stillbirth and neonatal death rates, which were both being monitored closely and a deep review for thematic learning was planned. All cases were subject to multidisciplinary team (MDT) review and no concerns had been raised regarding the care.

It was noted that following STHFT hosting an NENC Local Maternity and Neonatal System (LMNS) assurance visit, positive interim feedback had been received. A planned review would focus on the identified estates issues.

An improvement plan had been developed in response to the national request to review homebirth services, there were no safety gaps identified, however, a cohesive UHT approach was outlined as part of the plan and workforce modelling was in development to support on-call protected time whilst minimising disruption to community caseload and care delivery. A national steering group had been established to provide Homebirth framework and standards. The intrapartum service at the University Hospital Hartlepool (UHH) had been suspended in May 2025 due to workforce pressures and there had been an inconsistent provision at the birthing centre at the Friarage Hospital Northallerton (FHN) due to workforce pressures and acuity at the JCUH site. It was planned for the service at UHH to be reinstated in the summer. The Director of Midwifery highlighted that the outcome of the Amos review into maternity and neonatal services included six key areas of concern that may influence future plans for the UHT service.

For Assure, confirmation had been received that the Maternity Safety Support Plan for NTHFT had concluded and ongoing oversight would be with the Board and executive leadership. At STHFT, a targeted six-month support programme had commenced under the new Maternity and Neonatal Improvement Support Team framework.

Miriam Davidson, Non-Executive Director & Maternity Champion sought clarity regarding the timescales relating to the implementation of a new model of working for the UHT Maternity Services, highlighting that the current closure of the Rowan Suite at UHH had been raised in the recent Council of Governors meeting prompting a detailed discussion. Emma Nunez, Chief Nursing Officer explained that given the national focus on maternity services and the requirement for proactive engagement it was important to understand the needs of the population. This could take additional time, however, work was ongoing with the Communications and Maternity teams as well involvement of the MVP to engage with the local population to co-design a new offer as well as internally developing a new staffing model. As an aside, work remained ongoing to resolve operational and estates challenges where possible. An initial date for the re-opening of the Rowan Suite at UHH had been suggested, however, there may be a requirement to triangulate further in relation to choice around birthing options and national guidance, which may impact on the re-opening date. Matt Neligan, Deputy Chief Executive & Chief Strategy Officer sought to understand whether there was data available to demonstrate choice and where mothers deliver which may help with the proposals and rationale for service change.

Fay Scullion, Non-Executive Director shared some positive feedback from a student midwife who had thoroughly enjoyed her placement at UHNT, she had found all the midwives to be supportive and the training had been above and beyond her expectations, which was positive to note.

The Director of Midwifery placed on record thanks to Ann Baxter, Non-Executive Director & Midwifery Champion for her support in achieving the exit from the Maternity Safety Support Programme for NTHFT.

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

GB25/244 Perinatal Staffing Report Quarter 3: 2025/26

Steph Worn, Director of Midwifery presented the Perinatal Staffing Report Quarter 3: 2025/26 and highlighted the key points.

There were no items for Alert, for Advise Obstetric lead job planning was in development to support a UHT approach where appropriate.

In relation to Birth Rate+ requirements, in the event of a midwifery red flag event, the labour ward coordinator alongside the obstetric consultant determined the appropriate action to maintain safety. The Birth Rate+ reassessment options appraisal would be shared once developed.

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

GB25/245 People Committee Chairs Logs 27 January and 24 February 2026

Mark Dias, Non-Executive Director presented the People Committee Chairs Logs for the meetings held on 27 January and 24 February 2026 and took the report as read.

Under Alert, sickness absence remained off-trajectory and significantly above the level to achieve the 1% reduction target set for 2025/26. The impact of sickness absence across safe staffing, financial controls and operational delivery was recognised.

Regarding triangulation with the submission of the annual planning requirements and medium-term financial plan, Mark advised that the Committee had requested strengthened and prospective assurance following feedback from NHSE identifying a significant gap between planned WTE and financial targets, with assurance required throughout the workforce planning and financial-modelling cycling rather than retrospectively.

The GMC Survey Report demonstrated a deterioration in the trainer survey ranking for both trusts. The Committee expressed concern that the report could indicate that the formation of the UHT group structure and associated changes may be reflected in the results.

Regarding Mandatory Training, compliance remained below the 90% threshold, with the areas of most clinical risk being Resuscitation (72.56%) and Moving & Handling (81.02%). Variation in training cycles between sites was contributing to persistent gaps. Resuscitation training had been escalated to Quality Assurance Committee for oversight.

In respect of the Locum Consultant governance risk within confines of L2P, the Committee was assured with the planned actions to address this identified risk.

For Advise, current race and disciplinary cases were discussed at the Committee for oversight, noting the ongoing monitoring of case progression and outcomes for assurance. The Gender Pay Gap Reports were formally approved for both trusts.

In relation to Assure, the final Talent Management Plan was endorsed and the associated BAF action was formally closed. The Committee noted the positive cultural improvement work within Maternity. An anti-racism charter has been developed, with Board training planned and affinity groups being established to support inclusive cultural change.

A Recognition IMPACT Framework had been developed, responding directly to staff feedback and to support cultural improvement. The Committee sought assurance that the management of poor performance was being applied consistently and proportionately alongside the framework.

There were three areas for escalation and consideration by the Board:

1. The Board were asked to consider a more cultural and performance-based assessment in respect of the underlying causes of sickness absence, which remained a significant and sustained

organisational risk. Stacey Hunter, Chief Executive reported that it had been requested at the Financial Recovery Oversight Group (FROG) for a plan to be developed to support a different approach to tackling sickness absence, once agreed, the plan could be shared with Committee and Board.

2. Taking feedback from the recent Council of Governors meeting regarding appraisal compliance rates, it was identified that there remained a close link between performance, culture and continuous improvement and the Board were asked to consider whether the management of poor performance was sufficiently robust and consistently applied to shape the cultural expectations required for sustained improvement and supported managers to have difficult conversations with staff. The Chief Executive suggested that the Chief People Officer enquire through the Chief People Officer network to commence a piece of work regionally regarding how to reduce the burden of mandatory training. It was noted that there was a national piece of work in progress, however could potentially take longer than would want for an outcome. Secondly, it was important to note that work was ongoing about how to do things in an entirely different way and identifying required leadership behaviours as part of setting the culture through the Continuous Improvement work.

3.The Board to think about Group decisions and the disparity of each trust report. A broader risk within the group operating model where regulatory and process-driven reporting requirements could create structural imbalances in how performance was presented, which could result in one site or statutory body appearing to be comparatively underperforming. The Chief Executive suggested to explore as a Board the root and cause in a development session and in the meantime understand the effect to make sure it was being monitored.

Ann Baxter, Non-Executive Director & Maternity Champion suggested that each Committee could track when there was an issue, highlighting that it had been a shock in People Committee to discover that trainee doctors were required to be placed either in NTHFT or STHFT and not cross-site, which would be an issue for horizontal integration. Mike Stewart, Chief Medical Officer reported that notification had been received from the GMC that from 1 April 2026, the trusts would be treated as a single group, which was a positive development.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the plan detailing actions to tackle sickness absence being developed for FROG to be shared with Board and Committee; and
(iii) that, 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.

Comfort break restart 3:15pm

GB25/246 Nurse Safer Staffing Report

Emma Nunez, Chief Nursing Officer presented the Monthly Nurse Safer Staffing Report for the period December 2025 and highlighted the key points, which had also been picked up through the Chairs Logs. Members were reminded that the Care Hours Per Patient Day (CHPPD) per ward area set out staffing levels in relation to patient numbers and highlighted variances in compliance along with the mitigating actions undertaken, providing visibility of safe staffing. There were some changes to processes across teams particularly in relation to sickness management and redeployment to avoid recourse to bank and agency staff where possible.

Stacey Hunter, Chief Executive highlighted that as part of organisational engagement around the planning requirements was the need for organisations to reduce headcount and to live within allocated resource, which understandably made staff including front line teams anxious.

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

GB25/247 Safer Staffing Bi-Annual Establishment Review – STHFT

Emma Nunez, Chief Nursing Officer presented the Bi-Annual Establishment Review for STHFT and highlighted the key points, noting a report had historically been presented for NTHFT.

The report highlighted any variance between current budgeted establishments, actual staffing levels, the recommended safer staffing tool and the professional judgement assessments applied. Work had commenced to gather joint data in order to support a collective safe staffing report going forward to be able to address gaps in registered and non-registered staffing for UHT as a whole with mitigation and balance applied.

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

GB25/248 Guardian of Safe Working Report

Mike Stewart, Chief Medical Officer presented the Guardian of Safe Working Report for both trusts for the period 1 November 2025 and 31 January 2026 and highlighted the key points. There were three exception reports (ERs) marked as Immediate Safety Concerns (ISC) for NTHT and none for STHFT. The ISCs were mainly in relation to work intensity, staffing levels and working patterns/rest. Going forward overtime and breach data would be reviewed alongside rota reviews to ensure workloads were accurately reflected in rota design.

It was noted that recent enhancements to the ER system would improve the capturing of data and a modest increase in reporting was expected following the national changes to improving working lives as part of the Improving Resident Doctors Working Lives (IRDWL)10-point plan and the work internally to encourage more reporting. Strong compliance with the code of practice and national terms and conditions was reported, with auditable cost centres now in place strengthening compliance with ER reforms.

Ann Baxter, Non-Executive Director & Maternity Champion reported that as part of discussion in Shadow Board two questions had been posed regarding industrial action and benchmarking with other trusts. The Chief Medical Officer explained that the information was dependent upon rotas and specialties and the reliance on doctors to submit reports. In respect of industrial action amongst resident doctors, this was driven nationally and was not a matter for local employers and highlighted that the organisation had been invited to take part in some filming to support a national piece of work regarding the Improving Resident Doctors Working Lives (IRDWL)10-point plan, which was very positive and reflective of the work to date. Stacey Hunter, Chief Executive endorsed the excellent work of the CMO and team.

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

GB25/249 Equality Delivery System Annual Report 2025/26

Rachael Metcalf, Chief People Officer presented the Equality Delivery System (EDS) Annual Report 2025/26 for UHT, which comprised three separate domains covering patient services, workforce and leadership, highlighting that trusts were required to publish the EDS rating on its website.

To support continued EDS improvement, there was a Workforce EDI Action Plan and a Health Inequalities Programme aligned to the six High Impact Actions. An EDI and High Impact workforce dashboard was being developed, which would provide insight into workforce challenges and how staff could be supported.

Each year three service areas were selected for a deep dive, for 2025/26 these included Urology, Endoscopy and Paediatric Services (NTHFT) / Children and Young Person Emergency Department (STHFT). The individual scores for each domain were outlined:
Domain 1: 3 achieving, 1 developing
Domain 2: 3 achieving, 1 developing
Domain 3: 3 achieving

The overall score was 20 points, which was a rating of Developing. It was highlighted that recommending the organisation as a place to work and receive treatment had only scored one point, in addition to patients being free from harm when using services, noting that a wide range of factors were considered through feedback as part of the assessment including IPC, complaints, nutrition and noise, prompting discussion.

Ann Baxter, Non-Executive Director & Maternity Champion reported that the discussion at Shadow Board in relation to this report was around identifying which items were being presented to Board for approval or assurance, prompting discussion and recognising the balance between what is required to be presented from an accountability perspective and areas that require Board focus.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Equality Delivery System Annual Report 2025/26 ratings be noted.

GB25/250 Resources Committee Chairs Logs 28 January and 25 February 2026

David Redpath, Non-Executive Director provided a verbal update regarding the Resources Committee Chairs Log for the meeting held on 28 January 2026, which had included an extensive discussion regarding the planning submission for 2026/27 and highlighted that chairmanship of the Committee had transferred to Celia Weldon for the February meeting.

Celia Weldon, Non-Executive Director presented the Chairs Log for the meeting held on 25 February 2026 and highlighted the key points, noting some of the items had already been discussed on the agenda:

- Received a paper regarding productivity focusing on the areas performing in the lower quartile and actions being taken to improve performance as well as opportunities across both trusts, noting that compared to other trusts in region, the organisation benchmarked well with NTHFT having the lowest opportunity and STHFT the second lowest, which was positive.
- The IPR was presented with a focus on the areas graded as Alert, for NTHFT cancer 62-day pathway, 12-hour ED breaches, RTT incomplete pathways and RTT time to first appointment and for STHFT Diagnostic 6-week standard, RTT incomplete pathways and RTT time to first appointment. There was discussion highlighting that the focus of the Resources Committee needed to be at least equal between finance and performance going forward.
- The Month 10: 2025/26 reported financial position was a deficit of £9.9m, which was a favourable variance of £19k against the year-to-date plan.
- An update was provided regarding the revised annual submission of the medium-term financial plan, noting a £4m improvement in year 1 and improved position against RTT and cancer standards.
- CIP reported year to date delivery was £58.2m, which was 98% of the target, noting the forecasted position to achieve the £73.1m target at year-end, however, it was highlighted that the position was supported by a number of non-recurrent measures. The CSUs were behind target for 2025/26 and work was ongoing to prepare their plans for 2026/27.
- The Emergency Preparedness Resilience and Response (EPRR) annual report 2025 and compliance against the core standards 2025/26 were presented.
- An update was provided regarding the UHT Estates Strategy, with an issue highlighted regarding three missing landlord assurance letters from NHS Property Services (NHSPS) in relation to STHFT.
- An update regarding Sustainability was presented.

Triangulation to the People Committee was noted in respect of wider training issues highlighted in a number of the reports.

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

GB25/251 Finance Report: Month 10, 2025/26

Chris Hand, Chief Finance Officer presented the Finance Report for Month 10: 2025/26 and highlighted the key issues.

A deficit of £9.9m for the Group was reported, which was a favourable variance of £19K against the year-to-date plan, with a plan for the 2025/26 financial year to deliver an overall deficit control total of £9.1m, a break-even plan for NTHFT and a £9.1m deficit plan for STHFT (including an allocation of £11.5m ICS deficit support for STHFT). The reported position included over-performance of ERF income of £5.9m and additional non-recurrent measures. The organisation received a fair share allocation of national pressures funding for industrial action totalling £2.9m, which had reduced the risk relating to ERF income assumptions.

There was a continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTEs and expenditure run-rates throughout the remainder of the financial year to ensure delivery of the financial control total.

Deficit support funding had been confirmed and received up to and including Quarter 4, based on the ICS overall position at Month 8, which had contributed to a stronger cash flow position for STHFT for the remainder of 2025-26 and meant that an application to access revenue cash support was no longer required.

Reductions in temporary staffing and premium pay costs were a national priority set by NHSE, with the 2025/26 planning guidance requiring reducing agency spend by at least 30% from the prior year and to reduce bank spend by at least 10%. At Month 10, agency spend was reported at £1.6m (21% less) and bank spend £3.5m (13% less) than that incurred at the same point in the previous year (adjusted for inflation). Focus remained regarding workforce growth, with an overall net decrease of 53.39 WTE reported.

Capital expenditure for the Group to the end of Month 10 amounted to £40.2m, which was a slippage of £6.7m against the phasing of the 2025/26 year to date plan, largely relating to Salix grant and PDC funded schemes at STHFT. The cash balance was £71.2m for the Group and the continued strong cash balance supported good compliance with the Better Payment Practice Code for both trusts.

Ann Baxter, Non-Executive Director & Maternity Champion reported that the Finance Report had been discussed at Shadow Board with an interesting discussion as to whether it was reflecting a positive or negative position, prompting a brief discussion particularly around the context of reporting an improved position in some areas compared to performance in previous years, however still short of what was required in the current challenging financial landscape.

The Chair thanked the Chief Finance Officer and team for achievement of the current financial position and acknowledged the work of David Redpath, Non-Executive whilst chair of Resources Committee.

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

GB25/252 Integrated Performance Report

Neil Atkinson, Chief Delivery Officer presented the Integrated Performance Report (IPR) for the reporting period to 31 December 2025 and highlighted the key points not already discussed in earlier agenda items.

In respect of items in the Alert category, there were seven metrics remaining for NTHFT, four related to HCAIs, breast feeding at first feed, cancer 62-day standard and sickness absence. Ongoing collaboration with County Durham and Darlington NHS Foundation Trust (CDDFT) in support of the breast pathway was impacting on compliance and support continued to be provided by NHSE as part of tiering on certain pathways. Three metrics had been regraded to Alert from Advise in relation to 12-hour ED breaches rate, RTT incomplete pathways and RTT time for first appointment.

For STHFT. There were seven metrics remaining in the Alert category, HCAI, breast feeding at first feed,

diagnostic 6-week standard, RTT time to first appointment, sickness absence and mandatory training. In addition, four metrics had been regraded to Alert from Advise, in relation to a never event, HCAI, post-partum haemorrhage (PPH) and complaints closed within target.

It was important to note that the majority of the metrics remained graded as Advise for both trusts.

Progress of the monthly performance review meetings with the CSUs was shared with a continued focus on RTT and cancer standards, highlighting agreed actions could be shared with Resources Committee to provide assurance and oversight.

Matt Neligan, Deputy Chief Executive & Chief Strategy Officer sought to understand whether for any of the items graded as Alert, a different approach was required to improve performance or was sufficient progress being made. The Chief Delivery Officer explained that the report highlighted which areas required further discussion at Committee and Board and could prompt a deep dive for those metrics where there had been sustained underperformance to ensure the correct actions were being taken.

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

GB25/253 Emergency Preparedness Resilience and Response (EPRR) Annual Report

Neil Atkinson, Chief Delivery Officer presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025 and statements of compliance 2025/26, highlighting the process was based upon a self-assessment declaration, which had been shared with the ICB for oversight and agreement.

A statement of partial compliance was being declared for both trusts, with a programme of work in place to address the gaps identified by the assessments, however, it was noted that the partial compliance declaration did not impact on the ability of the organisation to respond to incidents and was reflective of the position of a number of organisations across the NENC region.

Ann Baxter, Non-Executive Director & Maternity Champion reported that discussion at Shadow Board highlighted consideration of what information was presented at Board and what was presented in other forums to obtain context, prompting a brief discussion. It was explained that the information had been fully discussed at Resources Committee, with a portion of information relating to the self-assessment reserved for discussion at private board earlier that day due to its nature, however, it was agreed that this be reviewed to ensure an appropriate amount of information was presented to public Board to support discussion and decision making, which had also been raised in relation to another item on the private board agenda.

It was highlighted that business continuity across UHT was being reviewed to establish a single approach with a single team supporting horizontal integration and would consider the output of the national resilience review.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, consideration be given regarding the appropriate amount of information to be presented to public board meetings to support discussion compared to information reserved for private board.

South Tees Hospital NHS Trust Unitary Board

GB25/254 Audit & Risk Committee Chairs Log: 29 January 2026

Ken Readshaw, Non-Executive Director presented the Audit and Risk Committee Chairs Log for the meeting held on 29 January 2026, highlighting under Alert, a review of the decision log for Board had been undertaken and it was identified that three items presented to a previous meeting were on the incorrect section of the agenda. It was noted there was no change to the agreed decisions, however, the items would be presented for ratification by the unitary board of each trust at the next meeting. It was positive to note the strengthening of the overall governance process for Board.

In addition, it was planned to apply similar control to the Council of Governors decision log.

In relation to Advise, the counter fraud risks were to be transferred to the operational risk register, following a change in requirements. It was noted that a number of tolerated risks had been identified on the risk register, which would be discussed with the Chief Finance Officer and reviewed at 6,9- and 12-months intervals.

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

GB25/255 Annual Filings

Jackie White, Director of Corporate Affairs / Company Secretary presented the Annual Filings Update, advising that the submission timetable for the annual filings had been published by NHS England (NHSE), and the final submission date for the Trust's Annual Report and Accounts was 26 June 2026.

Draft Group Accounting Manual (GAM) guidance had been issued by NHSE and the Department of Health and Social Care (DHSC) and a number of amendments to the Trust's accounting policies had made accordingly.

The Trust's external auditors, Mazars would undertake the audit of the 2025-26 Annual Report and Accounts, Quality Report and Annual Governance Statement. The Board were asked to delegate authority to the Audit and Risk Committee and the Quality and Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, delegated authority be granted to the Audit and Risk Committee and Quality Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

GB25/256 Use of Seal Report

Jackie White, Director of Corporate Affairs/Company Secretary presented the Use of Seal Report to seek retrospective approval for the items executed under seal, which was agreed.

It was suggested for future reports, that the Board be provided with information relating to the value of the contract and how the decision was reached be recorded.

Resolved: that, retrospective approval be granted for the items executed under seal and that in future that the Board be provided with information relating to the value of the contract and how the decision was reached be recorded.

North Tees and Hartlepool NHS Trust Unitary Board

GB25/257 Audit Committee Chairs Log: 29 January 2026

Ken Readshaw, Non-Executive Director presented the Audit Committee Chairs Log from the meeting held on 29 January 2026 and highlighted the same items for Alert as the Audit and Risk Committee Chairs Log.

A review of the Board decision log had been undertaken and it was identified that three items presented at previous meetings were on the incorrect section of the agenda. It was noted there was no change to the agreed decisions, however, the items would be presented at the next meeting for ratification by the unitary board of each trust. It was positive to note the strengthening of the overall governance process for Board.

In addition, it was planned to apply similar control to the Council of Governors decision log.

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

GB25/258 Annual Filings

Jackie White, Director of Corporate Affairs / Company Secretary presented the Annual Filings Update, advising that the submission timetable for the annual filings had been published by NHS England (NHSE), and the final submission date for the Trust's Annual Report and Accounts was 26 June 2026.

It was noted that draft guidance had been issued by NHSE and the Department of Health and Social Care (DHSC) as outlined in the Group Accounting Manual (GAM) guidance and a number of amendments to the Trust's accounting policies had been made accordingly.

The Trust's newly appointed external auditors, Mazars would undertake the audit of the 2025-26 Annual Report and Accounts, Quality Report and Annual Governance Statement. The Board were asked to delegate authority to the Audit Committee and the Quality and Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

Resolved: (i) that, the content of the report be noted; and
(ii) that, delegated authority be granted to the Audit Committee and Quality Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

GB25/259 Use of Seal Report

Jackie White, Director of Corporate Affairs/Company Secretary presented the Use of Seal Report to seek retrospective approval for the items executed under seal, which was agreed.

Resolved: that, retrospective approval be granted for the items executed under seal and that in future that the Board be provided with information relating to the value of the contract and how the decision was reached be recorded.

GB25/260 Any Other Business

There was no any other business reported. The Chair sought reflection from members regarding the meeting. It was suggested that for future agendas that comfort breaks be considered to help refocus and recharge.

GB25/261 Date of Next Meeting

The next meeting of the Board of Directors will take place on Thursday 7 May 2026 in the Boardroom, University Hospital North Tees.

Meeting closed: 4:25pm

Signed:  Date: 7 May 2026

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.	
05 March 2026	GB25/242	***Quality Committee Chairs Logs 26 January and 23 February 2026*** The letter received from Sarah-Jane Marsh, National Priority Programme Director, Urgent and Emergency Care, NHS England regarding corridor care to be shared with the Board for information	Mike Stewart Emma Nunez Jackie White	02 April 2026	Open	A letter had been received from Sarah-Jane Marsh, National Priority Programme Director, Urgent and Emergency Care, NHS England regarding corridor care following work undertaken with the Corridor Care Coalition which set out a number of actions. A review of the actions was being undertaken and it was agreed to share a copy of the letter with the Board for information.	
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	Open	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. It was suggested it would be useful to have a board development session deep dive into IPC and it was noted that it was on the schedule for 2026/27 for June.	
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	Open	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.	
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	04 June 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 hold a development session to explore the causes.	

University Hospitals Tees

Chair's Report

Meeting date: 7 May 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: (select from the drop-down list for why the report is being received)
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 Regional meetings

I attended the Foundation Trust Chairs meeting on 21 April 2026, we discussed the initial outcomes from the Aubrey learning event, which was held on 20 April 2026, well led reviews and received an update on the Alliance nested collaborative.

In terms of well led, University Hospitals Tees has agreed to undertake a developmental well led review in the Autum of 2026. The Director of Corporate Affairs is leading the procurement process which should go live in the next couple of months.

I accompanied the Chief Executive and a number of Director colleagues to a regional learning event on the Aubrey review. It was pleasing to hear the open and transparent conversations from the Chair and CEO of County Durham and Darlington FT and their experience and plans. We discussed in the room what we can do as a region to learn from their experience. At todays in committee meeting the Board discussed the learning event and an internal review of the findings undertaken by UHT and in June we will spend some board development time looking at this in more detail.

The CEO and myself attended a NENY regional meeting attended by Sir Jim Mackey and Elizabeth O'Mahony. This outlined the financial and performance parameters for the NENC and England and highlighted some of the local challenges which we hope to work collaboratively with to resolve.

3.2 Governors

An extra ordinary meeting of the Council of Governors for North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust was held on 30 April 2026. We discussed the final medium financial plan submission, the progress of appointing new non-executive directors and the process and timetable for appointing the NTH Lead governor.

On 20 May 2026, the Council of Governors will meet in common to discuss the national position regarding governors and what an alternative model might look like in order that we can feed into the national considerations our thoughts. Thank you to Healthwatch who will be supporting us with the session.

3.4 Board development / seminar

Board seminars on cyber security, fraud, Patient Safety Response Framework and PFI expiry. The Board have welcomed the opportunity to receive presentations from the Clinical service units outlining their strategy and implementation plans.

3.5 Board Capability Assessment

As mentioned at our last meeting the Provider capability ratings have now been published and can be access here: Home - NHS England Digital. Both Trusts within UHT were rated as amber green.

3.6 NEDs

I would like to put in writing my thanks to Ann Baxter, Vice Chair and Non-Executive Director who chaired the last public board meeting whilst I was on leave, and for her 6 years' service to UHT and previously North Tees & Hartlepool NHS Trust. Ann was instrumental in supporting the two Trusts on their journey to group status and support to me over that time and she will be extremely missed Also thanks to Alison Fellows, Non-Executive Director who has stood down from the Board.

Myself and Ali Wilson, Vice Chair have started our programme of appraisals within the Non-Executive Directors which should conclude by the end of May. The output of the meetings will be fed into the Nomination Committee meeting for governor assurance.

3.7 Other business

Volunteer steering group – I attended meeting on 1 April 2026, joint meeting of the two volunteer teams across UHT – discussed volunteer drivers and investment in volunteers' status across UHT.

Arts Council – significant amount of work being undertaken across UHT. Covid memorial will be unveiled at Friarage and James Cook during May.

Charity – working closely together this year and have funded £150k of projects to support patients and staff across UHT.

Derek Bell
Chairman

University Hospitals Tees

Chief Executive's Report

Meeting date: 7 May 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 Board will be aware that we have now agreed our 26/27 plans with NHS England for both trusts. The details of this have been shared with all Board members. The focus now is on firming up all of the delivery plans to meet the activity, performance, quality and financial requirements set out in the plans.

From a financial perspective both trusts delivered on the 25/26 plans which is excellent and thanks owed to all of our colleagues who secured this. As Board members will be aware whilst there is an on-going need to increase the level of recurrent savings year on year colleagues achieved more recurrent savings over the period than in previous years.

The Board will discuss the outputs and reflections following consideration of the Aubrey review at our in-committee 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.

The Board will recall I raised concern about the progress South Tees were making in relation to the Elective Sprint activities in quarter 4. I am pleased to report that the teams made much better progress during March and have exceeded 65% for RTT and delivered on the other specific measures we signed up for.

Board members will want to note that whilst there is further to go with cancer performance (which is detailed through our future plans) overall South Tees were the 14th most improved trust in England for 62-day cancer performance.

We continue to work with teams to get our activity plans, performance plans and our CIP plans for 26/27 to completion. This is work in progress and Board colleagues will know the challenging nature of some of the improvements required is significant.

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

My thanks to all of our teams for managing the latest round of resident doctor industrial action which took place over the Easter Holiday period. This was the 15th time resident doctors have been on strike and I am grateful to colleagues who continue to cover the gaps and to teams for maintaining their focus on elective activity and urgent work during the strikes. At the time of writing this report no further strike action has been announced

Recommendations:

The Board of Directors are asked to note the report.

Caring
Better
Together

Chief Executive's Report
Board of Directors
Thursday, 7 May 2026

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 5 March 2026.

2. National Priorities

2.1. Return To Constitutional Standards (RTCS) Capital bids (Funding - FY26/27, 27/28 and 28/29)

In addition to local operational capital CDEL allocations, trusts are able to bid for further national PDC capital funding that is available over the next 4 financial years to support the NHS to return to delivery of constitutional standards. The Group submitted a number of bids to NHSE and has now received confirmation that smaller bids totalling £2.7m have been approved, and that larger multi-year bids totalling £24.4m have also been supported to progress to the next stage (which requires submission of business cases before the end of May). If successful, these capital bids will enable the group to purchase diagnostic and medical equipment and undertake improvements to the estate over the next four years, to support delivery of the activity and performance trajectories in the Medium-Term Plan.

2.2. Industrial Action Update

The latest round of industrial action taken by resident doctors occurred from the 7th to the 13th of April, immediately after the Easter holiday weekend. Partly as a result of the holiday period, there were only 7 working days from the industrial action being announced to prepare for this. As with previous rounds, our senior leadership teams worked at pace to put safe arrangements for cover in place and as a result no patient safety concerns were raised during the industrial action. Whilst most clinical activity was maintained, including all urgent surgery and cancer care, regrettably some patients did have their outpatient appointments or elective surgery postponed and we will reschedule this work as quickly as possible.

Unfortunately, there is a risk of further industrial action, with no immediate path to resolution of this dispute.

The BMA have now also announced plans to ballot consultants and SAS doctors on industrial action over continued concerns about pay and conditions, which will run from 11th May to 6th July.

2.3. Stockton Neighbourhood Health Pilot – Update

Stockton is one of 43 national neighbourhood health pilot sites, focusing initially on people aged 50–64 with three or more long-term conditions in Stockton Central and Portrack. An Integrated Neighbourhood Multidisciplinary Team (INMT) has been operating since

January 2026, meeting fortnightly and bringing together primary care, community, mental health, social care and voluntary sector partners to test new models of case finding, care planning and patient engagement. Data collection aligned to the national evaluation has been completed, and early learning is informing service refinement. A partner workshop in May 2026 will agree plans to scale the approach across the Borough. Stockton has also been selected as a national incubator site for neighbourhood health digital tools, with development underway. In parallel, work is commencing to develop a Neighbourhood Health Centre model and business case focused on Stockton Town Centre, aligned with the Pride in Place regeneration programme.

2.4. NHS Leadership Event – Tuesday 28 April 2026

A meeting of trust and ICB Chief Executives, primary care leaders and the NHS England national and regional teams took place on 28 April. National leaders thanked colleagues across the NHS for all of the work and achievements in 2025/26 and flagged priorities for action in 2026/27 including transforming outpatients, ensuring urgent care is delivered conveniently for patients and developing neighbourhood health services. The group heard updates on the development of the NHS Leadership and Management Academy and the imminent National Quality Strategy. Breakout sessions focused on local ambitions to transform the interface between primary and secondary care that can helpfully inform action across local systems in 2026/27.

3. Regional Update

3.1. Integrated Care Board Regional Update

NHS England have appointed Bill McCarthy as regional chair for North East and Yorkshire. Bill was most recently interim chair of Greater Manchester Mental Health FT, and previously a director at regional, national and trust levels in the NHS. We look forward to developing our working relationship with Bill, Fiona Edwards and the wider regional team as they take on refreshed responsibility for assurance under the NHS “Model Region” approach.

Our integrated care board (ICB) colleagues in both North East and North Cumbria (NENC) and in Humber and North Yorkshire (HNY) are also moving to revised delivery arrangements as they evolve to their primary strategic commissioning function in line with the “Model ICB” approach. We thank those colleagues affected by these changes and in particular Dave Gallagher who has recently retired from his previous role as Chief Contracting and Procurement Officer and who has been a consistent supporter and ally of our work across UHT. We have worked with ICB partners in developing new governance arrangements that take on the previous function of ICB place committees to ensure alignment of partners locally in our shared agenda.

3.2. NENC Provider Collaborative Leadership Board (PLB)

The provider collaborative agreed the priorities for 26/27 within a reduced resources envelope aligned to the overall economic requirements across the NHS.
The programmes of work are all refreshing the workplans with nothing of significance to report to the Board this month.

3.3. NENC CEO System Leaders

NENC CEO System Leaders meeting took place on Friday 17th April to consider the ask from Jim Mackey's letter of 1st April, specifically how we build our strategic commissioning narratives to describe better how, as commissioners and providers, we intend to do this together. Emma Nunez represented me at this meeting as I was on leave. The discussion centred on 4 areas of focus:

- Strategic commissioning in our local system and how we intend to develop it over the next 3 years
- Our intentions and plans around development of neighbourhood care
- Consideration of any changes required to payment systems and financial flows, and what they are
- Any central NHSE support required to accelerate the pace of change

A proposed plan was agreed to work together on this between now and the 15th May when details will need to be submitted to NHSE.

3.4. Provider Capability Ratings

NHS England has recently published provider capability ratings for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust as part of the NHS Oversight Framework. South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust has been assessed as amber green. These ratings, alongside performance segmentation, directly inform the level and focus of regional oversight and improvement support. Both Trusts are working closely with the ICB and NHS England to address identified development areas and to demonstrate sustained improvement in governance, leadership and delivery.

3.5. Aubrey Report

A True for us look back review was undertaken across University Hospitals Tees setting out our organisational response to the findings of the independent Aubrey Review and the learning that is relevant across the UHT. The review confirms that strong governance arrangements are in place and independently assessed as effective. It also identifies areas where further strengthening is required, particularly in quality assurance, risk triangulation and contract oversight. A clear and focused programme of improvement is underway to address these gaps. The Board will continue to receive assurance that actions are embedded and delivering sustained improvements in safety, culture and accountability.

The Chairman, myself and a number of Executive colleagues attended a regional ICB learning event this month focused on the findings of the Aubrey Review. The event included shared learning from the Chair and Chief Executive of County Durham and Darlington NHS Foundation Trust following their review of issues arising from the breast screening incident. The Board will reflect on the learning from this event at a future Board development session.

4. Local update

4.1. UHT Fuller Compliance Exercise

A compliance exercise has been completed across University Hospitals Tees to assess compliance with the recommendations set out in the Fuller Phase 1 (2022) and Phase 2 (2023) reports, for recommendations which are applicable to NHS trusts. The exercise confirms the level of compliance against Fuller recommendations and an action plan and timescales to lead to full compliance, which will be reported on a 6 monthly basis going forward. The findings of the compliance exercise, including detailed gap analysis and proposed actions to support continued compliance with the Fuller recommendations, are being progressed through University Hospitals Tees established governance and assurance processes and will be presented in Public Board once these processes have been completed.

4.2. Quality Performance Reviews

The latest series of Quality & Performance Review (QPR) meetings took place in March 2026, following the introduction of Clinical Service Units from 1st November 2025. QPR meetings are based on six key headings (Quality & Safety; People; Performance; Productivity & Efficiency; Finance & CIP; Strategy & Service Development) and are an essential component of the Accountability Framework, which supports the delivery of the strategic objectives of University Hospitals Tees. Key themes from the meetings related to the ongoing work of our Clinical Service Units to shape the future delivery of our services and a focus operating within allocated resources. Meetings continue to take place monthly with clear escalation processes in place.

4.3. New Appointments

This month we welcome Russell Nightingale to University Hospital Tees as our Chief Delivery Officer. He joins us from Harrogate and District NHS Foundation Trust. Russell will play an integral role in our transformation work, and in delivering operational performance. We recently appointed Rob Armstrong who is currently a Deputy Chief Operating Officer to our vacant Chief Operating Officer role. This role is pivotal to the Chief Delivery Officers role supporting the Clinical Service Units to deliver and it is helpful to have attracted a high calibre individual. We are waiting confirmation of Rob's start date which is likely to July 2026.

Neil Atkinson will step into the role of Managing Director, with a focus on recovery in line with our financial and planning targets, with particular focus on the PFI contracts within the group. Neil will be supported by Stuart Irvine in his capacity as Deputy Managing Director and Director of Assurance.

4.4. Pre-Election Period

We have been working to ensure that we are continuing to apply the guidance of the pre-election period across University Hospitals Tees. There are elections set to take place across England on 7 May 2026. For University Hospitals Tees we have a local election taking place in Hartlepool.

5. In other news!

5.1. Urgent Care Treatment Centre Friarage

The Urgent Treatment Centre (UTC) at the Friarage Hospital recently celebrated six years of providing round-the-clock care for patients with minor illnesses and injuries, serving communities across North Yorkshire and beyond.

Since it opened in 2020 it has become a lifeline for local residents who wanted to be cared for without having to travel far away to either Middlesbrough or Darlington.

Patients using the service have shared their stories, calling it “exceptional” and praising the “compassionate care”.

5.2. Digital Skills Development Network

The Digital Skills Development Network, which promotes leadership, professional development and best practice across the NHS, awarded University Hospitals Tees the DDaT Team – Automation and Efficiency Award, recognising the value and impact of a new digital patient wellness questionnaire.

5.3. Health Professional Research Fellowship Award

Alice Franklin, Senior Specialist Physiotherapist, was awarded a Tessa Jowell Allied Health Professionals (AHP) Research Fellowship, the UK’s first national programme dedicated to AHP-led research in neuro-oncology.

Established by the Tessa Jowell Brain Cancer Mission (TJBCM) with investment from the National Institute for Health and Care Research (NIHR) in June 2025, the fellowships mark a pivotal step in strengthening brain tumour care across the UK.

5.4. One Stop Hospital Clinics

Melissa McKie and Val Cross, Advanced Breast Nurse Practitioners, recently achieved new qualifications and have outlined the vital role they play within one-stop clinics, giving patients a range of diagnosis and support in a single hospital visit. delivering same-day diagnosis, evaluation and support for women presenting with breast concerns.

Melissa and Val support a busy one stop service providing rapid, same-day diagnosis and evaluation for women who present with breast concerns.

5.5. Aspiring Health Care Workers

The University Hospital of Hartlepool recently welcomed in aspiring healthcare workers as part of a special career event, open to the children and families of University Hospitals Tees staff.

The event was held at the hospital’s Health and Social Care Academy. It saw 60 children and young people turn up to find out about different careers in the NHS – from emergency care to physiotherapy, and more.

6. Conclusion

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

University Hospitals Tees

Chair's Log of UHT Management Team Assurance Meeting – 19 March 2026

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 1.8

Report author: Stacey Hunter, CEO 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:

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

Key discussion points and matters to be escalated from the meeting

Financial Position for UHT (Planning)

I presented an update on the Trust's financial and performance position, drawing on the recent report from Simon Worthington and subsequent engagement with regional partners. The update highlighted the scale of current financial pressures, including the impact of non-recurrent commissioner funding, the need to strengthen cost improvement delivery, and the importance of restoring performance across both trusts. Both myself and the Chair met with the Regional Team to agree further actions required to support compliance with the financial plan, following which an updated plan has been developed, supported by specialty-level summaries to drive operational grip. Workforce changes form a key component of the plan, including a planned reduction in headcount. Ongoing discussions with the ICB, regional and national teams have resulted in further mitigations being explored, reducing the forecast deficit and clarifying the support required to move the organisation towards financial sustainability.

Quality Performance Review Meetings

The Managing Director provided an update on the next round of Quality Performance Review (QPR) meetings, highlighting ongoing work to strengthen the effectiveness of the process. This includes tailoring data packs to individual CSUs, improving the timeliness of workforce and performance data, and ensuring appropriate Executive attendance. Changes are being considered to improve meeting focus and efficiency, including refinements to structure, duration and etiquette, with a clearer emphasis on accountability and high-quality discussion. It was confirmed that actions arising from QPR are being followed through via existing operational and assurance routes, and that the process will continue to evolve to incorporate corporate teams and relevant subsidiaries. Opportunities to further strengthen alignment between QPR, the planning round and Board assurance were also noted.

CSU Escalations

Assurance provided regarding the recent cyber-attack, noting that the organisation responded effectively and that further measures have since been implemented to strengthen cyber resilience.

An update was also provided on delays to children's booster vaccinations following recent scheduling changes; appropriate teams are reviewing the position, with work underway to understand the causes and any potential impact.

NHS Oversight Framework

The recent the publication of the NHS Oversight Framework (NOF) Quarter 3 outcomes, confirmed that North Tees has retained Segment 1 status and improved its national ranking, while South Tees remains in Segment 3 due to the agreed deficit plan but has significantly improved its league table position.

Strategy Progress

The Chief Strategy Officer presented a progress update on the delivery of the Trust's strategy,

highlighting the development of 1-, 3- and 5-year CSU plans aligned to the overarching UHT strategy and the recent planning round submission. A portfolio of Priority 1 and Priority 2 strategic change projects has now been identified across CSUs, with early planning completed for a number of Priority 1 schemes. While good progress has been made, further work is required to strengthen data, confirm milestones and responsibilities, and ensure alignment between CSU proposals and centrally set efficiency and planning assumptions.

Green Plan

An update was provided on the progress against the Trust's Green Plan, highlighting findings from a recent external audit on waste management. The audit identified opportunities to improve waste segregation in line with NHS England requirements, with associated financial and environmental benefits. Actions are being taken forward, including the delivery of further staff training and targeted support where required. An update was also provided on NEAS's modernisation of its ambulance fleet, including the introduction of electric vehicles and the installation of charging infrastructure at the North Tees site, with no financial impact for the Trust.

Business Case Development

Work is underway to review quality governance arrangements and consider whether resources can be reallocated to strengthen compliance, with escalation to the Quality Committee or inclusion on the Board Assurance Framework if required. Operational pressures were also noted in relation to elective capacity and theatre utilisation, including emerging risks associated with the use of emergency and obstetric theatres and rising workforce costs. Further work is progressing to review workforce deployment, theatre governance and resource alignment to ensure services remain safe, sustainable and within agreed financial parameters.

Recommendations:

The Board 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: 23 April 2026

Reporting to: Board of Directors

Agenda item No: 1.8.1

Report author: Stacey Hunter, CEO 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:

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

Key discussion points and matters to be escalated from the meeting

Quality Performance Review Meetings

The Quality Performance Review (QPR) Escalation Report provided an overview of QPR meetings held over the past three months, highlighting continued improvements in focus, effectiveness and use of time. The review confirmed that CSUs are generally well prepared, demonstrating a growing knowledge and understanding of their directorates. There is further work for them to do in respect of being clear about their delivery plans for key performance, quality and financial targets. As would be expected the progress is differential across the CSUs which our Executive Tri (CMO, CNO and CDO) can observe and continue to target challenge and support as part of the development of the target operating model.

Ongoing themes include the need to strengthen corporate data, particularly workforce and performance information, improve Integrated Performance Reporting, and ensure reporting is tailored to CSU needs. Work is underway through the Business Intelligence and workforce teams to address these issues. The importance of timely, robust and live information—particularly a live Patient Tracking List—was emphasised as critical to effective operational management, with further work planned to align quality metrics, performance data and improvement trajectories within QPR reporting packs. There was a challenge to all to ensure that we didn't just focus on the process for QPR but we moved into ensuring delivery of key priorities in each CSU. This will require further focus and clarity from the directorate and CSU teams on what actions they are taking and what further support they need with regards delivery of their plans.

Outcome of the Strategic Sense Check Panel re UHT Reconfiguration Letter

The Trust received a formal letter from NHS England confirming the outcome of the Strategic Sense Check Panel in relation to the UHT Reconfiguration proposals. The panel recognised the scale and urgency of the challenges facing UHT, including estate, workforce, financial sustainability and health inequalities, and acknowledged the progress made towards an integrated group model. The letter provides early regional feedback and sets out a clear list of requirements to inform the development of the Pre-Consultation Business Case, highlighting the need for significant further work across areas such as demand management, consultation scope, inter-site transfers, capital dependency, workforce modelling, financial alignment, population health impacts and patient access.

Business Case Process

The business case process has been reviewed and the new proposal for a joint process includes refreshing and standardising documentation across UHT, aligning life-cycle processes and aligning approval limits. In developing proposals for the new UHT process, learnings from the good practice in the individual site processes has been adopted. One amendment to the proposals was agreed which was to route business cases via the Clinical Strategy Council so they can be discussed and endorsed or otherwise prior to coming to Group Management or Board for a decision.

Business Cases

The Radiography Business Case for CSU 6 was revisited following earlier consideration, where concerns had been raised regarding the level of investment requested and the likelihood of funding being secured through Specialised Commissioning. Further work has now been completed to refine staffing numbers and headroom assumptions. It was noted that the business case is complex due to the introduction of a new tariff, which is clearly articulated within the document. Both the tariff correction and additional capacity funding are supported and aligned with the expectations of Specialised Commissioning, and clarification was also provided in relation to staff headcount. This is subject to final confirmation from spec comm and if this is secured it will enable significant progress to be made over the coming months with our radiotherapy waiting times for patients. The benefits of this to patients experiences and to our cancer performance will be positive.

The UHT Fertility Services Business Case (CSU 1) was re-presented to the meeting following earlier discussion in February, at which time it was agreed that the fertility hub would need to be relocated. The purpose of the discussion was to determine a preferred relocation site, recognising the ICB's advice that location is a critical consideration. It was also noted that the option to decommission the service has now been formally included within the business case. The group determined that:

1) Further work needed to be done to ensure the service can cover its costs
2) It is strategically important to us that we continue to be able to offer Reproductive Medicine
3) The case set out two potential sites for the interventional aspects of this service (hub) and emphasised that all other elements of the pathway should be offered as locally as feasible across the patch. I will ask the CSO to provide an update to this in our in-committee session in May.

PFI Strategy Update

An update was provided on the PFI Strategy and Hand Back following the April Board session, which provided some key outcomes. Internal discussions have since taken place to assess the organisation's position over the next six years, leading to the identification of three priority workstreams covering BUA, PFI hand back and the estates capital programme. Going forward the team will be working closely with the Strategy Group to ensure alignment across all areas of work. The group recognise the importance of this work and requested that regular updates are provided.

Recommendations:

The Board 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

Board Assurance Framework Report 2025/26 (reporting to 28th February 2026) NTHFT/STHFT

Meeting date: 7th May 2026

Reporting to: Board of Directors

Agenda item No: 1.10

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

Executive director sponsor: Director of Assurance/Deputy Managing Director

Action required:
Assurance

Delegation status: Matter reserved to Unitary Board

Previously presented to: UHT Management Team (23rd April 2026)

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All sections of the Board Assurance Framework for each Trust.

Key discussion points and matters to be escalated from the meeting

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

Headlines

NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 9 strategic risks are outside of approved risk appetite, of which there are 6 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 86 planned mitigating actions within the BAF across the 8 domains.
- There are 4 reported completed actions (3 Trust Estate and 1 R&I).
- There is 1 action timescale extension request (P&C).
- Planned action timescale range – December 2025 – April 2035 (includes eradicating RAAC by 2035).

STHFT

- There are 31 strategic risks identified relating to South Tees Hospitals 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 88 planned mitigating actions within the BAF across the 8 domains.
- There are no reported completed actions.
- There is 1 action timescale extension requests (R&I).
- Planned action timescale range is December 2025 – April 2035 (this includes planned timescales linked to PFI exit strategy, 2033 and eradicating RAAC, 2035).

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

BAF Reporting 2026/27

As part of the continuous review of BAF reporting, with effect from 1st April 2026, the BAF will be reported against the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). Work has commenced to complete this transition.

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 to 31st May 2026 pending the refresh of the BAF for 2026/27.

Risk Appetite

A Board Development Session is planned in Q1 of 2026 to review and approve the risk appetite for 2026/27, in advance of the annual refresh of the Board Assurance Framework. The refresh exercise will further strengthen the standardisation and consistency that has been achieved during 2025/26 with the aim to transitioning towards reporting a single Board Assurance Framework, which is reflective of each Trust.

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

The internal audit on Board Assurance Framework and Risk Management processes has commenced and will conclude in April 2026. The assurance level and findings will be reported in due course.

Recommendations:

Board of Directors are asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 28th February 2026.
- Note the 6 red/high strategic risks for NTHFT and 7 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the ongoing work to refresh the BAF 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 28th February 2026)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 6 red/high strategic risks are outside of approved risk appetite (no change). • One step from approved risk appetite. • 86 planned mitigating actions. • 4 reported completed actions (3 Trust Estate, 1 R&I). • No changes to current risk scores. • 1 action timescale extension requests (P&C). • 1 new mitigating action (P&C). • Planned action timescale range – December 2025 – April 2035.	• 31 identified strategic risks. • 7 red/high strategic risks are outside of approved risk appetite (no change). • One step from approved risk appetite. • 88 planned mitigating actions. • No reported completed actions. • No changes to current risk scores. • 1 action timescale extension requests (1 R&I). • No new mitigating actions. • Planned action timescale range – December 2025 – April 2035.

1. Background

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

2. Purpose

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

3. Report Detail

BAF Arrangements

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

BAF Format

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

The strategic risks are linked to a BAF domain, which reflects key areas of our business/activity and enables an understanding of the nature of the risk.

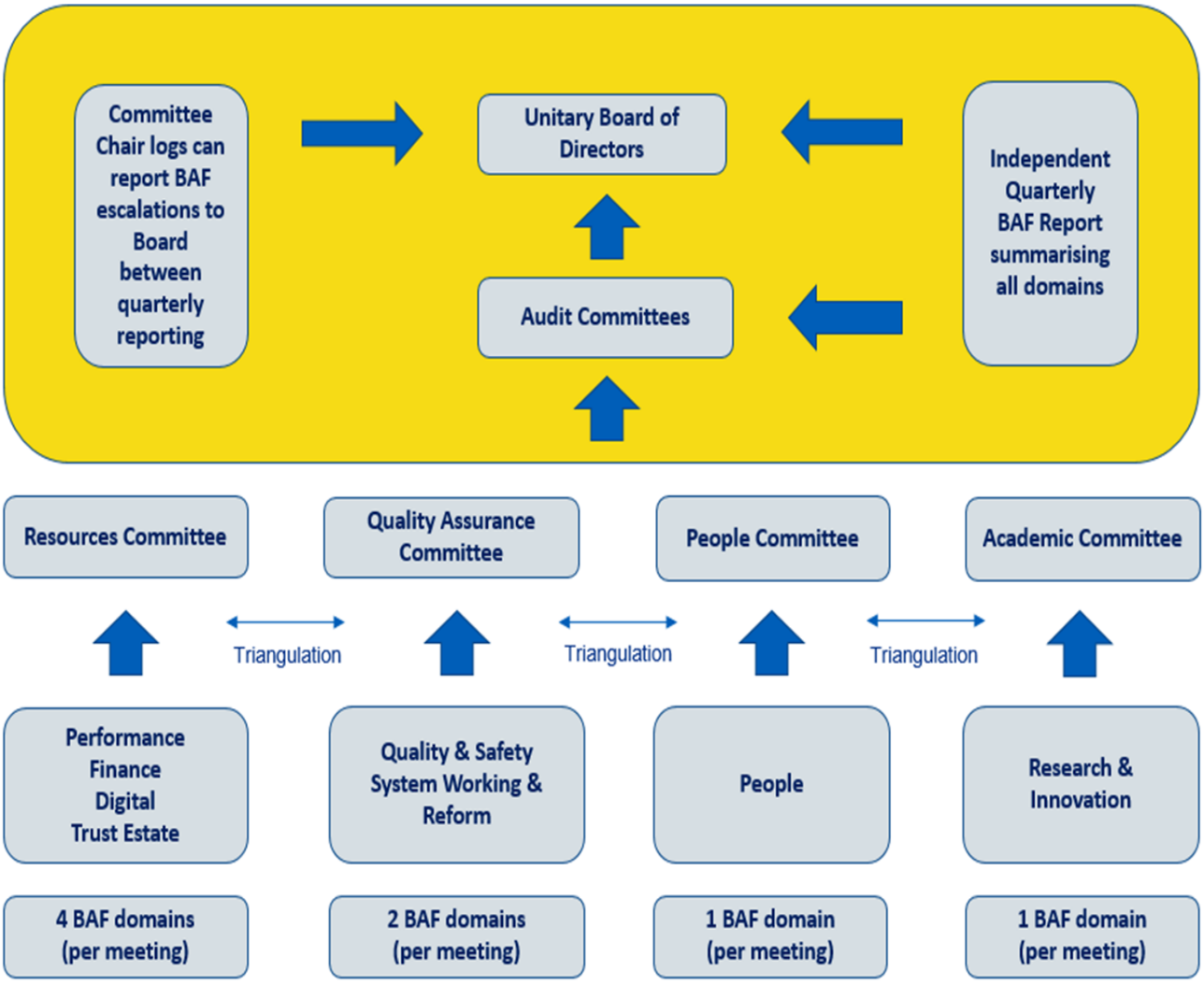
There are 8 BAF domains for each Trust. The BAF domains are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

The 8 BAF domains for each Trust are 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 is aligned to at least one BAF domain to support the delivery of strategic objectives. The BAF domain template require the BAF domain to be linked to at least one strategic objective. The mapping of BAF domains to strategic objectives for 2025/26 has been presented to the Board that confirms the strategic risks are linked to the BAF and are relevant for each organisation.

Risk Appetite

The approved risk appetites for the BAF domains for each Trust are set out in this report and reflecting the increased risk environment and challenges to deliver annual plans.

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

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

Risk Appetite Supporting Statements

The approved risk appetites and supporting risk appetite statements of each Trust are consistent. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by domain and supporting risk appetite statement. This maintains existing governance arrangements and ensures compliance with good governance requirements. Risk appetite is formally reviewed on an annual basis by the Board and an annual Board seminar on risk appetite is held. Attached at **Appendix A** is the approved risk appetite supporting statements.

Strategic Risk Score Analysis

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

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Quality & Safety	3	3	**3**	**3**	1	1	8	8
Performance & Compliance	3	4	0	**2**	0	1	9	8
Digital	4	4	0	0	0	0	16	7
People	4	4	0	0	0	0	9	9
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	5	15
System Working & Reform	2	2	0	0	0	0	22	22
Research & Innovation	5	5	**2**	**2**	1	1	12	14
Total Number	**30**	**31**	**9**	**10**			**86**	**88**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 9 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is December 2025 – April 2035.	• The Trust has 31 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 December 2025 – April 2035.

Included in the planned timescales are the actions linked to PFI exit strategy (2033 - STHFT) and eradicating RAAC (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 6 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
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**	3	Academic Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
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 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 7 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

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

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Innovation growth is limited by investment and resource constraints	Research & Innovation	**5 x 3 = 15**	2	Academic Committee
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.	Research & Innovation	**5 x 4 = 20**	3	Academic Committee

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

Trust Operational Risks/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 the newly formed UHT Risk Management Group, which replaces two separate meetings.

BAF Reporting 2026/27

As part of the continuous review of BAF reporting, with effect from 1st April 2026, the BAF will be reported against the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). Work has commenced to complete this transition.

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 to 31st May 2026 pending the refresh of the BAF for 2026/27.

External Assurance

The internal audit on Board Assurance Framework and Risk Management processes has commenced and will conclude in April 2026. The assurance level and findings will be reported in due course.

Risk Appetite

A Board Development Session is planned in Q1 of 2026 to review and approve the risk appetite for 2026/27, in advance of the annual refresh of the Board Assurance Framework. The refresh exercise will further strengthen the standardisation and consistency that has been achieved during 2025/26 with the aim to transitioning towards reporting a single Board Assurance Framework, which is reflective of each Trust.

4. Conclusion/Summary

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

- The requirement to maintain separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF domains to the relevant Group strategic objectives.
- Approved risk appetites for each BAF domain and supporting statement for 2025/26.
- The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.
- Board Committees have full oversight of the BAF report, in additional to the oversight responsibility allocation for BAF domains. A copy of the full BAF report for each Trust is placed in the Reading Library of each Committee and Board.
- Board Committees to escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Escalation Reports.
- The medium/long term strategy/plan that each BAF domain is linking/referencing strategic risks e.g. UHT Strategy, Quality Priorities, People Plan etc.
- Ensuring strategic risks in each BAF domain are strategic in nature (they may run beyond a 12-month period).
- Ensure mitigating planned actions are strategic and will either maintain a current risk score or achieve a target risk score.
- Review of linked operational risks to ensure they are they up to date and linked to strategic risks. Work in this area remains ongoing.
- The learning from internal audit report findings.
- The reported position of 30 strategic risks relating to NTHFT and there are 6 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- The reported position of 31 strategic risks relating to STHFT 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.
- 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

Board of Directors are asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 28th February 2026.
- Note the 6 red/high strategic risks for NTHFT and 7 red/high strategic risks for STHFT and the planned mitigating actions.
- Note the ongoing work to refresh the BAF 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

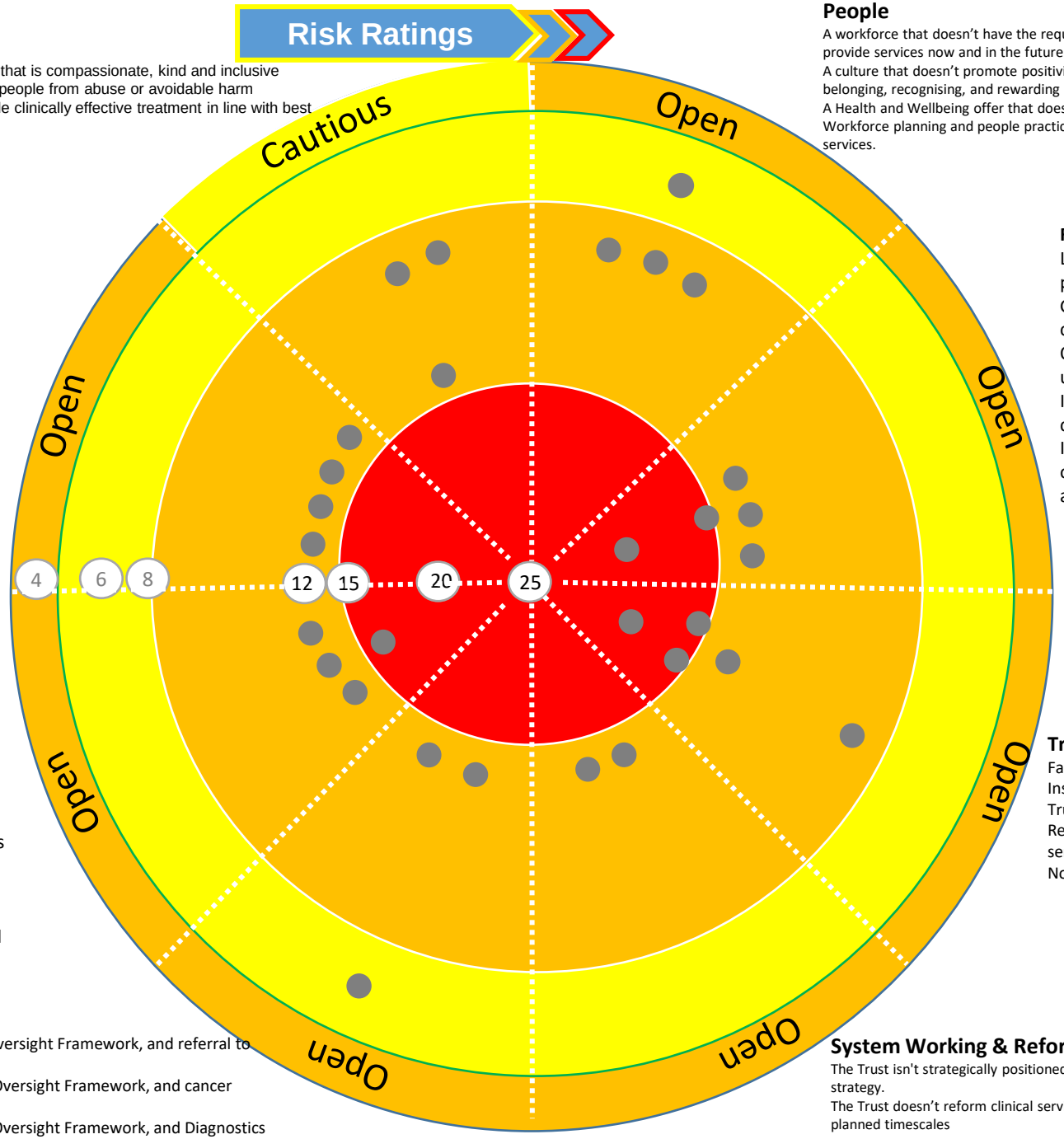
Quality & Safety	Digital	People	Finance	Performance and Compliance	System Working & Reform	Trust Estate	Research & Innovation
Patient safety – Failure to protect people from abuse or avoidable harm	Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and 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

28th February 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

NHS South Tees Hospitals NHS Foundation Trust

Quality & Safety

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

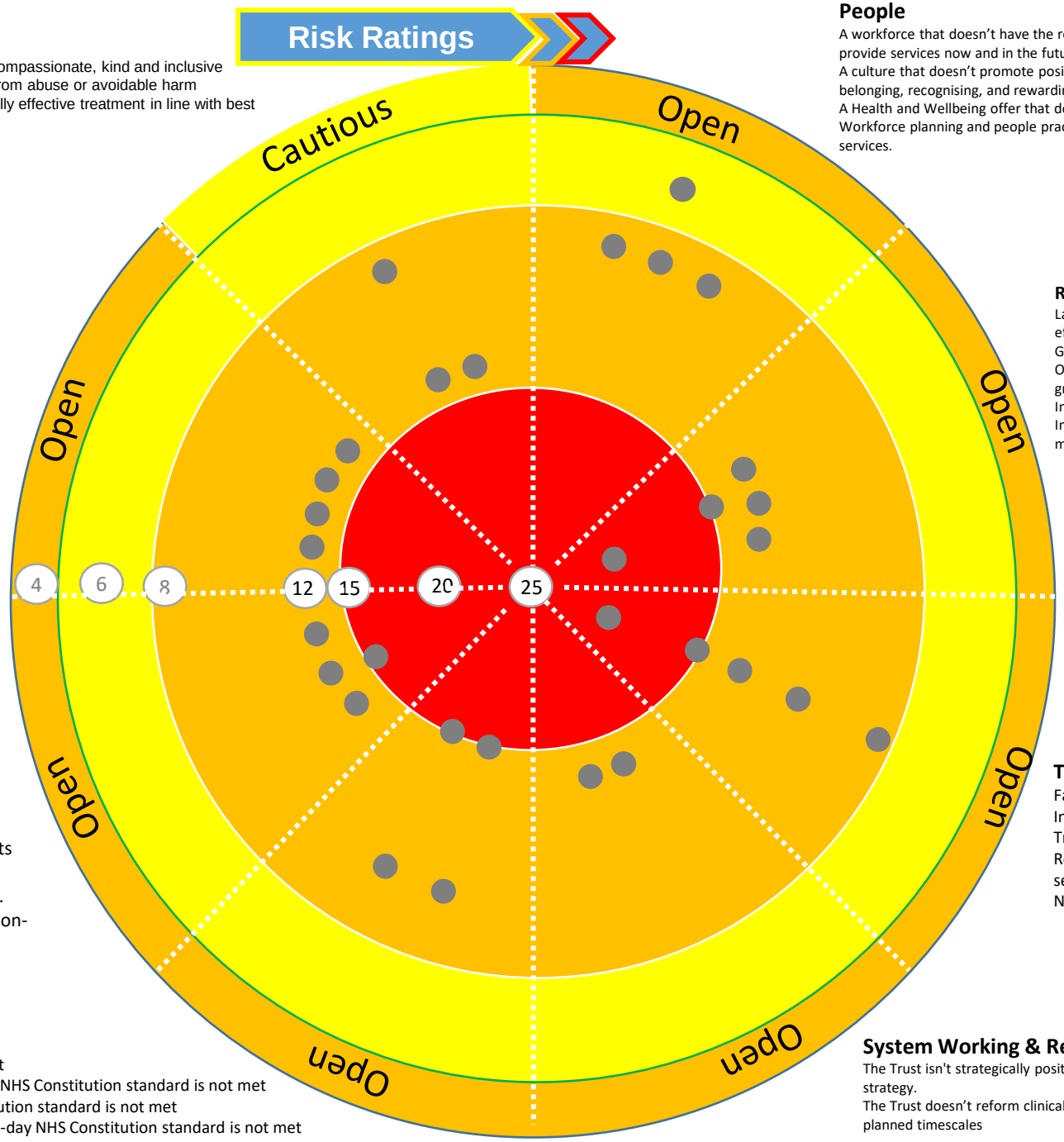
High
Moderate
Low

People

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

Digital

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



28th February 2026
BAF Risk Radar

Research & Innovation

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

Finance

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

Trust Estate

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

Performance and Compliance

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

System Working & Reform

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

Appendix F

North Tees and Hartlepool NHS Foundation Trust

Top 10 Operational Risks (28th February 2026)*

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
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	Leanne Boyd-Smith	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	Tom Bingham	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

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

Appendix G

South Tees Hospitals NHS Foundation Trust

Top 10 Operational Risks (28th February 2026)*

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	Taylor Slee	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	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	20
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 length	Neuroscience Services	Richard Bore	20
484	Risk of access to 2nd Obstetric emergency Theatre Team	Family Health Services	Lynne Staite	16
562	Risk that complex cognitive patients on Ward 26 may come to harm and have poorer experience as they are not receiving appropriate standards of psychological specialist care according to Neurorehabilitation Standards due to a lack of funding for 1 who	Neuroscience Services	Glynis Peat	16
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	Theatres, Anaesthetics & Critical Care Services	Michelle Carey	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
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	Lindsay 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

400	Risk that there is currently no counselling or psychological therapy cancer patient provision which can lead to sub optimal outcomes for patients causing long term harm and increased likelihood of self harm.	Cancer Institute	Graham Dyson	15
526	Risk that operational performance of critical care cannot be effectively managed due to Trust Wide Mandatory Training database is not an accurate reflection of Departmental database (2664)	Theatres, Anaesthetics & Critical Care Services	Martin Johnson	15
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	15
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	Michelle Carey	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	Helen Wilson	15
522	The inability to isolate patients in a timely and effective manner, leading to potential onward transmission of infection leading to sub optimal outcomes.	Theatres, Anaesthetics & Critical Care Services	Karen Banks	15

wners (via CSU and Corporate areas) to ensure all risks are validated.

Quality Committee

Monday 23 March 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 cycle of business considered at the Quality Committee reflects the Quality domain of the Board Assurance Framework, relating to patient safety, clinical effectiveness and patient experience.

The Integrated Performance Report metrics (at month January 2026) remaining as "Alert" included E.Coli, MSSA, Klebsiella, Pseudomonas, Breast feeding at first feed and Never Events.

The Readmission rate (NTHFT) and the Stillbirth rate (STHFT) were regraded to "Alert". The Quality Committee received and discussed reports on both matters providing insight into areas for further action. See further detail under "Advise".

Application of the Infection, Prevention and Control Board Assurance Framework (IBAF) helps UHT to assess against the National Infection Prevention Control Manual (NIPCM) as a source of internal assurance. The IBAF report flagged 2 criteria as non-compliant:

- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, highlighting the lack of a dedicated decant facility to allow enhanced cleaning, defined roles and

responsibilities for clinical and cleaning staff and classification and segregation of waste.

- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance, highlighting the ongoing improvements needed in EPMA, CSU's ownership of AMS Audits, improved awareness of policies and guidelines and a clear AMS Clinical lead.

Five areas of the IBAF were flagged as Partially compliant…the 2 areas above and gaps in ANTT across the organisation, lack of assurance around fit testing reporting, adequate laboratory and diagnostic support (including ribotyping) and policy alignment.

Members were updated on actions underway to address each of the above areas.

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 January 2026).

No strategic risks are outside of approved risk appetite and there are 22 planned mitigating actions to minimise the strategic risks.

The NHS Oversight Framework (NOF) Q3 Ratings were published prior to the meeting and while the overall position of both NTHFT and STHFT had improved, challenges remain requiring a continued focus on metrics including IPC.

The majority of IPR metrics remain graded "Advise" for both NTHFT and STHFT.

Emergency readmissions within 30 days of discharge from hospital is a nationally monitored metric and while not all readmissions are inappropriate (readmissions are linked to various factors including acuity, medical need, help at home services etc), they can be a useful quality indicator and a focus for improvement. The Quality Committee discussed a report on readmission rates benchmarking, NTHFT has shown an improvement while STHFT is relatively static. A Readmission outliers report (by specialty) is to be shared with CSUs and report to the Clinical Effectiveness Group.

The Perinatal Quality Surveillance Model (PQSM) report included a marginal increase in the crude rate for stillbirths at STHFT, (at February 2026), reviews of each case included an external reviewer with no cases graded at D.

The Quality Committee discussed the ongoing work to develop a service model for a Homebirth service and birth location choice for UHH and FHN. A staff consultation timeline is in development alongside Maternity Voices consultation via both Maternity and Neonatal Voices Partnerships.

The Quality Committee was advised about a Never Event and an overview was provided about a returned guide wire in cardiothoracic theatre. Immediate learning was to focus on

appropriate LocSSIP procedure (Local Safety Standards for Invasive Procedures), i.e., NHS specific protocols to prevent harm. The Quality Committee was informed that a detailed review is being carried out for further learning.

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

Annual Effectiveness Review Report 2025/26

The Annual Effectiveness Review Report 2025/26 was discussed. The review focussed on the effectiveness from the establishment of the Quality Committee.

The Committee has met in line with its terms of reference and items scheduled in line with the cycle of business and the Trust Board has received escalation reports as appropriate.

Consideration will be given to the sub-Committee structure.

Maternity

An improvement has been observed in booking by 9 + 6 weeks for NTHFT

The crude rate for stillbirths at NTHFT is below the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) comparator group with ongoing monitoring.

IPC

Five criteria of the Infection Prevention and Control Board Assurance Framework (IBAF) have areas flagged as compliant. The IBAF for UHT is aligned to the Risk Register with systems in place for regular monitoring, reviewing and reporting.

Chairs Log completed by Miriam Davidson (Vice Chair of QAC) on behalf of Fay Scullion (Chair of QAC).

Caring Better Together

Quality Assurance Committee

27 April 2026

Connecting to: Board of Directors

Chair of Committee: Ali Wilson (on behalf of 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.

A national alert has been issued in relation to system C (maternity) identifying an auto-population error which is being proactively managed.

The PSII system continues to be embedded across University Hospitals Tees (UHT) however, the timescale for completion is still challenging with some impact on the implementation of learning and patient experience. Work is underway to expedite the completion and final sign off, of the most long-standing reports.

Four never events were reported during the last quarter. The Committee were assured that work continues to embed learning from these and all other incidents.

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.

Pathology services – The Committee were provided with an update on UCAS accreditation. Trusts have completed actions as required, however UCAS are yet to confirm a date for an accreditation review. Work is underway to ensure impacts are managed

between the two Trusts. It was noted that sickness absence in the service has improved significantly and is now at 4%.

Complaints – An update was provided on progress with developing a new UHT complaints policy. Whilst this remains in progress, significant training and development is taking place with both the complaints team and clinical leads. Whilst this will take some time to fully embed, the quality and timeliness of responses to complaints is already much improved.

PWC have undertaken an audit on regulatory Compliance (CQC must do actions) for NTHFT. There were 12 recommendations all have which it was confirmed have been completed.

Infection prevention and control (IPC):

Despite evidence of increased focus and actions by staff and the IPC team, we continue to see levels of Healthcare Acquired infection (HCAIs) that are above trajectory. This has included an outbreak of MRSA in the neonatal unit at JCUH resulting in the closure of a number of cots. It has since been confirmed all cots are now open. In addition, outbreaks of norovirus during February were reported in both Trusts. An inability to decant wards for intensive cleaning continues to be a factor.

Antimicrobial stewardship remains a high priority although attempts to recruit a medical lead for this work has been unsuccessful.

UHT is working on IPC improvement with independent global consultants from the World Health Organisation facilitated by the NENC ICB. Having concluded an initial review of leadership, culture, governance and organisational learning, we are expecting a full report and recommendations in early June.

Incident reporting:

The implementation of Healthcare Guardian in STHFT whilst now in place, did negatively impact on reporting during implementation. The data suggests that this was a temporary blip and reporting is again increasing. The implementation of this system across UHT presents an opportunity for more sophisticated data capture and reporting across the organisation. In addition, alignment of policies relating to the management of incidents across UHT is expected to be completed by the end of May.

Quality Accounts:

The draft Quality Accounts, which for the first time is a combined report for both Trusts, was shared to provide assurance on progress with preparation of the report prior to circulation between stakeholders for their feedback. The report accurately reflects the broad spectrum of work that has taken place during 2025/26 in order that the quality of services and patient safety actions are effectively monitored and to ensure delivery of our agreed quality priorities. The joint report highlights Trust specific metrics and some excellent examples of achievements over the last year. Six quality priorities are proposed for 2026/27. The draft report will be shared with stakeholders (Local Authority, Healthwatch and ICB) prior to finalisation and approval by the Quality Committee in June. We agreed that whilst the

requirements of NHS England in respect of this report is very prescriptive, a more accessible summary document will be produced.

Maternity:
The Committee were alerted to a higher than average sickness and absence rate in the NTHFT midwifery workforce. Monthly meetings with the people teams continue to optimise support and return to work.

Both maternity services are in the process of remodelling the community service to facilitate choice of place of birth that is not on the acute sites.

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 review of operational risks and delivery actions and timescales will be undertaken for the **Quality and Safety BAFs and the System working BAF** as we approach the year-end reporting period and new timescales will be reflected in future reports.

The **annual review of Terms of Reference and the Cycle of business** was reviewed with an agreed addition to the ToR relating to communication and escalation across Committees and into relevant executive forums as we endeavour to achieve greater levels of triangulation in delivery of all aspects of the business. The Cycle of Business was approved, recognising it may need to flex to accommodate additional reports throughout the year.

Maternity Incentive Scheme (MIS) Year 8- the scheme focuses on six core safety actions this year. These reflect the essential foundations of safe maternity and neonatal care and are intended to support consistent, high-quality services across the country. The actions provide a stronger focus on outcomes for women and babies and the workforce.

Maternity and Neonate Improvement Team - The external assurance from the Improvement team working with South Tees is positive and making good progress.

Recommendations:

To receive the update from Quality Committee and note areas of assurance and challenge.

University Hospitals Tees

Perinatal Quality and Safety Report: Quarter 4, 2025/26

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 2.2

Report author: Stephanie Worn, Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Safety Champions meeting and Quality Oversight Group

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

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

A national alert has been issued by System C to all Trusts using BadgerNet electronic patient record as notifying of an auto-population error. Both North and South Tees are working through mitigations.

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.

Publication of Maternity Incentive Scheme (MIS) Year 8, introducing revised, principles-based safety actions with a stronger focus on outcomes for women, babies and the workforce; detailed review to inform implementation, building on existing governance arrangements and learning from prior scheme years. Year 7 have been published; North Tees and Hartlepool achieving all ten safety actions and South Tees achieving 9 safety actions.

Community services in both North and South Tees are implementing workforce remodelling to support future service delivery, with staff consultation forming a key component of the approach. Both services are working through mitigations and actions in place following notification that primary care will cease prescribing for all maternity related requirements.
Working through mitigations

External assurance is positive for South Tees making progress within the Maternity and Neonatal Improvement Support team framework with no escalations

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

Recommendations:

The Board of Directors members are asked to note the content of the report.
The Board of Directors members are asked to approve the 2025 maternity Survey action plans.

University Hospitals Tees
Perinatal Services Safety and Quality Report
Quarter 4, 2025/26

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Board of Directors members that there is an effective system of clinical governance in place monitoring the safety of our perinatal services with clear direction for learning and improvement. The data within this report is for quarter 4 of 2025/26. This report contains the perinatal quality oversight model report for March (Appendix 1). Where any data provided sits outside this reporting timeframe, this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHS England revised publication 'Perinatal Quality Oversight Model', previously known as Perinatal quality Surveillance Model.

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

1.Maternity services overview

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

Table 1 – Maternity activity

	University Hospitals Tees	North Tees & Hartlepool		South Tees	
		North Tees	University Hospital Hartlepool	James Cook	Friarage
Bookings	1660	528		1132	
All Births	1710	596	0	1114	22
Home birth	12	1	0	7	4
Elective LSCS	410	113		297	
Induction of labour	808	272	0	536	0

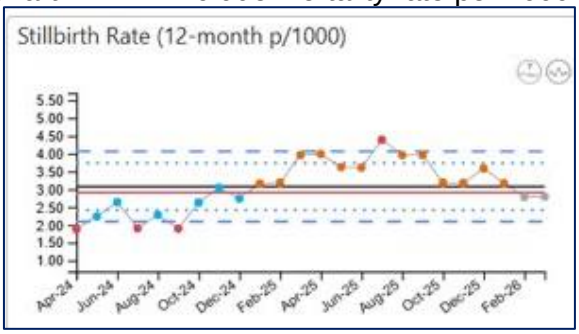
In May 2025, the intrapartum service offer by the Maternity Continuity Care (MCoC) team for UHH was suspended temporarily due to workforce pressures. Following a review in January 2026, the intrapartum offer for birth at UHH is to be reinstated in the summer. Workforce planning is in development as the MCoC team will not re-established with working groups established to focus on rota's, training, guidelines and governance, with a case for change to for community staff to provide a birth availability being finalised which will be taken forward in Quarter 1 2026/2027.The Friarage birth centre offer was not available on 9 occasions; 8

occasions were due to workforce pressures and high acuity at the JCUH site, 1 was attributed to sickness.

2. Perinatal mortality rate

In quarter 4, the crude 12-month rolling annual stillbirth rate per 1000 births for NTHFT was 2.80 and STHFT rate was 3.72 (exclusive of medical termination of pregnancy). The crude12-month rolling neonatal death rate per 1000 births for NTHFT was 0.40 and STHFT was 1.76 (inclusive of early and late neonatal deaths) (Charts 1 and 2).

Chart 1 NTHFT crude mortality rate per 1000 births



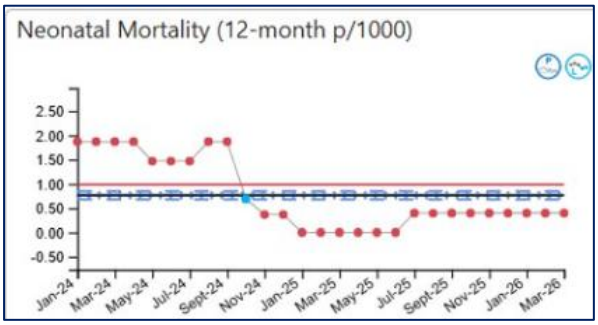
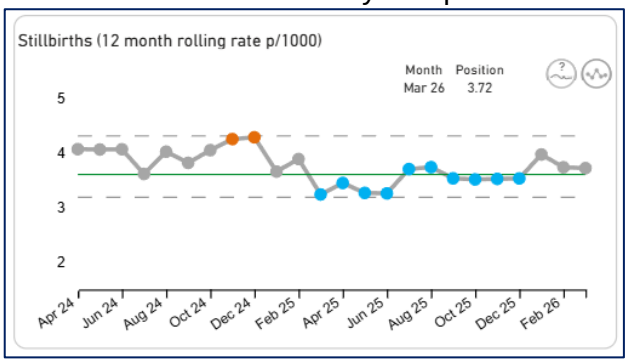
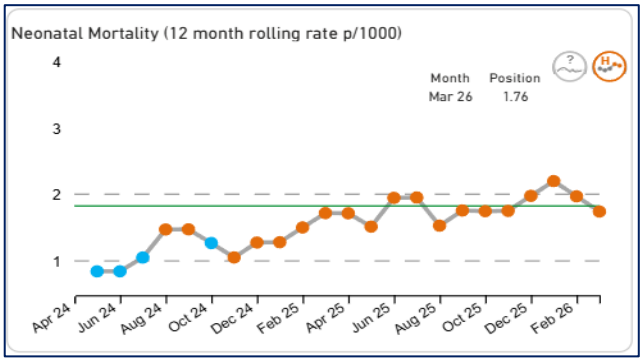


Chart 2 STHFT crude mortality rate per 1000





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

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

Learning from PMRT reviews in Quarter 4

A rapid response to learning is undertaken to identify and action any immediate learning until the full PMRT review has been completed within the expected timeframe. Improvement plans have been developed, and further details are provided in the quarter 4 perinatal morbidity and mortality report presented to the in-committee to minimise patient identifiable details. Learning points from review meetings across the group are:

- Following discharge from hospital there needs to be a clear process for obtaining transport for patients from out of the area- identified as a workstream for review regionally with the LMNS
- There needs to be a focus on following guidance for immediate management of severe PET – this case has been discussed in the enhanced maternal care meeting
- Reminder to all staff to ensure any blood tests results are followed up when a low haemoglobin was not managed according to guidance
- Where appropriate placentas need to be sent for histology as this can assist in determining a cause of death- a new SOP has been developed and ratified to address this

3. Maternity and Neonatal Safety Investigation (MNSI)

MNSI teams undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018). Alongside this, NHS Resolution have a proactive approach to investigate specific brain injuries for determining if negligence caused harm, known as the Early Notification (EN) scheme. The intentions for both MNSI and EN are to identify learning, improve processes for transparency and candour, and to meet the needs to the family in real time.

Reported and investigation progress update

University Hospitals Tees reported five events to be triaged by MNSI with less than five events accepted Reporting of such events have met compliance requirements for MIS year 7. Limited information is shared within this report to minimise patient identifiable details, and a full report is provided to the Group Board of Directors In-Committee.

Coroner Reg 28 made directly to the Trusts

No requests made in this reporting period.

4. Maternity and Neonatal events

All events graded as moderate harm and above are discussed at the trust response-planning meeting, attended by the patient safety team and chaired by the patient safety operational lead. The overall number and moderate of events reported are shown in table 2

Table 2. Grading of events

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
No Harm	129	139	166	82	75	53	47	64	113
Low Harm	77	162	180	16	28	34	61	134	146
Moderate and above	8	3	1	1	3	1	7	0	1
Q4 Total	214	304	347	99	106	88	115	198	260

Maternity and /or neonatal services suspension/divert/closure

There were no suspension/divert or closures for North Tees. South Tees diverted services on 2 occasions this quarter.

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

North Tees and Hartlepool

In January 2026, the service received confirmation the Maternity Safety Support Programme (MSSP) had concluded as the service achieved the requirements. This is an opportunity I personally would like to thank all colleagues within the maternity service for their commitment and team work. Sustainability and oversight will continue via the safety and quality governance arrangements.

South Tees Hospitals

In January 2026 the service received confirmation the MSSP had formally transitioned to the new framework called the Maternity and Neonatal Improvement Support Team (MNIST), after being formally accepted onto the programme in May 2025. The new arrangement is a 6month focused programme that will cover the below themes and monthly progress meetings with the executive team:

- Culture and leadership
- Workforce development
- Governance and board effectiveness
- Obstetric leadership
- Clinical leadership

The service is making progress with no concerns or escalations.

6. NHS Resolution Maternity Incentive Scheme (MIS)

Each service submitted year 7 declaration and it has been confirmed NTHFT achieved compliance with each of the ten safety actions (appendix 2). STHFT achieved compliance with nine of the ten safety actions (appendix 3) and an application for discretionary funds has been submitted. Year 8 was published in April with revisions to the safety actions. The focus is on strengthening the core elements of safe, effective care and making the scheme simpler through a model which is more principles based, outcomes focused and aligned with the needs of women, families and the workforce (appendix 4). The trust executive board holds accountability and oversight. The safety actions are:

A. Workforce and capacity
B. Training
C. Learning from reviews and investigations
D. Service user voice and equity

E. Care bundles
F. Board oversight, governance, culture and leadership

7. Saving Babies Lives Care Bundle version 3.2

Both North Tees and South Tees received confirmation of compliance for each of the six elements. The oversight of progress has yet to be confirmed as it was previously done by the ICB/LMNS. Each service continues with the implementation and audit of interventions.

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

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

Table 5. ATAIN quality improvement

North Tees & Hartlepool	
ATAIN rate Jan - 5.83% Feb - 4.02% March - 4.1% **Q4 = 4.65%**	Quality improvement project: To reduce monthly term admissions by 1% • Teaching sessions commenced across labour and postnatal ward for intravenous antibiotic administration. • MDT review for respiratory admissions • Review of Tier 1 attendance at deliveries when escalated
South Tees	
ATAIN rate Jan - 4.1% Feb - 6.3% March - 6.2% **Q4 = 5.3%**	Quality improvement project: Prevention and management of neonatal hypoglycaemia • Ongoing teaching sessions as required • Spot audits being completed with live feedback

9. Transitional Care Service

South Tees continues progress towards offering transitional care to late preterm babies against the action plan previously approved by the Board of Directors. All staff have been trained with nasogastric feeding and trust policies have been developed and are awaiting approval from the team. At North Tees, progress continues against the ongoing transitional Care action plan that is reviewed regularly through the perinatal governance structure and MIS. The guideline has been updated in relation to babies 34 weeks and over to be considered for neonatal transitional care.

10. NENC Local Maternity and Neonatal System (LMNS)

The Service is awaiting an update on the future of the LMNS following a restructure within the ICB.

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

The service has worked in collaboration with the NENC Local Maternity and Neonatal System (LMNS) to develop a maternity training syllabus to meet the requirements of Core

Competency Framework v2 (CCFv2), supporting standardisation of training, servicer user involvement and shared resources. The obstetric and neonatal department Trust core 10 mandatory training is shown in Table 6, 7 and 8. Compliance will continue to be monitored monthly and to support staff to access training.

Table 6 NTHFT core training

North Tees	Jan-26	Feb-26	Mar-26
Midwifery and support staff	89.79%	90.26%	91.63%
Medical (Obs/Neonates)		87.01%	86.31%
Neonatal Nursing and Support staff		95.78%	96.84%
Grand Total	**89.79%**	**90.67%**	**91.87%**

Table 7 STHFT core training

South Tees	Jan-26	Feb-26	Mar-26
Midwifery and support staff	77.33%	73.79%	72.98%
Medical (Obs/Neonates)	58.33%	74.48%	71.93%
Neonatal Nursing and Support staff	92.86%	79.99%	81.67%
Grand Total	**77.32%**	**75.40%**	**75.11%**

Table 8 UHT Core training

UHT	Jan-26	Feb-26	Mar-26
Midwifery and support staff	83.26%	82.10%	82.28%
Medical (Obs/Neonates)	58.33%	79.48%	77.41%
Neonatal Nursing and Support staff	92.86%	84.43%	85.83%
Grand Total	**83.24%**	**82.33%**	**82.57%**

12. Insights from service users

Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in table 9 and 10. Following a system change, some data fields have had limited accessibility thus a low number. The team are working to remedy this for the next report. The above has been communicated to maternity staff through mandatory training and ward meetings. Complaints are monitored via the trust complaints process.

Table . Complaints

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
Stage 1	7	7	10	3	7	7	4	No data	3
Stage 2	0	0	3	0	0	3	0	No data	0
Stage 3	2	1	1	1	1	0	1	No data	1
Total	9	8	14	4	8	10	5	No data	4

Table 10. Compliments

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
Communication	2	4	0	2	4	0	0	No data	0
Compassionate care	2	1	9	0	1	4	2	-	5
other	71	33	22	71	33	22	0	-	0
Total	75	38	31	73	38	30	2	-	5

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

The service continues to monitor friends and family test feedback, triangulating data with complaint themes. The latest results outlining positive feedback are identified in the table 11.

Table 11. FFT

		Dec-25	Jan-26	Feb-26
North Tees	Maternity Experience (%)	95.30%	97.80%	96.80%
South Tees	Maternity Experience (%)	89.90%	87.80%	86.10%
UHT	Maternity Experience (%)			88.70%

Trust Claims Scorecard

An update is provided in appendix 5 and 6.

Maternity and Neonatal Voice Partnership (MNVP)

Both NTHFT & STHFT have coproduced an action plan following release of the 2025 CQC national maternity survey (appendix 7 and 8).

Service user insights taken from a recent CQC peer review

The service received results of the 2025 CQC maternity survey, immediate actions were developed within the services, and a report is being prepared by patient experience. Both sites are currently developing actions plans which will be co-produced with MNVP leads.

14. Community midwifery services

Following the Ockenden report in 2022, there is no longer a national target for Maternity Continuity of Carer (MCoC). NTHFT had been unable to maintain the MCoC team (Rowan team based in Hartlepool) due to workforce pressures which led to the decision to suspend

the intrapartum service offer, to support safe staffing levels. Following a review in January 2026, the intrapartum offer for birth at UHH is to be reinstated in the summer though the MCoC team will not be reinstated. Workforce modelling is in development which will require a staff consultation.
STHFT service for the population served by the Friarage team is under workforce remodelling as the birth centre will be operated by an on-call model offered by the community team which will require a staff consultation.
Both services provide a bespoke offering to vulnerable women and their families. The models have been supported by external funding, that has enabled the team to expand from midwifery support such as social prescribers. However, the funding available for North Tees is non-recurrent and the role will cease by summer. South Tees have secured funding for 3years for the service.
Both services are working through mitigations and actions in place following notification that primary care will cease prescribing for all maternity related requirements.

15. Quality improvement and research

Research

An update will be provided for quarter 1 2026.27.

Quality Improvement

NTHFT:

- Each baby counts learn and support toolkit – to improve clinical escalation and in so doing so reduce incidence of intrapartum and neonatal morbidity. Diagnostics were ran as recommended by the RCOG toolkit to establish what the issues were and working groups have been established to progress the project:

- Working group to look at improving decision to birth time interval. The data currently shows a marked improvement from decision to birth interval in line with NICE recommendations. Next piece of work to look at timings when instrumental deliveries proceed to cat 1.
- Staff interviews undertaken to understand knowledge of the project, staff requiring further training and a plan made to provide video example or escalation encounter.
- Badges ordered for all medical team to have coloured name badges (representing tier levels) to support escalation.
- Ward boards in all areas to support team of the shift. SPC charts show week on week improvement.

Antenatal bookings – project is to increase booking by 9+6weeks. Following data collection 70% of late bookings had made early contact via the online referral system. Ongoing work to ensure bookings are actioned rapidly in each team with data identifying improvement across quarter 3.

Smoking in pregnancy –Retrospective look back for those who continue to smoke at delivery to understand what the reasons and challenges are to support clinical pathway improvements.

STHFT:

- **Booking by 9+6-** QI project to address compliance commenced in May 2025. Project improvement interventions have been implemented, and current data has shown an improvement in booking by 9+6 of 10% during the quarter.
- **Prevention of neonatal hypoglycaemia-** QI project commenced May 2025. PDSA cycles are being utilised to address six areas of focus. Previous audit results identified further work to be completed, on-going spot audits and targeted teaching taking place.
- **Postpartum Haemorrhage (PPH)-** Project ongoing, initial Due to increasing rates staff have been allocated to case review to extrapolate learning and improvements.
- **3rd/4th degree tears-** Due to increasing rates of 3rd and 4th degree tears a member of the medical team has been allocated to work with the pelvic health midwife to review the cases to determine where improvements can be made. The service has reviewed education of OASI and implemented online training for all staff.

Specialist Midwifery roles

An update will be provided for quarter 1 2026.27.

16. Culture and Leadership

Board level safety champion meetings

The board-level maternity safety champion act as a conduit between the board and the service level champions. The service at both sites at a minimum hold bi-monthly meetings and agendas reflect the required standards including National, Regional and system developments along with local feedback, performance and service developments. Monthly walkabouts are facilitated and feedback shared with all team members. The feedback from the perinatal walkabouts are:

North Tees & Hartlepool	
Areas visited: Triage & Hartlepool Community Base.	Feedback. Triage – Positive visit, noted having medical staff available between hours of 8-4 has aided in patient flow. Staff discussed challenges with staffing model, especially overnight. Discussion around how well newly qualified midwives are supported but less support regarding retention of more experienced staff. Hartlepool – Key issues surrounding IT Kit, accessing records and equipment. Discussions around imminent return to working a 'short shift' pattern.
South Tees	

Areas visited: Wards 17, 19, triage, ANC, CDS EPAU and neonates.	Positive visits in all areas - concerns persist around estate on the antenatal ward, with RACC work and in preparation for new maternity build. Neonates discussed positive developments with installation of omnicell and work on the golden hour Maternity services expressed concerns around digital limitations in terms of provision and proficiency

Perinatal Culture and Leadership Programme

The service has a perinatal leadership aligned to the 2 locations: NTHFT and STHFT. There are no escalations for the in quarter 4 position.

17. Risk register

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

Table 10 grading of risks

	North Tees & Hartlepool		South Tees	
	Maternity	**Neonates**	**Maternity**	**Neonates**
High Graded risk	0	0	0	0
Moderate graded risk	3	1	9	1
Low graded risk	1	1	2	3
Very low graded risk	0	0	0	1
Within approval process	4	0	15	3

18. CQC action

STHFT have installed a pool on the James Cook site. The outstanding action relates to the wider estate which is in progress; RAAC replacement work.

19. Key issues, updates, significant risks and mitigations

North Tees and Hartlepool

- Estate issues which impact patient flow and appropriate environment for women and families particularly with triage and antenatal clinic.
- Demand for elective caesarean sections exceeds capacity – on-going discussions across the trust to support an increase in theatre capacity.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand. A new clinic template is to start later this month.

South Tees Hospitals

- Estate issues which impact patient flow and appropriate environment for women and families under review.
- Demand for elective caesarean sections exceeds capacity – on-going discussions across the trust to support an increase in theatre capacity.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand exercise is in progress.

National/Regional/System updates

No updates for quarter 4.

19. Assurance and Recommendations

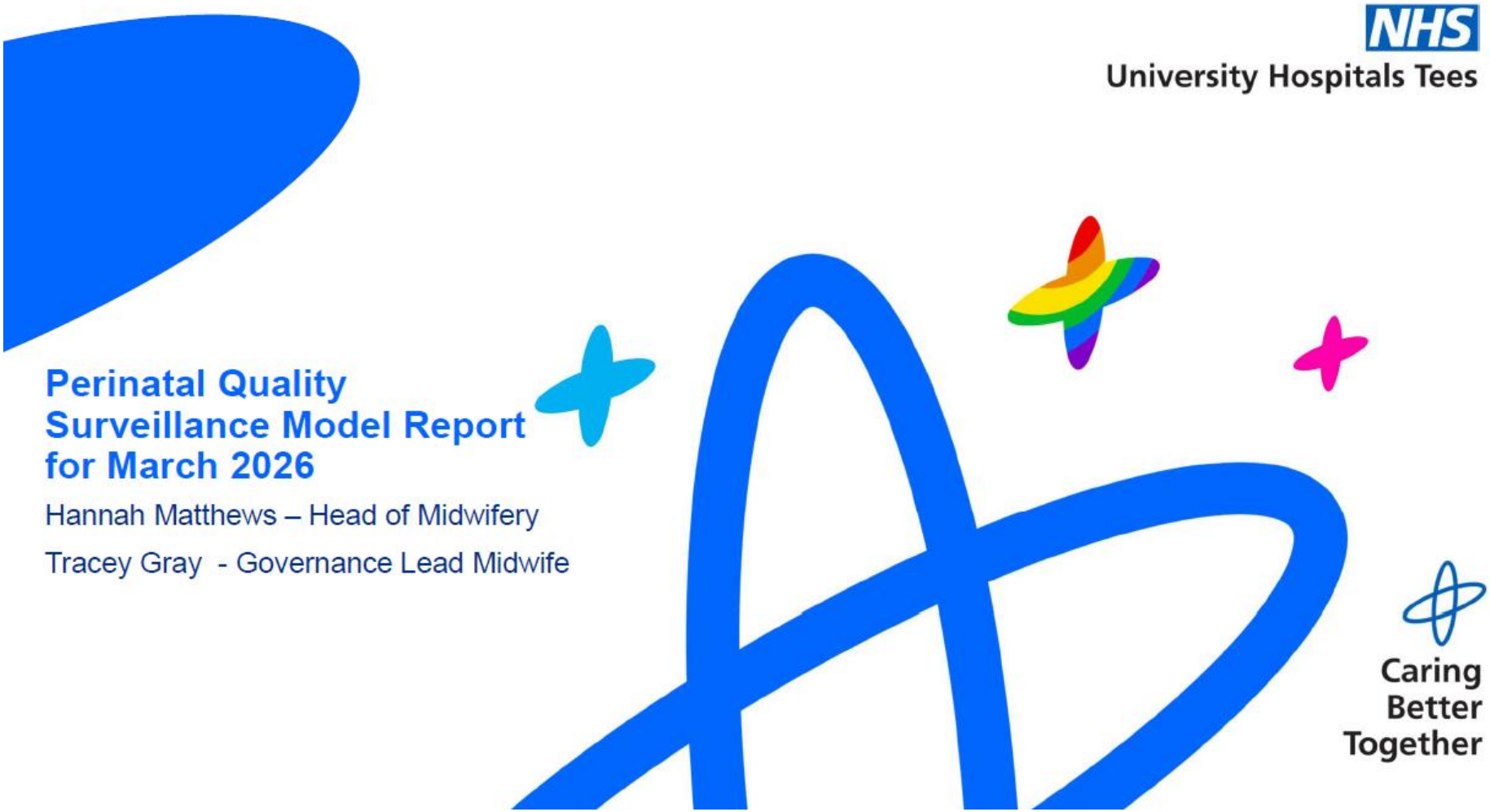
The Board of Directors are asked to receive and note the significant on-going work to meet National Maternity recommendations.

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

Appendices

Appendix 1. PQOM March report
Appendix 2. MIS year 7 conformation letter (NTHFT)
Appendix 3. MIS year 7 conformation letter (STHFT)
Appendix 4. MIS year 8 letter
Appendix 5. NTHFT scorecard
Appendix 6. STHFT scorecard
Appendix 7. NTHFT 2025 maternity survey action plan
Appendix 8. STHFT 2025 maternity survey action plan

Appendix 1. UHT PQOM report for March



Key Performance Metrics

KPI	Unit	Standard	UHT			NTH			STH		
			Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26
Booking at 9+6	Percent	90%	73.91%	70.58%	65.98%	70.63%	77.59%	69.60%	60.00%	66.14%	62.53%
Smoking status at Booking	Percent	<10%	5.78%	6.59%	7.05%	5.94%	4.98%	7.10%	6.61%	7.61%	7.01%
Right Place of Birth	Percent	>95%	96%	98%	100%	100%	92%	100%	100%	100%	100%
Births	Numeric		603	550	594	214	185	197	389	365	397
Preterm birth rate (22-36+6)	Percent	<7%	10.41%	7.83%	9.14%	3.74%	6.45%	5.64%	7.80%	8.54%	10.86%
Induction of Labour	Percent		43.73%	46.31%	46.74%	46.01%	46.45%	45.88%	48.57%	46.24%	47.16%
PPH >1.5L	Rate per 1000	31	32	27	26	9	37	15	26	22	31
3/4th degree tear	Percent	<3.5%	1.10%	3.88%	2.74%	3.64%	3.03%	3.16%	3.15%	4.29%	2.58%
Stillbirth Rate	(12 mnth) Rate per 1000	North 2.91 South 3.60				3.17	2.79	2.80	3.96	3.73	3.72
Neonatal Mortality Rate	(12 mnth) Rate per 1000	North 0.99 South 1.84				0.40	0.40	0.40	2.21	1.98	1.76
Smoking status at Delivery	Percent	<6%	6.07%	5.17%	5.14%	1.41%	6.56%	7.65%	3.64%	4.46%	3.87%
Breastfeeding at first feed	Percent	74%	58.82%	61.22%	63.14%	55.14%	46.24%	53.33%	65.49%	69.41%	68.28%
VTE Score	Percent	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ATAIN	Percent	6%				5.83%	4.02%	5.41%	4.18%	6.31%	6.23%
Apgar <7 at 5 mins	Rate per 1000	24	27	22	19	0	17	27	17	24	14
HIE Rate	12 mnth - Rate per 1000					1.19	1.20	1.20	0.40	0.44	0.44
Baby re-admissions	Percent	<6%	3.72%	1.52%	1.52%	2.35%	0.54%	1.03%	1.55%	3.31%	0.51%
Mother re-admissions	Percent	74%	1.89%	4.44%	4.44%	1.40%	2.67%	5.13%	3.12%	3.62%	1.80%

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

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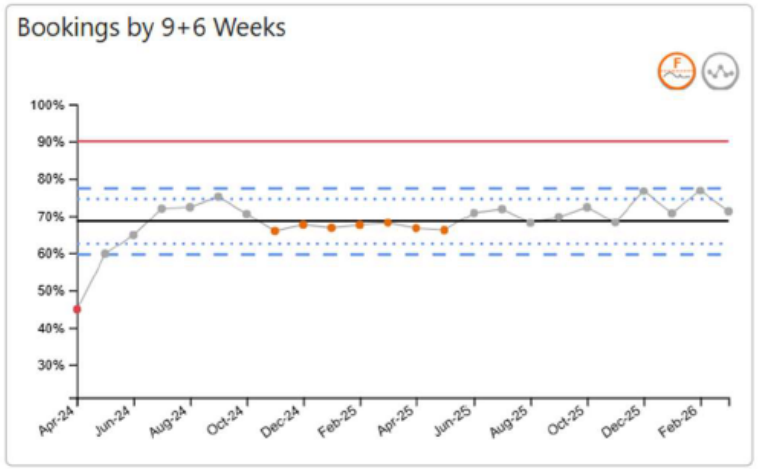
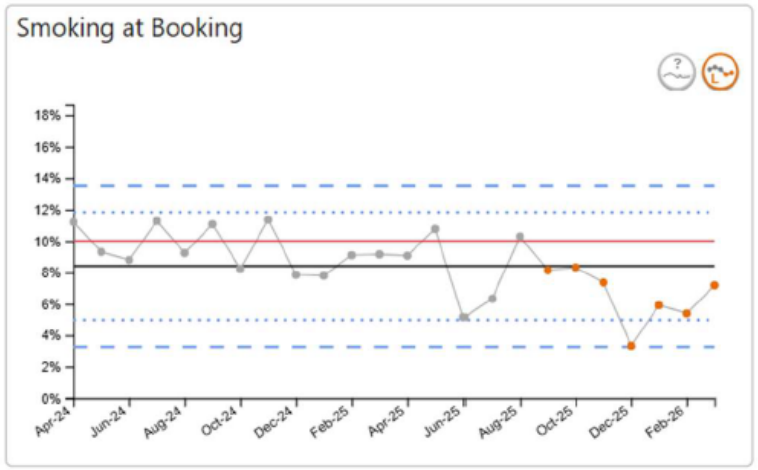
Antenatal NTHFT KPI overview





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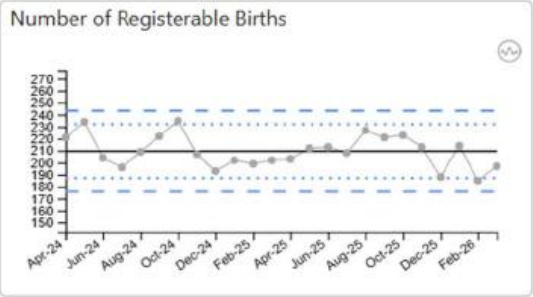
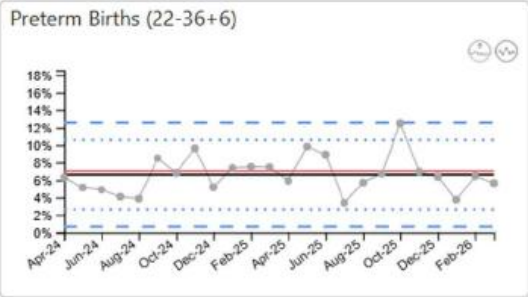
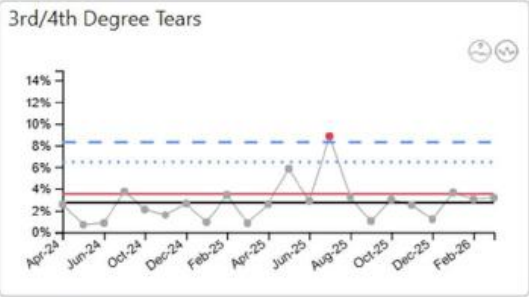
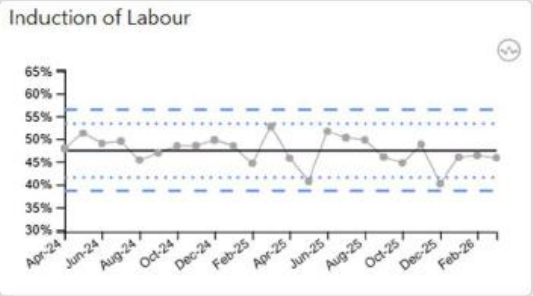
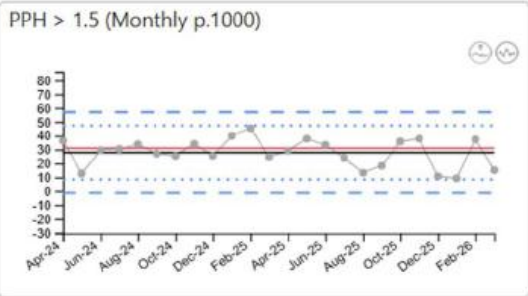
Births NTHFT KPI overview

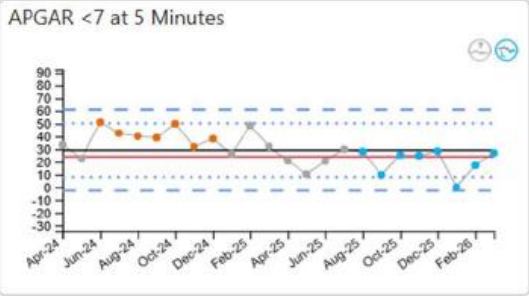


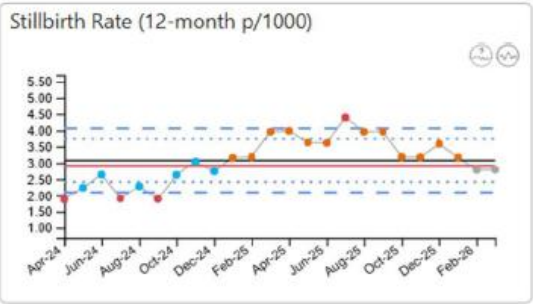












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Postnatal NTHFT KPI overview

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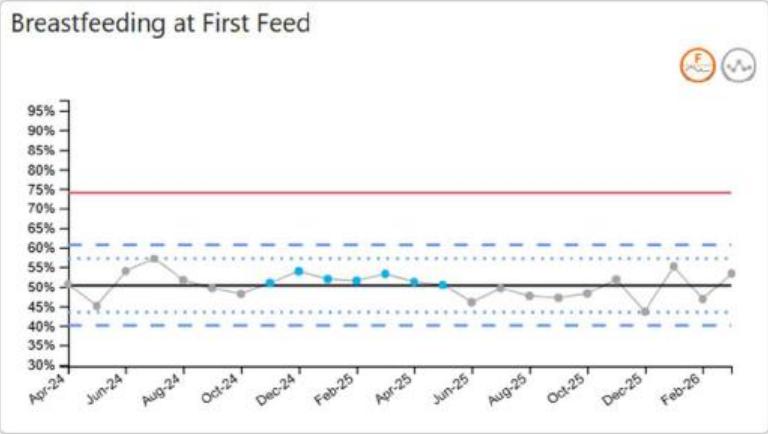

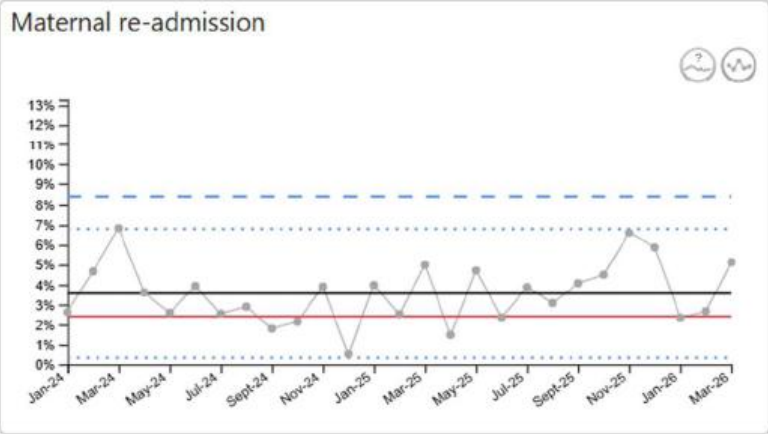

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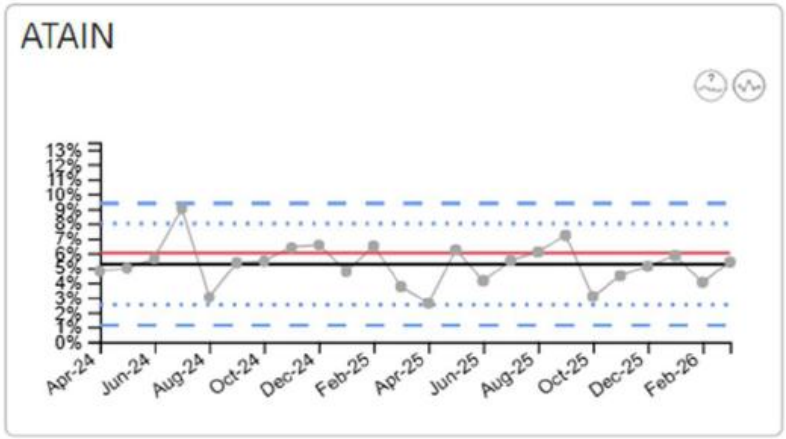
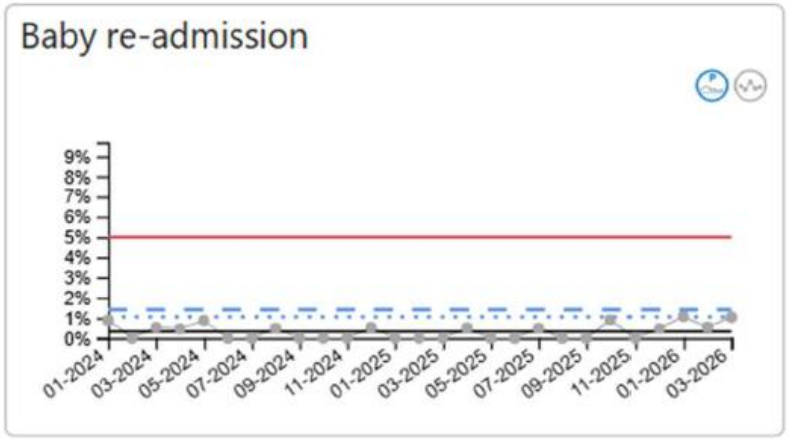
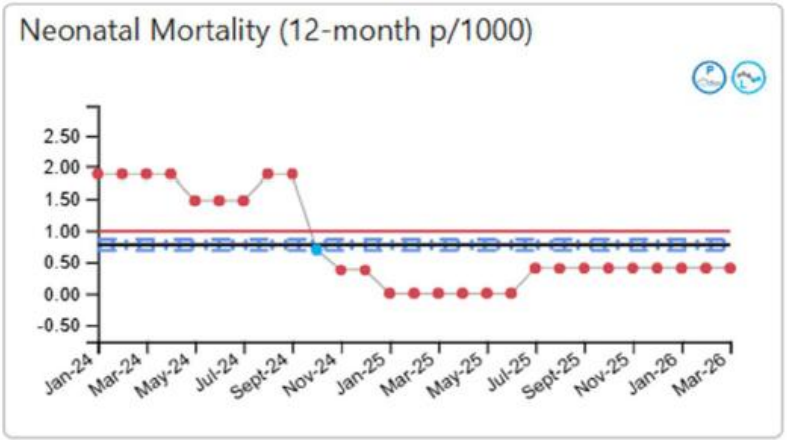
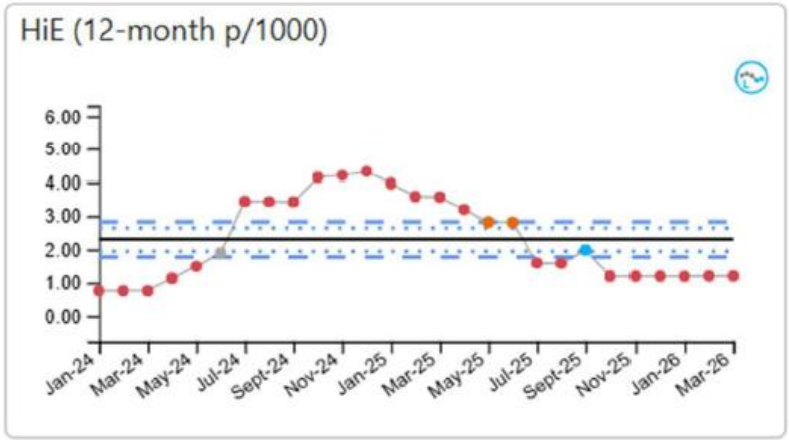
Neonatal NTHFT KPI overview









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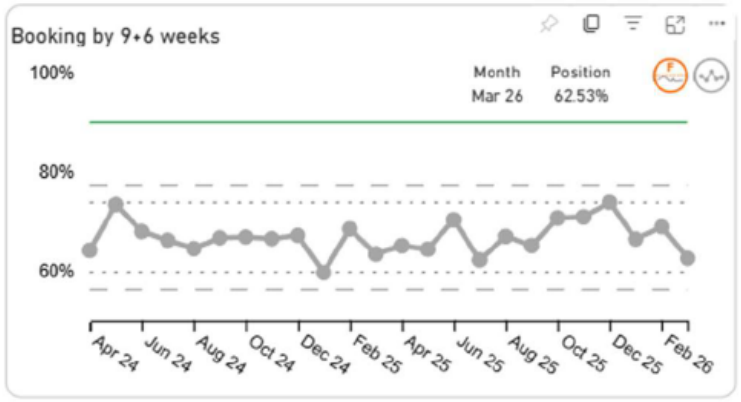
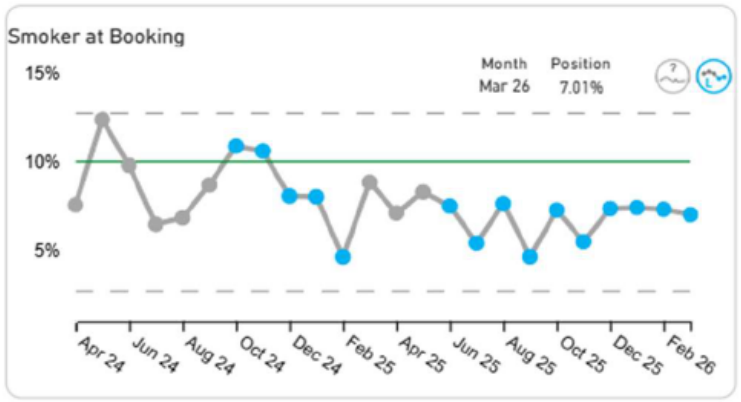
Antenatal STHFT KPI overview





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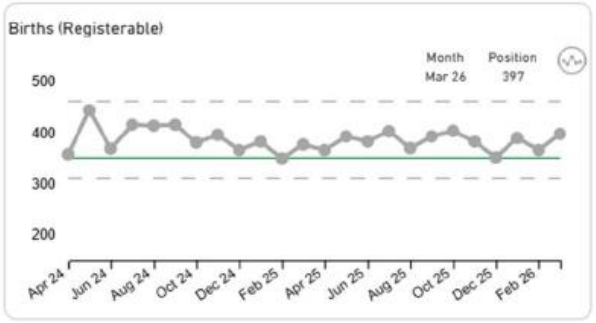
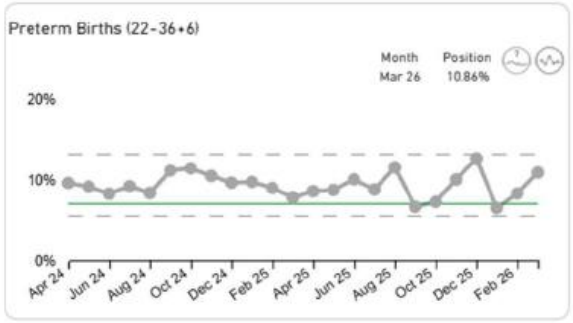
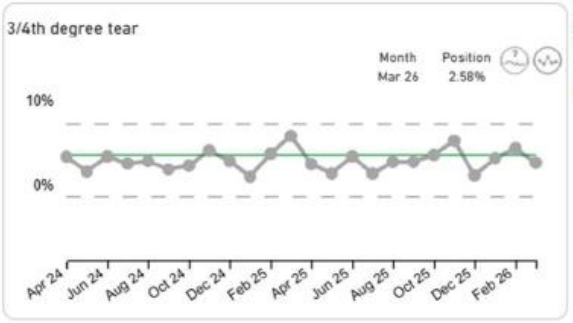
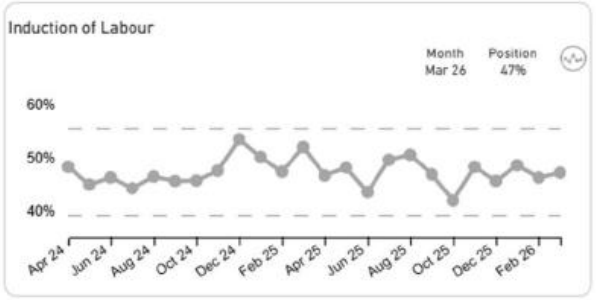
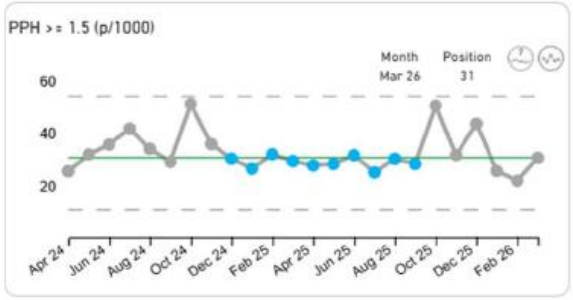
Births STHFT KPI overview

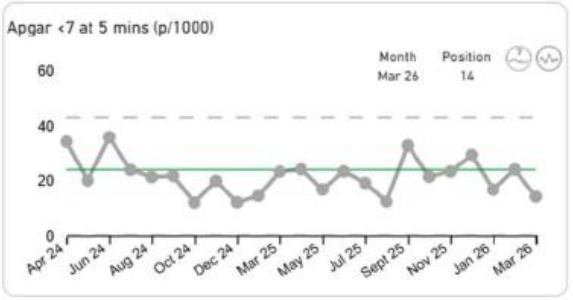












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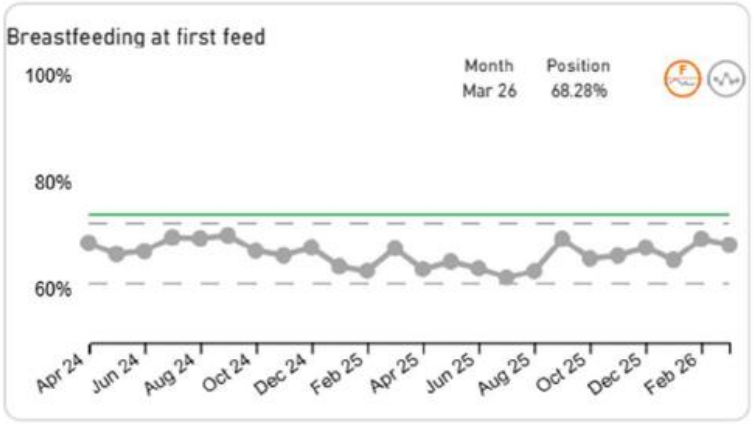
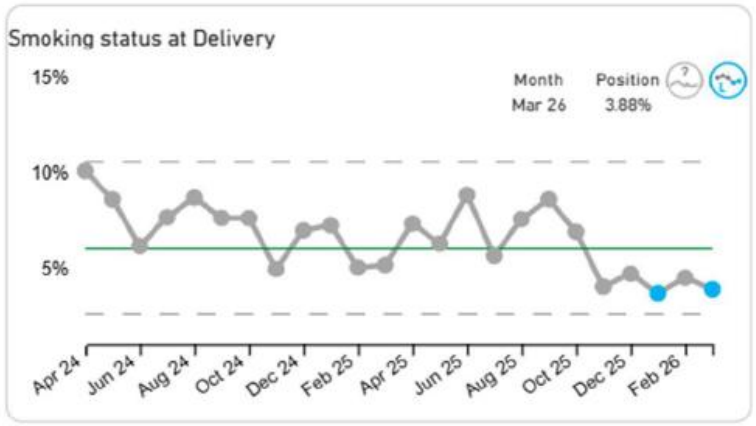
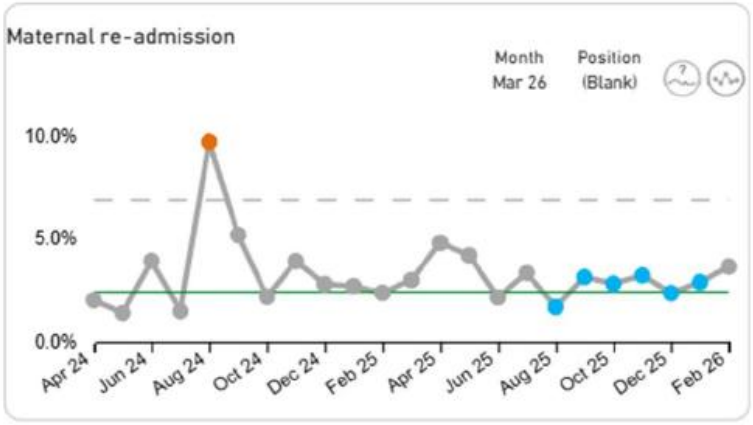
Postnatal STHFT KPI overview







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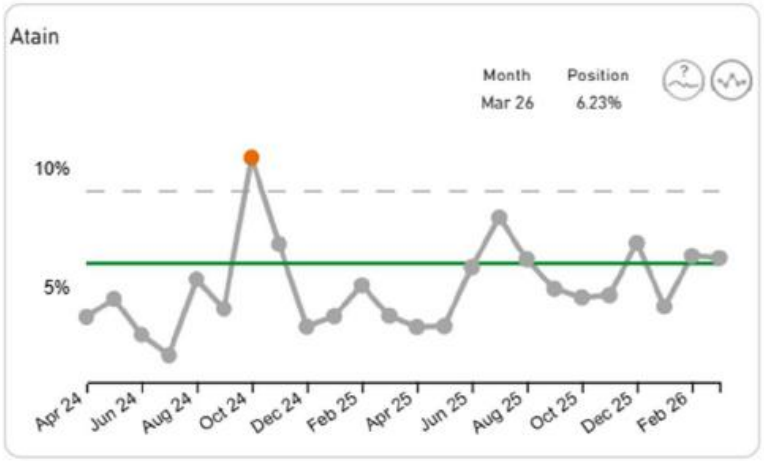
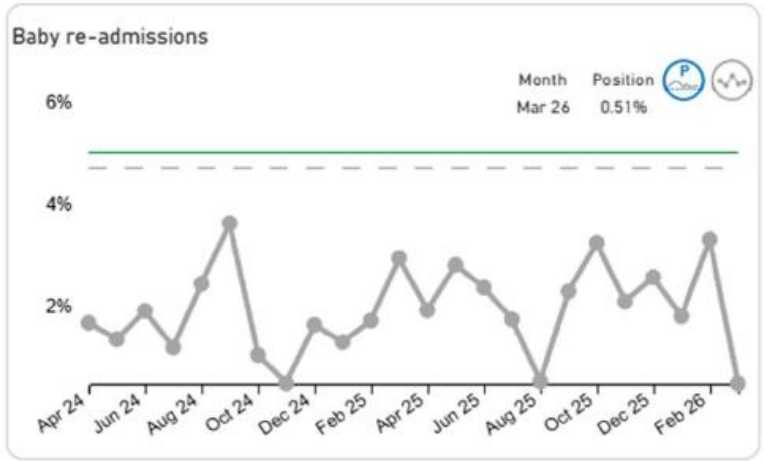
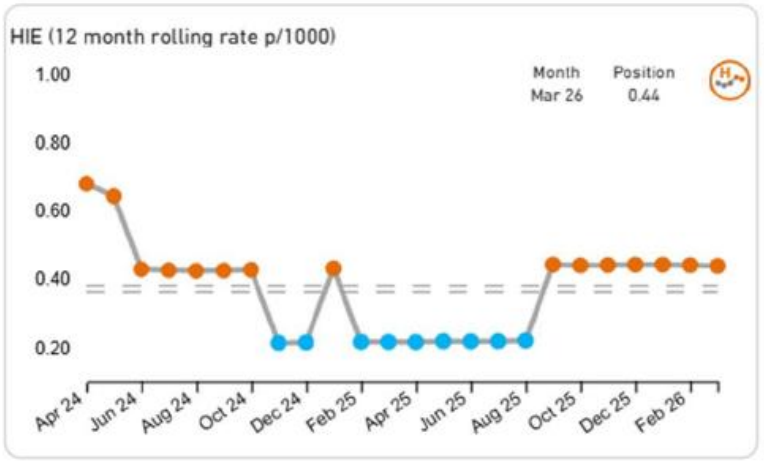
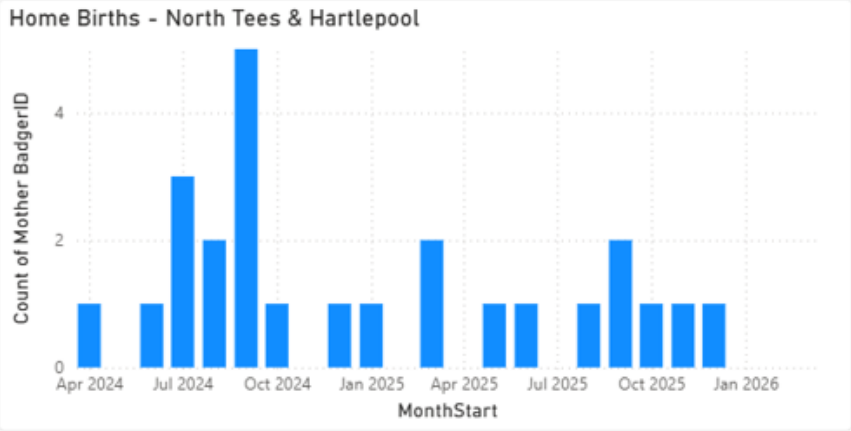
Neonatal STHFT KPI overview

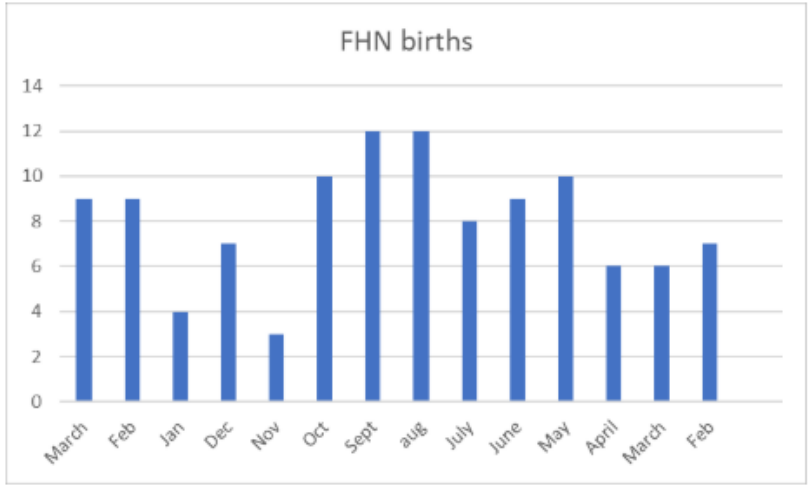






Home Births





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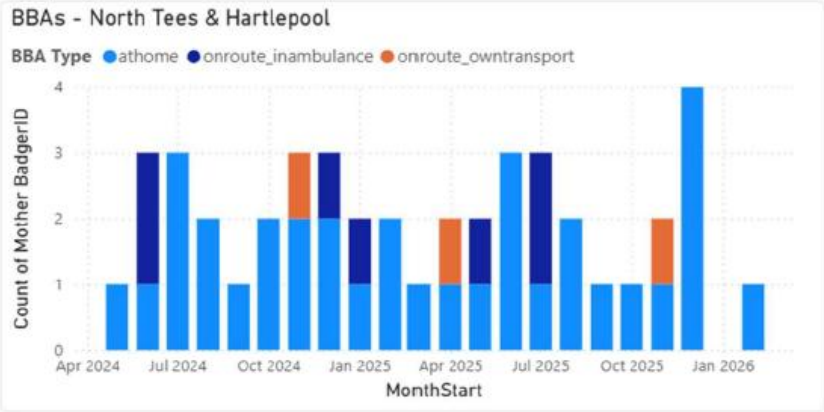
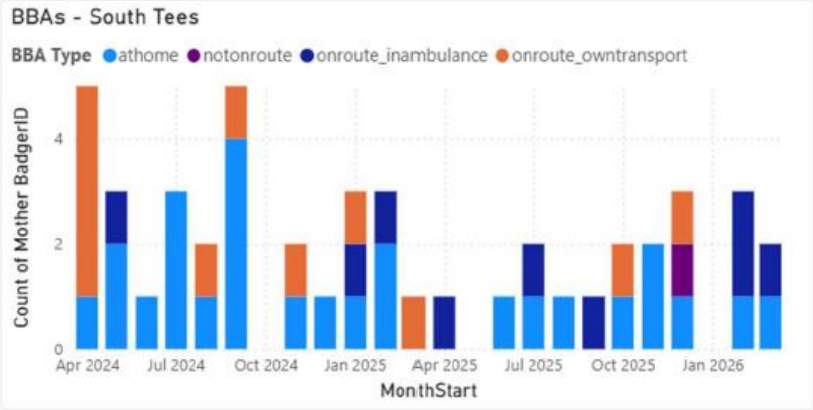
BBAs





MonthStart	athome	notonroute	onroute_inambulance	onroute_owntransport	Total
Apr-24	1			4	5
May-24	3		1		4
Jun-24	2		2		4
Jul-24	6				6
Aug-24	3			1	4
Sep-24	5			1	6
Oct-24	2				2
Nov-24	3			2	5
Dec-24	3		1		4
Jan-25	2		2	1	5
Feb-25	4		1		5
Mar-25	1			1	2
Apr-25	1		1	1	3
May-25	1		1		2
Jun-25	4				4
Jul-25	2		3		5
Aug-25	3				3
Sep-25	1		1		2
Oct-25	2			1	3
Nov-25	3			1	4
Dec-25	5	1		1	7
Jan-26					
Feb-26	2		2		4
Mar-26	1		1		2

Preterm optimisation metrics - Q3

information validated via Neonatal ODN therefore data reports are delayed

North Tees

BAPM 7 KPIs – Local data received via ODN re % of women receiving the interventions: *Please check your unit's data received via ODN.*	Oct-25	Nov-25	Dec-25
Early breast milk	1 of 5 (20%)	2 of 5 (40%)	0 of 2 (0%)
Thermoregulation	4 of 5 (80%)	5 of 5 (100%)	2 of 2 (100%)
DCC	4 of 5 (80%)	4 of 5 (80%)	1 of 2 (50%)
Intrapartum antibiotics	1 of 1 (100%)	3 of 4 (75%)	2 of 2 (100%)
Magnesium sulphate	N/A	N/A	N/A
Antenatal steroids	5 of 5 (100%)	4 of 5 (80%)	2 of 2 (100%)

South Tees

BAPM 7 KPIs – Local data received via ODN re % of women receiving the interventions: *Please check your unit's data received via ODN.*	Oct-25	Nov-25	Dec-25
Early breast milk	7 of 7 (100%)	16 of 19 (84%)	21 of 22 (95%)
Thermoregulation	7 of 7 (100%)	19 of 19 (100%)	21 of 22 (95%)
DCC	6 of 7 (86%)	17 of 19 (89%)	12 of 22 (55%)
Intrapartum antibiotics	2 of 4 (50%)	5 of 8 (63%)	8 of 9 (89%)
Magnesium sulphate	2 of 2 (100%)	3 of 4 (75%)	7 of 8 (88%)
Antenatal steroids	7 of 7 (100%)	19 of 19 (100%)	18 of 22 (82%)

Caring Better Together

Insights for Safety, quality and learning: March

Theme	Insight	NTHFT	STHFT
Engagement	Friends & Family Test		91%
	MNVP	The MNVP continues engagement with service users through , Q4 MNVP meeting undertaken with staff and service users. Equality and Diversity lead appointed as part of the team and attending mother and baby events whilst also able to translate.	The MNVP has been working around managing patient expectations with moving around the region based on capacity. There is a meeting planned with the baby banks and 'close knit' charity to deliver parent packs to vulnerable women. Work is ongoing on the birthing pool with a provisional plan for this to be available for women to use in the next fortnight.
	Complaints	Stage 1 – 7, Stage 2 – 3, Stage 3 – 0.	Stage 1-3 Stage 2-0, Stage 3-1
	Compliments	28	171
	FTSU	None	None
	Safety Champion engagement	Walkaround completed on Triage – positive visit, noted having medical staff available 8-4 has helped. Staff discussed challenges with staffing model especially overnight. Discussed how well NQM are supported but less retention for experienced staff. HPL – Key issues around IT kit, access to records and equipment. Discussions around imminent return to working a 'short shift' pattern.	Walkaround completed on triage, ward 19, EPAU, ward 17, ANC and delivery suite- Positive visit well received by staff who were seen to be very busy. Concerns expressed related to lack of break room provision on ward 19, and around facilities for maternity outpatient clinic when building works start on new maternity development. Digital challenges were expressed in both triage and delivery suite with issues around accessibility of IT equipment and printers and systems being slow to respond. In antenatal clinic the lack of provision of a rainbow clinic was identified as an issue for escalation. FHN walkround completed at the end of February- concerns expressed around delays to staffing model for friarage birth centre and positive feedback around smoking cessation service for women in North Yorkshire
	PCLP / SCORE Survey	Action plan ongoing and monitored via Board safety champion meeting	Action plan developed and monitored via Board safety champion meeting
	% midwives would recommend their Trust as a place to work or receive treatment	50% / 54%	49.86%/63.9%
	%speciality trainees responding with excellent or good for clinical supervision out of hours	82%	86%
Safety and learning Regulatory	PMRT reportable and completed	2 Stillbirth reported. 0 Neonatal death reported.	1 stillbirth 2 neonatal deaths reported
	MNSI / PSII	1 reported in month. 0 active MNSI/ 1 active PSII.	0 reported in month, 1 active MNSI, 1 awaiting final report 1 final report received
	Moderate events	1 moderate harm,	1 moderate physical harm/5 moderate psychological events
	NHSR claims scorecard	Presented November	Presented November
	MIS compliance	Board declared compliance with 10/10 safety actions for MIS year 7	Board declared compliance with 9/10 safety actions for MIS year 7
	CQC rating & actions	Requires improvement. Actions completed.	Requires improvement. 2 outstanding actions, estates related.
	MSSP – now MNIST	Completed MSSP. For regional oversight	6month focused support programme commenced January 2026
	Coroners Reg 28 request	N/A	N/A
	Safety signals	Stillbirth rate. HIE LMNS review undertaken in Nov, awaiting report.	N/A
	Quality Improvement	ATAIN, ARGAR score, ERC	

Midwifery Workforce: March

Midwifery Establishment

Budget	NTHFT					STHFT				
	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (July 2025)	Projected 6 month (Oct 2025)	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (Dec 2025)	Projected 6 month (Mar 2026)
B5/B6 RN's/RM's	107.27	110.60	+3.33	+7.73	+9.13	174.68	173.19	-1.49	177.01	177.01
B7 Clinical and Specialist Midwives	29.42	26.34	-3.08	-3.08	-3.08	38.32	41.87	3.55	42.80	42.80
Grand Total	136.69	136.94	+0.25	+1.03	+1.43	213.00	215.06	2.06	219.81	219.81

Workforce safe staffing metrics	NTHFT	STHFT
Obstetric labour ward cover	100%	100%
LWC supernumerary start of shift	100%	100%
1-1 care in labour	100%	100%
Midwife to Birth ratio	1:17	1:22
Registered midwife fill rate	83%	101%
BAPM compliance	100%	81%

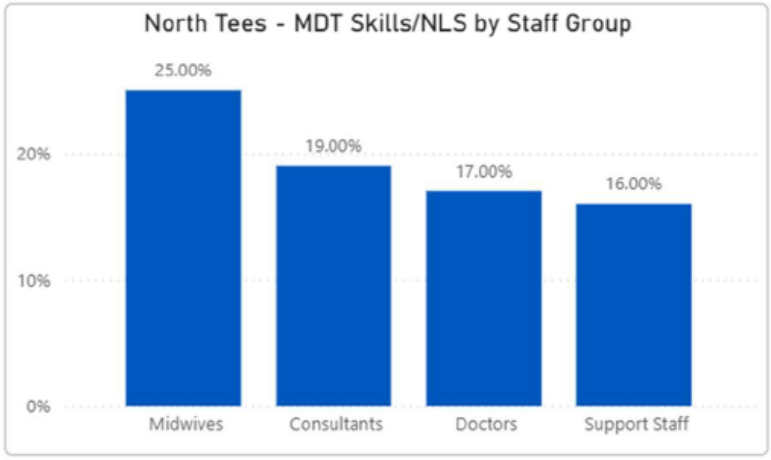
Red Flags	NTHFT	STHFT	comments
1-1 care in labour	0	0	
Delay in IOL	0	13	
Time critical	4	38	
Missed or delayed care	1	3	
Delays in Triage	0	0	

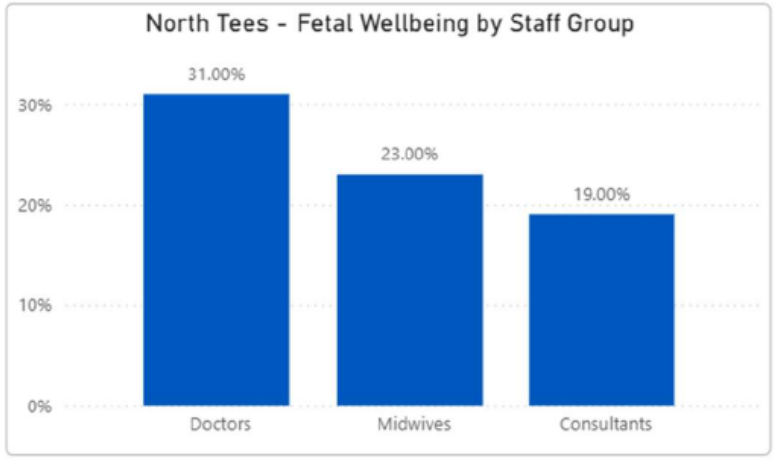
Caring Better Together

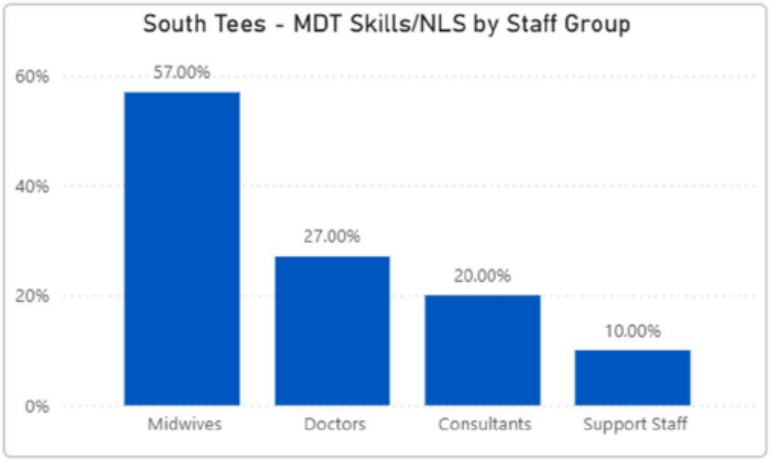
16

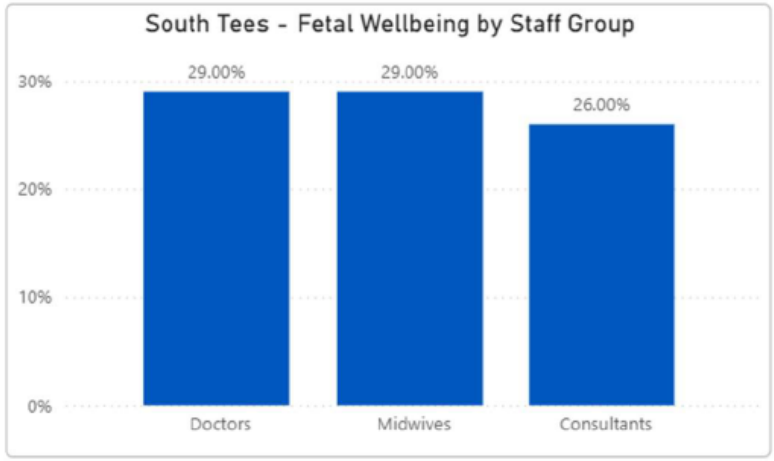
MIS year 8 training compliance overview

Caring Better Together









Caring Better Together

Key Updates

NTHFT

- Implemented a dedicated pre-alert phone installed on the labour ward
- Ongoing work preparing case for change proposal in view of the revision of the workforce model to offer birth choice location for either homebirth or Rowan Suite at UHH.
- Live MEWs and NEWTT charts – national observation charts
- Plan civility sessions offered by RCM
- Trauma informed care project – use of VAR headsets

STHFT

- Implemented a dedicated pre-alert phone installed on the labour ward
- Revision of the workforce model to offer birth choice location for either homebirth or FHN.
- Birthing pool installed at JCUH
- Live NEWTT chart. MEWS live on TracCare, though not the new version
- Plan civility sessions offered by RCM
- Trauma informed care project – use of VAR headsets

National, Regional, System

- National shortage of prostin – pharmaceutical method used to induce labour. Alternative methods are available and new guideline has ben updated. Both services continue to use the mechanical method as the primary method for induction of labour

Appendix 2 MIS year 7 confirmation letter (NTHFT)

Dear NHS Trust,

Thank you for participating in year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity (Perinatal) Incentive Scheme (MIS) and submitting your completed Board declaration form.

Following confirmation through the external verification process and discussion with our Collaborative Advisory Group (CAG), **I am writing to congratulate your organisation on meeting all 10 safety actions for Year 7 of MIS**.

Your organisation will now be eligible for the return of your contribution into the incentive fund, with a share of unallocated funds to follow. This rebate will be returned to the original funding source. NHS England and the Chief Midwifery Officer have highlighted that compliant Trusts should consider how MIS funds have been used to support maternity and neonatal safety and continue to impact and improve services. You will be notified of the final amount, and payments will be processed in due course.

Please do not make any public announcements regarding your results until NHS Resolution has published the national results of the scheme in full, pending the outcome of any appeals. We will contact you in due course to confirm when the publicity embargo has been lifted.

Maternity (and Perinatal) Incentive Scheme Year 8

Year 8 of the Maternity (Perinatal) Incentive Scheme will be published on 31 March 2026, and MIS contacts will be notified as soon as the updated guidance is made available.

We would encourage you to join the NHS Resolution FutureNHS MIS Workspace for regular updates and resources, and please ensure your MIS contact details are kept up to date.

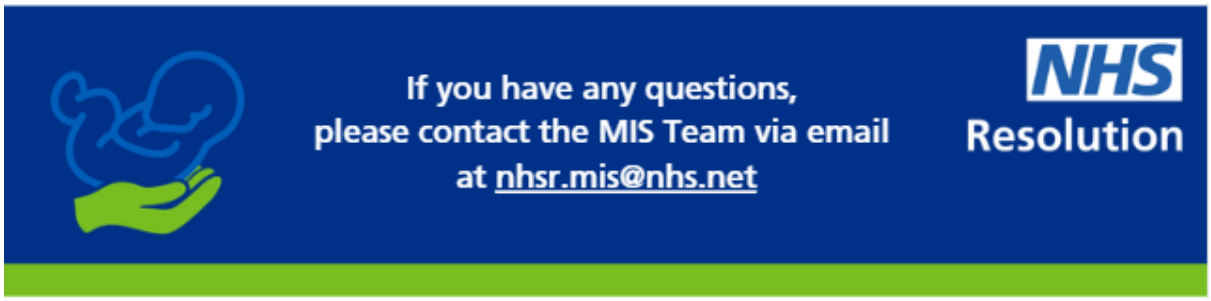
Contacts

If you have any questions, please contact us via email at nhsr.mis@nhs.net for:

- Bridget Dack, NHS Resolution's Maternity Incentive Scheme Clinical Lead, or
- Selina Dubison, NHS Resolution's Maternity Incentive Scheme Associate

Yours faithfully,

MIS Team



Appendix 3. MIS year 7 conformation letter (STHFT)

Dear South Tees Hospitals NHS Foundation Trust,

Thank you for participating in year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity (Perinatal) Incentive Scheme (MIS) and submitting your completed Board declaration form.

As **your Trust is not fully compliant with all 10 safety actions for Year 7 of MIS**, you will be unable to recover the contribution to the CNST maternity incentive fund. However, in line with the scheme's rules, the Trust may submit a safety improvement plan alongside the Board declaration form, together with a request for discretionary funding to support delivery of the safety actions not met. If an improvement plan and associated funding bids have not yet been submitted, please contact the MIS team as soon as possible to discuss this, as **submissions must be received by midday on 1 April 2026** to be considered. Further information is provided below on how to develop your improvement action plan.

If you wish to appeal the outcome for your Trust of MIS year seven, please complete the appeals template, and return to the MIS Team via email at nhsr.mis@nhs.net between 24 March 2026 and 7 April 2026 by midday.

Appealing the results

The MIS Appeals Advisory Committee will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.

There are two possible grounds for appeal:

1. Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.

2. Technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.

Action plans submitted must be:

- Submitted on the action plan template in the Board declaration form.

- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and WTE.
- Action plans must be sustainable - funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions

Please do not make any public announcements regarding your results until NHS Resolution has published the national results of the scheme in full, pending the outcome of any appeals. We will contact you in due course to confirm when the publicity embargo has been lifted.

We would, however, encourage you to discuss your final results with your regional leads (and local Maternity Improvement Advisor if applicable) at the earliest opportunity. The NHS England Chief Nursing Officer wrote to NHS Trusts on 8 April 2021 confirming that commissioners must ensure that any discretionary funding awarded from NHS Resolution to implement an agreed safety improvement plan is ringfenced by the trust for the maternity service to deliver the identified improvements.

Maternity (and Perinatal) Incentive Scheme Year 8

Year 8 of the Maternity (Perinatal) Incentive Scheme will be published on 31 March 2026, and MIS contacts will be notified as soon as the updated guidance is made available.

We would encourage you to join the NHS Resolution FutureNHS MIS Workspace for regular updates and resources, and please ensure your MIS contact details are kept up to date.

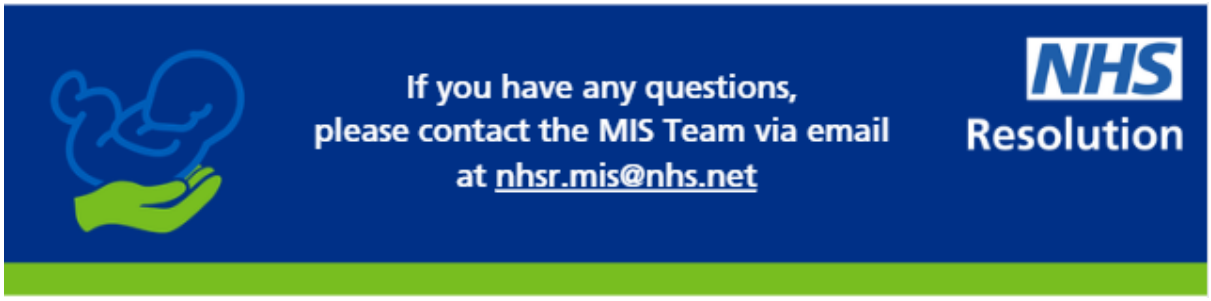
Contacts

If you have any questions, please contact us via email at nhsr.mis@nhs.net for:

- Bridget Dack, NHS Resolution's Maternity Incentive Scheme Clinical Lead, or
- Selina Dubison, NHS Resolution's Maternity Incentive Scheme Associate

Yours faithfully,

MIS Team


If you have any questions,
please contact the MIS Team via email
at nhsr.mis@nhs.net
NHS
Resolution

NHS
University Hospitals Tees

Appendix 5. NTHFT Scorecard

Claims Scorecard (10 years of claims) Quarter 4 2026 (January February March)

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

Complaints Q4 25-26

Communication – staff attitude
Care Provided
Food provision
Information availability in different languages

Incidents Q4 25-26

Escalation (Staffing Issues) impacting on service provision
PPH
Test results –documentation/ Follow up /
Emergency C Sections
3rd and 4th Degree Tears

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

NHS
NHS
North Tees and Hartlepool
NHS Foundation Trust

Themes Q4 25-26

- Escalation staffing
- Documentation via electronic health care record system
- Increase capacity for c sections
- Service provision

Learning Q4 25-26

Ensure documentation includes all information related to birth (Apgar)
Review of blood Group on electronic health care record system.
Bereavement support for those women who deliver at another hospital

Not started		In progress		Completed	

Action Plan Q4 25-26

Implementation of Each Baby counts to support (WI project)	31.03.26	
Review of C Section provision	30.06.26	
Embed correct practice for multiple swab counts	30.06.26	

Appendix 6. STHFT Scorecard

Claims Scorecard (10 years of claims) Quarter 4 2025-26 (Jan Feb Mar)

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

Complaints Q4 25-26

Communication – Lack of effective communication
Care provided – postnatal
Care provided – perineal/wound care

Incidents Q4 25-26

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

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

Themes Q4 25-26

- Trust processes
- 3rd/4th degree tears

Learning Q4 25-26

Management of OASI
Digital processes

Action Plan Q4 25-26 Not started | In progress | Completed

Review of PPH	By 30.4.26 (KW)	
Wound management audit	By 31.07.25 (TA)	
OASI review	31.5.26 (RK)	
Review hyperstimulation cases	30.06.25 (SL)	

Appendix 7. 2025 NTHFT maternity survey action plan

2025 CQC Maternity Survey Action Plan (Condensed Version) 15/12/25, 30/01/26, 25/03/26

Safety Action 7
Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Key to BRAG rating: B - Completed G - Action on track A - Action at potential risk R - Action remedial required P - Not yet started

Section Number	Section	Performance Key (please use drop down to detail current position)	Quality Improvement / Key Action Steps	Timeline	Expected Outcome	Person/Group responsible	Progress/Comments	BRAG Rating
S01_1	The start of your care in pregnancy	About the same as expected						
S01_2	Antenatal check-ups	About the same as expected						
B.9	During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	Somewhat worse than expected	Patients provided with phone numbers available via Badgernet /Implementation of Badgernet	Ongoing	Appropiate sign posting	SCM	Implemented	
S02_1	Your labour and birth	About the same as expected						
C.10	Did the staff treating and examining you introduce themselves?	Somewhat worse than expected	Review of customer care training	Ongoing	Improved rapport the care giver	All staff	Implemented	
C.14	Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?	Worse than expected	MDT Stimulation training	Ongoing	Improved team working	All staff	Simulation training continues to be delivered	
C.15	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	Worse than expected	Training /Patient Feedback /FT/Complaints /MNVP	Ongoing	Reduce complaints	All staff	Further development of information in different languages	
C.16	Thinking about your care during labour and birth, were you involved in decisions about your care?	Somewhat worse than expected	Badgernet information provided(different languages)/ Review of information provided with MNVP	Ongoing	Improved outcomes for patients / reduaction in complaints	All staff/MNVVP	Further development of information in different languages	
C.17	Thinking about your care during labour and birth, were you treated with respect and dignity?	Somewhat worse than expected	Friends and Family/MNVP facebook page /Complaints / Civility training	Ongoing	Reduction in complaints	All staff	MNVP feedback/ Complaints /reflections	
C.19	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	Worse than expected	Ward rounds / DOC/Debrieth/reflections service / Review of debrief process	Ongoing	Reduce complaints and provide an opportunity to dicuss concerns	Medical Staff	Patient offered debrieth /Birth reflections /Friends and Family	
C21	Thinking about your care during labour and birth, were you treated with kindness and compassion?	Somewhat worse than expected	Friends and Family/MNVP facebook page /Complaints / Civility training	Ongoing	Provide enjoyable birth experience reduce complaints	Training Lead/Ward Matrons/MNVP	Information fedback to staff with regards complaints	
S02_2	Staff caring for you	About the same as expected						
D.7	Do you think your healthcare professional did everything they could to help manage your pain in hospital after the birth?	Worse than expected	Electronic prescribing in place / risk assessments	Ongoing	Reduce complaints/Improve patient mental health	SCM Delivery suite		
S03_1	Care in the ward after birth	About the same as expected						
S03_2	Feeding your baby	About the same as expected						
G.12	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	Somewhat worse than expected	Badgernet information	Ongoing	Earlier referral	Digital Midwife		
G.13	Were you given information about your own physical recovery after the birth?	Somewhat worse than expected	Review of information provided via Badgernet	Ongoing	Earlier referral	SCM For In hospital		
G.14	In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby?	Worse than expected	Employment of further infant feeding midwife	Ongoing	Support provided	Infant Feeding midwife		
S03_3	Care at home after birth	About the same as expected	Contact numbers provided / Further review and development within the service of Triage service .	Ongoing	Recogition of any abnormality and seek support sooner	SCM For In hospital		

Appendix 8 2025 STHFT maternity survey action plan

Section Number	Section	Performance Key (please use drop down to detail current position)	Quality Improvement / Key Action Steps	Timeline	Expected Outcome	Person/ Group responsible	Progress/ Comments	BRAG Rating
B.1	**Were you offered a choice about where to have your baby?**	**About the same as expected**	Birth Choices SOP and Leaflet ratified and in use FMC taking part in MUSA Personalised care launched and taught on mandatory training, Birth choices video made	Ongoing personalised care work	Women will be able to make informed decisions about their care	Consultant Midwfe/ MNVP		
B.2	**Did you get enough information from either a midwife or doctor to help you decide where to have your baby?**	**About the same as expected**		Ongoing personalised care work	Women will be able to make informed decisions about their care	Consultant Midwfe/ MNVP		
S01_1	**The start of your care in pregnancy**	**About the same as expected**						
B.6	**During your antenatal check-ups, did your midwives listen to you?**	**About the same as expected**	Birth choices clinic set up					
S01_2	**Antenatal check-ups**							
B.8	**Were you given enough support for your mental health during your pregnancy?**	**About the same as expected**	STEPS prohramme, full time band 7 midwofe Group MMHS project in progress.	Ongoing	Referral to appropiate services	All staff	Implemented	

B.12	**During your pregnancy did midwives provide relevant information about feeding your baby?**	**About the same as expected**	Antenatal conversation improved with increase in team					
B.13	**Did you have confidence and trust in the staff caring for you during your antenatal care?**	**About the same as expected**	Diamonds pathway in use					
B.14	**Thinking about your antenatal care, were you treated with respect and dignity?**	**Somewhat better than expected**	Ongoing mandatory training					
D.3	**If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?**	**About the same as expected**	Question score has increased from 6.6 in 2024 to 7.8 in 2025					
D.4	**Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?**	**About the same as expected**	Question score has increased from 7.3 in 2024 to 7.9 in 2025					

D.6	**Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?**	**About the same as expected**	Question score has increased from 3.8 in 2024 to 5.2 in 2025					
D.7	**Do you think your healthcare professional did everything they could to help manage your pain in hospital after the birth?**	**About the same as expected**	Question score has increased from 7.3 in 2024 to 8.1 in 2025					
F.14	**Thinking about the last time you attended traige in person , how did you feel about the length of time you waited before you weer seen by a midwife**	**About the same as expected**	Question score has increased from 6.5 in 2024 to 8.3 in 2025					

NHS Resolution

19 February 2026

Dear Colleagues,

As we have done in previous years, we are writing to provide advance notice of the forthcoming publication of the Maternity (Perinatal) Incentive Scheme (MIS) Year 8, expected to be published on 31 March 2026, and to support Trusts in preparing for implementation ahead of this.

As the scheme has undergone a substantial refresh this year in line with system priorities and feedback, we are providing this briefing prior to publication so that Trust Boards and perinatal leadership teams have early awareness of the Year 8 direction, themes and structural changes.

As in previous years, the detailed Year 8 Core Standards and Supplementary Guidance will be published on the NHS Resolution website once launched. The FutureNHS MIS workspace will be refreshed to reflect the updated scheme, and a new audit tool will be available. An online national launch event for all Trusts will take place on 23 April 2026 to share information around the scheme and the support available, and registration details can be found here. We encourage all organisations and those working with the MIS to attend.

This correspondence is intended to provide an overview only. Please do not contact the MIS team with queries ahead of the anticipated full publication on 31 March.

Overview of the MIS Year 8 Development

Year 8 represents a significant shift in how MIS functions. It responds directly to the findings of our MIS evaluation, national inquiries, system feedback, and Trust-level learning from previous years. The refreshed scheme focuses on:

- Greater focus on outcomes, and the assurance of these, rather than processes
- Flexibility for local implementation, recognising that Trusts deliver safe care to meet the needs of their local population in diverse ways
- A single, coherent set of six safety actions, replacing the previous ten, promoting greater join-up via themes and across professions
- Increased Trust flexibility while emphasising Board accountability

This represents a reduction in prescribed process, combined with a greater emphasis on demonstrating the outcomes and improvements that matter most for women, babies and staff.

Year 8 provides a bridge between the established MIS model and an approach that is more flexible, proportionate and focused on outcomes. It affords organisations more flexibility and accountability for focusing on the priorities that are specific to their organisation, and which matter most to women and families. This refreshed MIS is underpinned by a set of agreed priorities, developed among the system partners and service user voice representatives on our Collaborative Advisory Group.

The revised standards for Year 8 have been developed and agreed collaboratively with our Collaborative Advisory Group (CAG) which includes NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), College of Operating Department Practitioners (CODP), the Neonatal Clinical Reference Group (CRG), The British Association of Perinatal Medicine (BAPM), the Neonatal Nursing Association (NNA), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI), the Nursing and Midwifery Council (NMC) and a group of service user representatives.

The Year 8 documents have also been shaped through external review with input from a wide range of provider Trusts including midwifery and neonatal leaders, obstetricians, neonatologists, governance and assurance leads, and service user representatives, alongside extensive feedback from regional maternity teams. We are sincerely grateful for the time and insight colleagues have contributed. Their input has helped refine the structure, clarify areas of ambiguity, and ensure the scheme reflects the realities of maternity and neonatal services.

Summary of Key Changes in Year 8

A streamlined set of six Core Safety Actions

The Year 8 Safety Actions have been designed to be clearer, more meaningful and less duplicative. Each follows an **Outcome / Why / What** structure, instead of long lists of technical requirements.

Trusts will have greater freedom to determine **how** the minimum standards are delivered locally, but Boards must be able to demonstrate:

- Assurance of safety outcomes
- Clear linkage between learning, action and improvement
- Effective governance and escalation
- Embedded service user voice
- The capacity, capability and readiness of maternity and neonatal teams

Separate **supplementary guidance** will provide examples of “what good looks like” rather than mandating specific approaches. This reflects practices which might be expected to be already established in high-performing Trusts.

Strengthened expectations for Trust Boards

Year 8 provides much clearer expectations around:

- The Executive Board's role in oversight, scrutiny, and approval of the final MIS declaration
- The relationship between the Quality Governance Committee (or equivalent) and the Trust Board
- The expectation that maternity and neonatal safety is monitored through a consistent governance cycle, aligned with the Perinatal Quality Oversight Model (PQOM)

Boards must be assured not only of compliance, but of the quality, impact and sustainability of local maternity and neonatal safety systems, with all evidence retained.

Updated requirements for cross-professional workforce planning

Year 8 integrates workforce expectations across midwifery, obstetrics, anaesthetics, neonatology, and perioperative teams (including trained anaesthetic assistants). Trusts must demonstrate funded establishments aligned to BR+, neonatal nursing and BAPM standards, alongside annual Caesarean birth capacity mapping and governance oversight of maternity and neonatal interdependencies.

Enhanced training requirements

Training expectations have been strengthened and re-focused to align with the BAPM Neonatal Airway Safety Standard, Avoiding Brain-injury in Childbirth (ABC) implementation preparation, and national MDT learning themes.
Two training compliance checkpoints are required each MIS year:

- **30 November** (mandatory), and
- **one other Trust-selected checkpoint**, declared in advance.

The principles around which staff groups are required to be included in training calculations, and exception rules, have been clarified to ensure equity and consistency across Trusts, including new and rotational staff, and those on long-term leave.

Stronger learning and investigation expectations

Learning from the Perinatal Mortality Review Tool (PMRT), MNSI, Early Notification Scheme (EN), Patient Safety Incident Response Framework (PSIRF), NHS Resolution claims scorecard and Maternity Outcome Signal System (MOSS) is brought together under a single Safety Action, with clearer expectations around:

- Notification timeliness
- External reviewer involvement
- Meaningful engagement of families
- Quarterly thematic learning reports to the Executive Board
- Demonstration of learning-into-action, including equity considerations

This aims to ensure genuine learning impact rather than procedural compliance.

Updated expectations around Service User Voice and Equity

The role of the Maternity & Neonatal Voices Partnership (MNVP) has been a major focus of feedback from providers, regional leaders and ICBs.

Year 8 reflects the reality that:

- MNVP commissioning models vary significantly across the country, and
- MNVP infrastructure does not sit under Trust control or MIS governance.

For this reason, Year 8 does not mandate the presence of a fully commissioned MNVP in order to meet the Safety Action. However, key expectations remain unchanged:

- Trusts must continue to ensure that service user voice is embedded in safety, improvement and decision-making.
- Where an MNVP exists, the MNVP Lead remains the gold-standard partner for independent service user representation.
- Where MNVP capacity is limited or absent, Trusts must take responsibility for ensuring that service user voices - particularly from underserved groups - are captured systematically and influence local priorities and improvement plans.

Trusts will be required to progress local work ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. They must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.

Care Bundles – SBLCB v3.2 and Maternal Care Bundle (MCB)

Trusts must report to Boards quarterly updating on overall progress on SBLCB v3.2 with oversight of all elements, and a focus on progressing locally agreed priorities. They must agree a Board-approved plan to implement the national Maternal Care Bundle in collaboration with all relevant services by March 2027, alongside a governance-approved neonatal pulse oximetry guideline.

Governance changes

Alongside strengthened Board-level oversight, there is now greater clarity on governance arrangements and organisational responsibilities. Trusts will be required to demonstrate that they have implemented the MOSS in accordance with NHSE guidance and can provide evidence to support this.

Key Dates for Trusts

3 March 2026	Final submission date for MIS year 7
31 March 2026	Expected publication of full MIS Year 8 core standards and separate supplemental guidance
23 April 2026	National MIS Year 8 launch event (online) – registration link
2 March 2027	Final submission date for MIS year 8

Year 7 Feedback Survey

To support ongoing refinement of the scheme with a focus on the way that our team support you, we are inviting trusts to complete a short survey on your year 7 MIS experience, including any suggestions, and reflections on the resources available.

Please submit your response using this MIS Year 7 feedback survey link

We thank you for your continued commitment to improving maternity and neonatal safety. We recognise the significant operational pressures on services, and it is our intention that Year 8 supports Trusts in focusing on the core elements of safe, effective care, informed by learning and supported through clear, proportionate assurance.

We look forward to working with you over the coming months and to engaging with your teams during the national launch event on **23 April 2026**.

The MIS Team
NHS Resolution

University Hospitals Tees

Perinatal Staffing Report: Quarter 4, 2025/26

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 2.3

Report author: Stephanie Worn; Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Leadership Team meeting, Quality Oversight Group and Quality 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.

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.

North Tees midwifery workforce has observed a higher than average sickness and absence rate. Monthly meetings with the people teams continue to optimise support and return to work.

Both maternity services are in the process of remodelling the community service to facilitate choice of place of birth that is not on the acute sites.

Obstetric medical lead posts have been advertised and there is an expectation to recruit to the obstetric gap at North Tees and Hartlepool Trust.

Both sites continue to monitor neonatal nurse staffing as per BAPM guidance.

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

Recommendations:

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

University Hospitals Tees
Perinatal Staffing Report
Quarter 4, 2025/26

PURPOSE OF REPORT

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

1. Background

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

2.Minimum safe staffing maternity services

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

3.Midwifery staffing

The midwifery service is compliant with the recommended funded midwifery establishment by BirthRate+ for North Tees and Hartlepool and South Tees Hospitals (Table 1). Appendix 1 outlines the actions and mitigations to minimise risks when the staffing levels are below template. The registered midwifery (RM) vacancy position at the end of quarter 3 is shown in table 2, and the rates are in table 3. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). In the event of a red flag (table 4), the labour ward co-ordinator along with the obstetric consultant determines the appropriate action to maintain safety; clinical and management (appendix1, 2 and 3).

Perinatal staffing levels, including midwifery, nursing and medical as well as activity are monitored and reviewed through daily safety huddles, during which staff discuss current workload, patient acuity and staffing allocations. These huddles provide an opportunity for

the team to identify potential risks, escalate concerns and implement appropriate actions to maintain safe staffing and quality care.

Table 1 Birthrate+ recommendations

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

Table 2 Midwifery vacancy position (clinical)

	North Tees and Hartlepool						South Tees					
	Budget	Jan	Feb	Mar	**3month forecast**	**6month forecast**	**Budget**	Jan	Feb	Mar	**3month forecast**	**6month forecast**
B5/6	107.3	110.53	112.51	110.6	111.41 +4.11	111.81 +4.51	174.68	172.87	173.19	175.22	177.01	177.01
B7 incl Specialist	29.42	27.34	27.14	26.34	26.34 -3.08	26.34 -3.08	38.32	44.00	41.87	41.71	44.00	44.00
Total	**136.69**	137.87	139.65	136.94	**137.72 +1.03**	**138.12 +1.43**	**213.00**	**216.87**	**215.06**	**216.93**	**221.01**	**221.01**

Table 3. Midwifery sickness and absence rates

North Tees	Jan-26	Feb-26	Mar-26
Sickness Rate	6.35%	4.75%	4.72%
Sickness WTE	9.11	6.95	6.96
Maternity Leave Rate	6.23%	6.28%	5.81%
Maternity WTE	8.94	9.2	8.57

South Tees	Jan-26	Feb-26	Mar-26
Sickness Rate	5.32%	5.59%	5.16%
Sickness WTE	11.67	12.24	11.34
Maternity Leave Rate	5.10%	5.18%	5.47%
Maternity WTE	10.89	11.04	11.69

UHT	Jan-26	Feb-26	Mar-26
Sickness Rate	5.72%	5.25%	4.98%
Sickness WTE	20.78	19.2	18.3
Maternity Leave Rate	5.55%	5.62%	5.61%
Maternity WTE	19.83	20.24	20.26

Table 4 Red flags

	North Tees & Hartlepool			South Tees		
	Jan	Feb	Mar	Jan	Feb	Mar
Delayed or cancelled time critical activity	0	12	4	43	29	38
Delay between admission for induction and beginning of process.	0	0	0	18	24	13
Labour Ward Coordinator (LWC) not supernumerary.	0	1 (not start of shift)	0	0	0	0
One - one care in active labour	0	0	0	0	0	0
Delay in Triage	0	0	0	0	0	0
Missed or delayed care	0	4	1	1	2	3

Supernumerary Labour Ward Co-ordinator (LWC)

Availability of a supernumerary LWC is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and

guidance to clinical staff and able to manage activity and workload through the labour ward. For the purpose of Maternity Incentive Scheme year 7, the LWC is to have supernumerary status at the start of every shift (table 5).

Table 5. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance North Tees and Hartlepool	Compliance South Tees
Jan	31	62	100%	100%
Feb	28	56	96% (1 case)	100%
March	31	62	100%	100%

One to One in Established Labour

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

Table 6. 1-1 care in labour compliance

	Jan	Feb	Mar
North Tees	100%	100%	100%
South Tees	100%	100%	100%

4.Obstetric staffing

South Tees hospital

The service meets full requirement established at consultant grade. There has been some pressure within the consultant workforce since October, available for on call and elective obstetric work due to Maternity leave, occupational health requirements and sabbatical leave. The department has successfully recruited one Locum Consultant on a fixed term contract who started in February covering maternity leave vacancy. Return to work plans have been made for the consultant on planned sick leave with intention for phased return from February and full-on call duties from May.

In response to this the existing Consultant workforce are undertaking additional shifts to mitigate the current 2 gaps in the rota. A locum consultant Obstetrician through the trust verified agency has been appointed from 1st February to support the on-call rota. Weekly obstetrics and gynaecology staffing is coordinated by the rota Consultant Rota Lead, rota administration team and the College tutor to ensure safe staffing and meeting the training needs of the doctors in training in the department. There is an emergency rota cover contact every day for resident doctor sickness and absence, reflected on the Medi rota. There are twice daily multidisciplinary team handovers of care for obstetrics and twice daily consultant led multidisciplinary ward rounds taking place. There is on-going monitoring of consultant attendance for obstetric emergencies to ensure appropriate consultant attendance for complex obstetric emergency care in line with the national recommendations of Royal College of Obstetrics and Gynaecology.
The departmental support for enhancing perinatal medical leadership has continued with job planned dedicated time for the preterm birth and fetal monitoring consultant lead roles in place.

North Tees Hospitals

The service is at full establishment at consultant grade for Obstetrics and Gynaecology.
The pressures within the consultant workforce relate to cover for the emergency work within obstetrics due to long term sickness absence, occupational health recommendations and maternity leave. This has resulted in the requirement for additional cover for 2 gaps in the consultant rota. There were 4 gaps last year now reduced to 2 as the maternity leave consultant and the planned sick leave consultants have returned. The current gaps have been covered by the existing consultant workforce. Recruitment to a new consultant post is expected which is going to be advertised in April with intention to start from July

5.Neonatal nurse staffing

North Tees and Hartlepool

The staffing compliance rate over quarter 4 was 87% in comparison to the national average for the quarter of 89% for SCBUs. The service used the National neonatal workforce calculator tool and have developed an action plan shared with the Neonatal Operational Delivery Network previously agreed by the Board of directors in quarter 1. Compliance is managed through escalation of additional shifts paid via NHSP and overtime in times of increased occupancy and acuity. Contributary factors to the decreased compliance are an increased occupancy rate and an infant requiring an aspect of care which generates an Intensive Care Day but that could be appropriately managed in a SCBU setting. This has impacted negatively on the compliance rate in January (70%) reducing the overall quarter compliance. However, it should be noted that compliance was improved in February (92%) and March (100 %). Qualification in Speciality (QIS) qualified staff remains at 91% due to new starters but remains well above the national standard of 70% of registered nurses with QIS qualification. The number of shifts staffed to meet BAPM recommendations of QIS nurses remains 100% complaint over the quarter. The neonatal nurse workforce has a nominated lead for preterm birth.

South Tees Hospitals

The BAPM nurse staffing compliance rate for Q4 was 85%. NHSp continues to cover sickness absence along with support from the paediatric areas.
63% of staff have the Qualification in Speciality Qualification (QIS) which is below the standard rate of 70%. The lower compliance is due to staff leavers who hold the qualification, and new recruits require training. A development plan has been actioned with the rate increasing to 67% by the summer. The vacancy position is 0.8wte, and initial approval was given thought withdrew due to the Trust vacancy freeze.

6.Neonatal Medical staffing

North Tees and Hartlepool

The neonatal medical staffing continues to be compliant with BAPM guidance in all tiers. The Advanced Neonatal Nurse Practitioner (ANNP) Workforce is at over establishment following agreement to facilitate additional trainee posts to ensure skill and competence is maintained given the age profile of this work group with the two trainees finishing Year 2 and joining the rota in October 2025. This will facilitate ANNPs being able to spend time at James Cook hospital for skills maintenance and development which has continued in quarter 4. A review

of the new BAPM framework for medical staffing in SCBU's has commenced. The neonatal lead has returned from maternity leave in January 2026.

South Tees Hospital's Neonatal medical staffing

- Tier 1 is 100% compliance.
- For Tier 2 the compliance is 98% with 7.8 WTE with recommendation as 8WTE. It is due to LTFT trainees. However, ANNPs and deanery trainees have managed to cover the 0.2 WTE internally with locum cover.
- For Tier 3, the compliance is 100%. There are 9 consultants in total. One of the consultants is on maternity leave. The maternity leave gap is covered by a locum consultant. The consultant who was on sabbatical has returned to work and is on the rota.

Anaesthetics staffing

In quarter 4, 24hour anaesthetic provision was provided for both services evidenced via rotas.

APPENDICES

Appendix 1 Clinical excess activity actions
Appendix 2 NTHFT Staffing Factors and Clinical Actions
Appendix 3 STHFT Staffing Factors and Clinical Actions

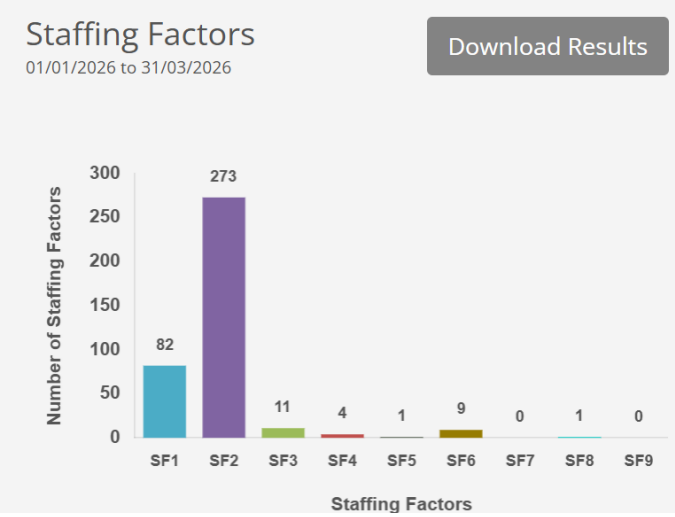
Appendix 1

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

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

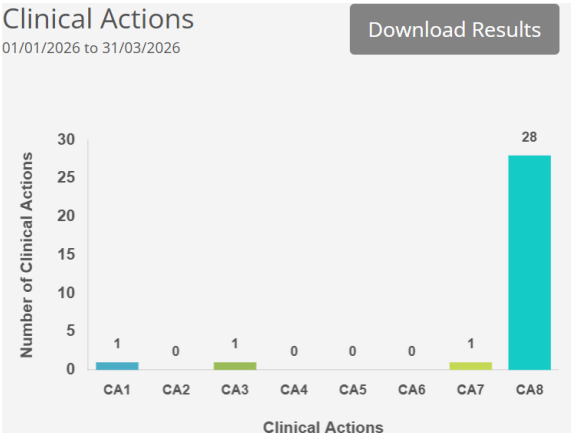
All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

Appendix 2 NTHFT Staffing Factors



Number of Staffing Factors
01/01/2026 to 31/03/2026
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	82	22%
SF2	Unable to fill vacant shifts	273	72%
SF3	Staff redeployed to another area	11	3%
SF4	MW on transfer duties	4	1%
SF5	MW redeployed to another area	1	0%
SF6	Support staff less than rostered	9	2%
SF7	More than 3 band 5 MWs on duty	0	0%
SF8	No Band 7 Coordinator available	1	0%
SF9	Coordinator taking AN/PN care	0	0%
TOTAL		381	



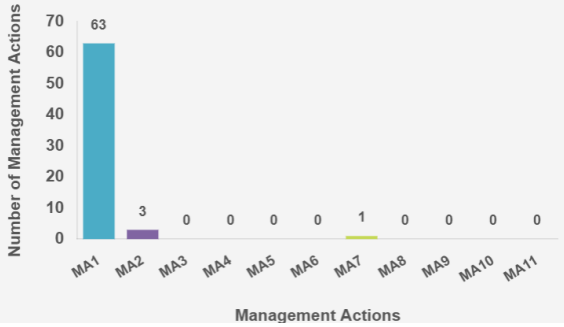
Number of Clinical Actions
01/01/2026 to 31/03/2026
Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	1	3%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL (as per Trust guidelines)	1	3%
CA4	Delay/cancel planned procedures e.g. ECV, Ferrinject, cervical suture	0	0%
CA5	Delay in transfer of cases to theatre (perineal repair, MROP)	0	0%
CA6	Delay Elective LSCS > 24hrs	0	0%
CA7	Delay admissions for IOL	1	3%
CA8	Delay in ongoing IOL/ARM	28	90%
TOTAL		31	

Management Actions

01/01/2026 to 31/03/2026

Download Results



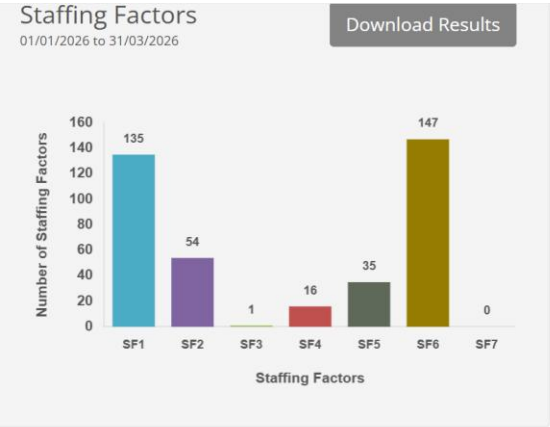
Number of Management Actions

01/01/2026 to 31/03/2026

Download Results

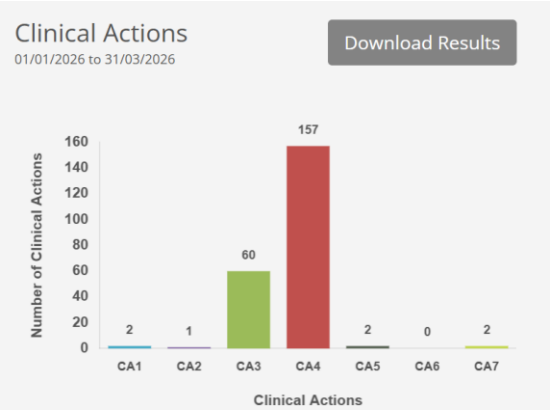
Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	63	94%
MA2	Redeploy staff from community	3	4%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	1	1%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Maternity unit on Divert	0	0%
MA11	Home Birth Service suspended	0	0%
TOTAL		67	

Appendix 3 STHFT Staffing Factors, clinical actions and management actions



Number of Staffing Factors
01/01/2026 to 31/03/2026
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	135	35%
SF2	Unable to fill vacant shifts	54	14%
SF3	MW on transfer duties	1	0%
SF4	MW redeployed to another area	16	4%
SF5	No MCA on duty	35	9%
SF6	No ward clerk on duty	147	38%
SF7	Skill mix issue (identify)	0	0%
TOTAL		388	



Number of Clinical Actions
01/01/2026 to 31/03/2026
Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	2	1%
CA2	Delay in accepting transfers	1	0%
CA3	Delay in commencing IOL from admission (>2hrs)	60	27%
CA4	Delay in continuing IOL (>4hrs)	157	70%
CA5	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	2	1%
CA6	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	0	0%
CA7	Delay/cancel planned procedures, e.g. Ferrinject,cervical suture	2	1%
TOTAL		224	

Management Actions

01/01/2026 to 31/03/2026

Download Results

Number of Management Actions

01/01/2026 to 31/03/2026

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	113	88%
MA2	Staff unable to take allocated breaks	3	2%
MA3	Staff stayed beyond rostered hours	1	1%
MA4	Specialist MW working clinically	3	2%
MA5	Manager/Matron working clinically	2	2%
MA6	Midwifery manager called in out of hours	0	0%
MA7	Close Marton Suite	3	2%
MA8	Low dependency women re-directed to FMC	3	2%
MA9	US dept. to undertake EPAU/MAU scans to free MW sonographers	0	0%
MA10	Contact community midwifery team to explore if any visits or clinics could be cancelled and midwives utilised	0	0%
MA11	Maternity Unit on Divert	1	1%
TOTAL		129	

People Committee

24 March 2026 & 28 April 2026

Connecting to: Board of Directors

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.

Medium Term Financial Plan: Workforce Reduction Programme – Delivery Risk

The Committee noted the 12-week vacancy and recruitment freeze across UHT that commenced on 1 April 2026. Safety-critical posts will continue to be reviewed by the Executive Vacancy Control Panel. When triangulated with the Resource Committee, it is clear that restricting talent acquisition represents only a partial mechanism for managing WTE.

Assurance will continue to be sought about the pace and order of workforce reduction plans. The Committee noted that financial assumptions are not yet fully aligned with operational readiness. Challenges for maintaining safe staffing, service continuity and positive employee relations would continue to be monitored.

Sickness Absence – Sustained Deterioration

Sickness absence remains above plan at 6.5% across both organisations. The Committee noted the deep-dive work underway (as per the Safer Staffing report) and that attendance management processes have resulted in 21 dismissals to date.

The Committee noted that further assurance is needed on the approach to reducing sickness absence by 1%, as well as on progress toward the longer term 4% target. Continued levels of absenteeism are having a noticeable impact on the financial plan.

Annual Appraisal Compliance

Appraisal compliance across University Hospitals Tees remains below the 85% threshold, with February 2026 performance at 78.3%. Compliance has declined over recent months, particularly at South Tees.

Appraisals were subject to a deep dive at the April 2026 People Committee. Of concern, the Committee recalled that appraisals were escalated to the Board 12 months ago, which prompted a temporary surge in completion. The recent deterioration suggests that the underlying management culture has not materially changed.

The committee were briefed on the actions underway to address the poor performance of appraisal management. An update will be provided for assurance within 3 months.

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.

Mandatory Training
The Committee received partial assurance on progress - albeit slow - towards the 90% mandatory training target, with overall compliance at 86.3% and only one CSU currently meeting the threshold. Ongoing dialogue continues with CSU leaders regarding the value, prioritisation, and return on investment of mandatory training.

Retention
Voluntary turnover stands at 7.12%, remaining below the national average. The Committee noted a positive reduction in resignations within the first two years of service, addressing a previously highlighted area of concern.

Workforce Data Alignment
The Committee noted ongoing challenges in aligning workforce data between NTHFT and STHFT, which continues to limit assurance and weakens benchmarking capability. This standardisation work extends into workplace policies, many of which are still being simplified and harmonised.

Employment Tribunal
The Committee received sight of a reserved Employment Tribunal judgment and has initiated a structured learning process in response to its findings.

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

Health & Wellbeing
UHT awarded Ambassador Status for health and wellbeing at work, reflecting strong organisational commitment.

Menopause Support – Sector-Leading Offer

UHT recognised as an Employer of Choice for Menopause Support and provides clinical menopause services.

Leadership Development Programme
The refreshed leadership curriculum has launched successfully with strong uptake and positive early feedback.

Apprenticeship Strategy
The Committee received positive assurance on the proposal to establish the Education and Learning Oversight Group (ELOG) to strengthen governance, forecasting, and CSU engagement. The reforms represent a major strategic shift with both financial and workforce implications. Without stronger governance, forecasting, and diversification, UHT risks losing levy funds and weakening leadership pipelines.

Recommendations:

Phased Workforce Reduction Plan
Management is asked to provide clear direction, practical support, and firm oversight to ensure that TOM/TOD-aligned workforce-reduction plans — evidencing delivery of the required WTE reductions and the 5% CIP — are delivered to the required standard and within the agreed timescales. Workforce-reduction plans should demonstrate clear triangulation of their impacts on quality, safety, and employee relations, ensuring that all three domains are fully assessed and transparently mitigated.

Absence Management
Management is asked to produce a structured, measurable, and accountable plan that sets out the actions required, the responsible owners, and the mechanisms for tracking progress to reduce sickness absence.

Appraisals
Management is requested to direct targeted intervention on leadership behaviour, accountability, and consistency of management practice; without this, appraisal performance will continue to fluctuate and undermine staff engagement, regulatory assurance, and overall organisational performance.

Academic Committee

19 March 2026

Connecting to: Board of Directors

Key topics discussed in the meeting:

Key agenda items discussed in the meeting included (not exhaustive);

- Board Assurance Framework (Research & Innovation)
- Innovation Update (including Financial Overview)
- Research Update
- Nursing, Midwifery and Allied Health Professionals Presentation
- Education and Learning Annual |Report
- Pharmacy Update
- Committee Effectiveness Review
- Finance Update

Key Points:

- **Board Assurance Framework:** (Research & Innovation) there were no changes to the risk appetite or current risk scores for the 5 strategic risks. There are two red strategic risks relating to innovation growth and innovation embeddedness. Mitigation actions are in place for all strategic risks and extension requests for 11 actions were approved. The BAF report for R&I is reported at each committee meeting.
- **Innovation Update:** Commercial opportunities continued to be an issue at South Tees Hospitals NHS Foundation Trust (STHFT) due to lack of experience and capacity. Funding had been agreed for the Innovation Manager post however, the position remained vacant pending approval of the Vacancy Panel. Absence of the Innovation Manager was impacting on the implementation of the Innovation Strategy. The expectation was that the new manager would drive grant funding applications, manage intellectual property,

support strategic objectives and increase engagement with staff to generate innovative ideas. The Committee reviewed the Innovation department's forecasted deficit, noting the lack of core Trust funding and reliance on legacy funds. The long-term plan was for the department to become self-sustaining through new income streams, including grant funding and SLAs. It was agreed that a three-year financial forecast be developed for Board assurance.

- **Research Update.** A new Senior Clinical Leadership and Research structure had been established. The new structure, which introduced a Director of Research across UHT and two Deputy Directors, one for Research and one for Research Delivery, would increase engagement from academic research units in senior meetings, with the aim of supporting the development of a joint research office and expanding academic units into additional specialties. Approval was being sought for 'UHT Research' to be the new name for all UHT research activity (delivery and development) to align with other group terminology. It was proposed that 'Tees Valley Research Alliance' (TVRA) remained a trusted brand but would represent the wider work across the Tees Valley with multiple external stakeholders. An application was to be submitted to the National Institute for Health and Care Research (NIHR) Capital Infrastructure to fund a fully equipped clinical research "pod" (£1m) to be based on the University Hospital of North Tees (UHNT) site to support recruitment into commercial interventional trials and vaccine studies.
- **Education and Learning Annual Report** provided an overview of Education and Learning activity across UHT for 2025/26 and highlighted achievements, risks, and priorities aligned to strategic workforce, academic and organisational objectives. Significant progress had been made in strengthening governance, enhancing educational delivery and improving alignment between education, workforce planning and clinical priorities. The three key focus areas of the Plan were; building a competent and sustainable workforce, influencing system-wide education and maximising the use of resources, including education tariff and apprenticeship levy funds. Apprenticeship reforms posed operational and financial risks, including potential levy underspend however, UHT had strengthened its collaborative approach across the Integrated Care System (ICS) to minimise fund loss and support talent development.

- **Committee Effectiveness Review:** A review of the effectiveness of the Committee was undertaken in March 2026 by the Company Secretary. The review considered work of the Committee during 2025/26 and concluded that the Committee had met its terms of reference, identified areas for improvement in reporting and Sub Group engagement. An issue was raised with regards to NHS education funding, particularly NMAHP Continuing Professional Development (CPD) funding and the Committee agreed to consider including this as a regular agenda item to ensure comprehensive oversight of workforce development. The Committee agreed that it had discharged its duties, the need for stable membership, improved assurance reporting and the need for agreed future priorities.
- **Finance Update:** The financial position for research, innovation, and education was noted, with small deficits in some areas highlighted. There was a need for more granular reporting to understand the true costs and income associated with academic activities.. The Committee discussed the importance of setting clear expectations for the financial contribution of research and education to the overall UHT position, considering the impact of national policies on cost improvement and the need to protect research funding. It was agreed that summary documents be developed for the Board of Directors, that clearly outlined costs, income and strategic rationale for research and innovation activities, as well as education, with the aim of providing reassurance and supporting informed decision-making. This would be a vast piece of work therefore, updates would need to be brought in bite-sized chunks however, an update would be provided at the next meeting.

Escalated items:

- **Education and Training Financial Transparency:** a summary document was to be produced for Board assurance detailing the overall income and expenditure for research, innovation, and education activities, including whether there was a net loss or surplus.
- **R&D Finances Policy Consolidation:** a joint Group Research and Development Finance Policy be developed that included fundamental principles around cost application and strategic direction, consolidating individual Trust and group policies.

Risks (Include ID if currently on risk register):

- No new risks identified.

University Hospitals Tees

NHS Staff Survey Overview 2025

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 3.3

Report author: Karagh Brennan, People Experience Partner

Executive director sponsor: Rachael Metcalf, Chief People 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:

BAF Strategic Risk: A culture that doesn't promote positivity, respect, inclusion and focus on recognising, respecting and rewarding achievements.

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.

This paper provides a summary from the 2025 staff survey, the data shared is from the pre-embargo staff survey information, using the raw and unweighted data set for University Hospital Tees.

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

Recommendations:

The Board of Directors is requested to acknowledge the contents of this paper and are advised of the recommendation for leads to engage and be involved in the formulation and delivery of any improvements or transformation resulting from the staff survey results in their service area.

2025 NHS Staff Survey Overview

March 2026

1. Introduction

The Annual NHS Staff Survey represents the collective voice of our workforce and provides invaluable insight into the experiences, challenges and aspirations of those who deliver patient care across University Hospitals Tees.

During 2025, North Tees and Hartlepool (NTH) and South Tees (ST) Hospitals NHS Foundation Trusts have continued their journey towards more standardised ways of working as a Group, University Hospitals Tees (UHT). This has included the development and implementation of shared group arrangements, most notably the establishment of Clinical Support Units (CSUs), designed to enable greater consistency, collaboration and efficiency across services.

As these changes have progressed, colleagues are adapting to new structures, roles and ways of working. While such developments bring opportunities for improvement and innovation, they can also present uncertainty and challenge as individuals and teams adjust. People experience change differently; some welcome the opportunity to work in new ways, while others may find periods of transition more demanding.

Alongside the continued pressures associated with workload and clinical demand, this period of organisational change provides important context for understanding staff experience in 2025. The Staff Survey results therefore offer a timely and valuable insight into how our workforce feels during this phase of transition, and where further support, engagement and clarity may be required as the Group continues to evolve.

2. Responses

The 2025 Staff Survey saw North Tees and Hartlepool NHS Foundation Trust achieved 2,114 completions out of 5,062 staff, resulting in a 42% response rate. This represents a 3% decline compared to last year, aligning with the national trend of a 3% decrease in completions. South Tees NHS Foundation Trust recorded 3,008 completions from 10,518 staff, maintaining a 29% response rate, consistent with its performance in the previous year. Combined, the two Trusts achieved a Group completion rate of approximately 33% with a total of 184 departments receiving a bespoke department report.

2.1 NHS Staff Survey Themes: People Promise

The NHS People Promise comprises seven indicators**.** Each of these indicators are considered below, providing results from each Trust, the Group position and a comparison of the previous years' results.

The Staff Survey is aligned to the themes included in the NHS People Promise; plus, a further two additional themes of Staff Engagement and Staff Morale. National theme benchmark results, and free text comments for 2025 will be available after March 12th 2026 (when the embargo is lifted).

The below results have been updated using the benchmarking report that will published nationally following the embargo being lifted. These have changed from the raw data due to the weighting applied to the questions by the national team.

- **We are compassionate and inclusive**

Key indicators in this theme relate to compassionate culture, compassionate leadership, diversity, equality and inclusion.

Trust	2024 Result	2025 Result
South Tees	7.24	7.14
North Tees	7.44	7.41
UHT	7.34	7.28
National Average	7.29	7.28

Both Trust's 2025 results are lower this year at a combined group result of 7.28. However, we remain in line with the 2025 national average of 7.28. Both organisations have scored above the national average (8.37) for the subtheme 'Diversity and Equality' (ST – 8.44 / NTH - 8.57).

- **We are recognised and rewarded**

This theme relates to recognition of good work, feeling valued, satisfaction with pay and colleagues showing appreciation to one another.

Trust	2024 Result	2025 Result
South Tees	5.80	5.63
North Tees	5.99	5.94
UHT	5.90	5.79
National Average	5.94	5.92

Both Trusts have shown a decline in the results within the theme this year, with a combined group result of 5.79.

Both Trusts score below the national average (41.9%) for 'Satisfaction with the extent to which the organisation values my work (ST – 34.47% / NTH – 41.32%).

- **We each have a voice that counts**

This theme explores how colleagues feel about raising concerns and having a voice that is listened to.

Trust	2024 Result	2025 Result
South Tees	6.59	6.46
North Tees	6.74	6.67
UHT	6.67	6.57
National Average	6.67	6.60

Both Trusts 2025 results are lower this year compared to last. The Group result of 6.57 is now marginally lower than the national average of 6.60. Within this theme, 89.75% (NTH) and 89.04% (ST) staff agree/strongly agree that they are trusted to do their job.

- **We are safe and healthy**

This measure covers the health and safety climate, burnout and negative experiences from a safe, health and wellbeing perspective.

Trust	2024 Result	2025 Result
South Tees	5.99	5.81
North Tees	6.27	6.17
UHT	6.13	5.99
National Average	6.13	6.07

Both Trust's 2025 results are lower this year than last and show a combined Group result of 5.99; remaining lower than the national average of 6.07, this theme has declined nationally. Across the Group the results for the questions relating to burnout, fatigue and work related stress continue to be a concern.

- **We are always learning**

This indictor considers opportunities to learn and develop and how supported individuals feel in order to reach their potential; including appraisals.

Trust	2024 Result	2025 Result
South Tees	5.39	5.25
North Tees	5.47	5.54
UHT	5.43	5.40
National Average	5.64	5.57

Across the Group we have seen a minor reduction from 5.43 to 5.40 within this theme, with a 0.07 increase at North Tees. However, both North Tees (67.8%) and South Tees (67.4%) are above or in line the national average (67.4%) for the question 'I have opportunities to improve my knowledge and skills.'

- **We work flexibly**

This theme relates to home life balance and flexible working.

Trust	2024 Result	2025 Result
South Tees	5.83	5.70
North Tees	6.32	6.31
UHT	6.08	6.01
National Average	6.24	6.22

There has been a slight reduction across the Group of 0.07 in relation to working flexibly, and the combined average score is below the national average of 6.22.

- **We are a team**

This theme looks at team and inter-team working and line management; including how we learn from and support each other and take time to celebrate successes.

Trust	2024 Result	2025 Result
South Tees	6.54	6.48

North Tees	6.76	6.78
UHT	6.65	6.63
National Average	6.75	6.75

There has been a slight reduction in this theme overall across the Group. However, on a positive note 79.2% (ST) and 80.2% (NTH) of staff enjoy working with colleagues within their team.

2.2 NHS Staff Survey: Additional themes

- **Staff engagement**

This theme measures motivation, involvement and individual advocacy.

Trust	2024 Result	2025 Result
South Tees	6.78	6.55
North Tees	6.89	6.74
UHT	6.84	6.65
National Average	6.84	6.74

There has been a decline across the Group in Staff Engagement. Both Trusts report only 46.1% (ST) and 50.8% (NTH) of staff look forward to going to work, this is slightly below the national average of 52%.

- **Morale**

Morale is dependent on the culture of the organisation and is influenced by multiple factors. This theme includes individual's thoughts on leaving the Trust as an employer.

Trust	2024 Result	2025 Result
South Tees	5.84	5.59
North Tees	6.01	5.91
UHT	5.93	5.75
National Average	5.93	5.84

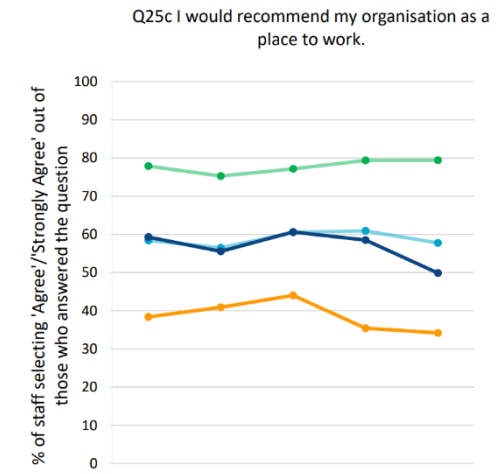
Levels of morale has decreased across the Group. However, only 19%% (NTH) and 20.6% (ST) agree that they will look for a new job in the next 12 months, whilst concerning, this is below to national average of 21.1%.

2.3 Key Questions: Staff Friend and Family related

It is important to consider responses relating to whether the people working across University Hospitals Tees would recommend the organisation in which they work to their friends and family. These questions are measured as a percentage of people that either agree or strongly agree that they would recommend their organisation as a place to work or receive treatment.

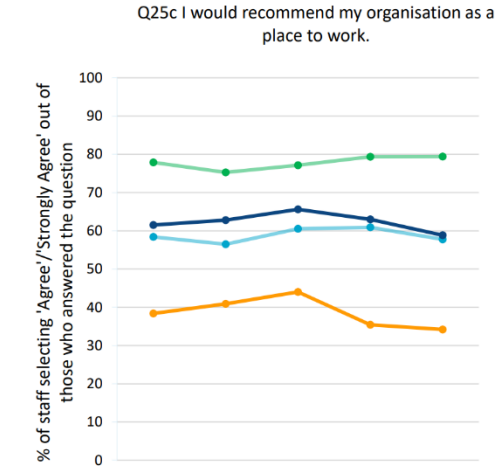
- **I would recommend my organisation as a place to work**

South Tees



	2021	2022	2023	2024	2025
Your org	59.31%	55.56%	60.61%	58.49%	49.86%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2851	3321	3456	3030	2988

North Tees

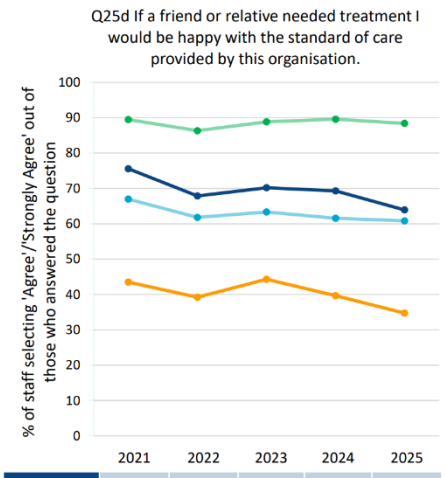


	2021	2022	2023	2024	2025
Your org	61.50%	62.79%	65.60%	62.99%	58.83%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2403	2348	2432	2326	2098

Both North Tees and South Tees have seen a decline in the responses to this question (NTH from 63% to 59% in 2025 and ST from 59% to 50% in 2025). Both organisations are at the lowest score for this question over the past 5 years.

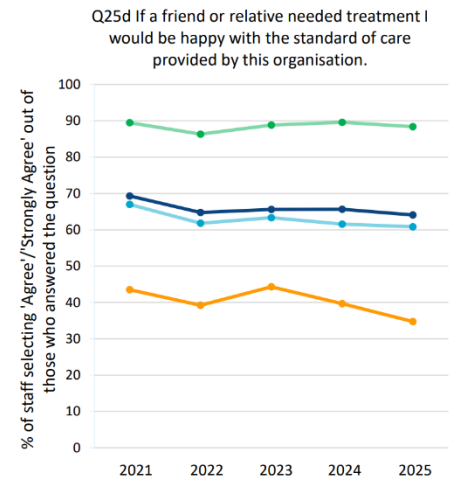
- **If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation**

South Tees



	2021	2022	2023	2024	2025
Your org	75.57%	67.89%	70.20%	69.30%	63.90%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2847	3322	3456	3030	2981

North Tees



	2021	2022	2023	2024	2025
Your org	69.30%	64.74%	65.59%	65.67%	64.08%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2394	2342	2431	2325	2099

Caring Better Together

Response levels were the same for both North Tees and South Tees for this question (64%) and both organisations remain above the national average (61%) however again, both organisations are at the lowest score for this question over the past 5 years.

3 Summary and Next Steps

While the 2025 Staff Survey results indicate an overall decline across the Group, key cultural strengths remain evident. 'Compassion and inclusivity' continues to be a consistent area of strength, closely followed by 'staff engagement', 'having a voice' and 'we are a team'. These themes reflect the positive aspects of our working culture and provide a strong foundation for further development.

The 2025 Staff Survey results show that, in particular, South Tees has experienced a decline across all People Promise themes. While this mirrors the national picture and reflects wider pressures across the NHS, it nonetheless provides an important signal that we must act with focus and urgency. These findings give us a clear mandate to strengthen the mechanisms, processes and policies that shape staff experience and to accelerate our improvement efforts. In response, the Culture Team will undertake detailed analysis of the results and work closely with CSUs and department managers to develop targeted, forward-looking action plans.

Despite the overall decline across the People Promise themes, the survey results also show areas of genuine strength. South Tees has seen improvements in several question-level scores, particularly those relating to line management. Staff report higher scores than in 2024 for statements such as *"My immediate manager cares about my concerns," "My immediate manager takes effective action to help me with any problems I face,"* and *"My immediate manager values my work."* These gains indicate that, even amid increasing operational pressures and a significant period of organisational change, the quality of local leadership and day-to-day support remains a positive and stabilising factor for many colleagues. This provides an important foundation on which to build as we move into the next phase of our improvement work.

CSU-level results have already been shared, and individual departmental reports will be issued alongside a toolkit to support interpretation and action planning now that embargo has lifted (from 12 March 2026). One-to-one support will be available for line managers through the Cultural Development Team, complemented by virtual Staff Survey Masterclasses and a coordinated communications plan. To deepen understanding and drive improvement, the ten lowest-scoring departments will also be supported to undertake a TED survey, with TED remaining available as an open offer to any department seeking further insight.

The data will be presented on the Power BI platform and will be broken down into CSU level and department level data, presenting People Promise themes, subthemes and question scores. The data is available in the raw data format broken down in alternative ways. This includes; staff group, job role, area of work, age, ethnicity, gender identity, religion and sexuality. The Cultural Development Team are analysing this information and are able to create bespoke reports using this raw data upon request.

Appendix 1 shows our position in relation to the Trusts within our ICB.

Below is the high-level staff survey plan which outlines the delivery of action.

Date (2026)	Action
January/February (embargo period)	Preparation of detailed reports and analysis

February (embargo period)	National benchmarking reports available
March	Embargo lifted; data shared with CSU's
April	Detailed survey data shared with CSU's and Department leads, action plans developed
May	Results shared with staff. Staff Survey Masterclasses for department leads
July-August	Data sort for 2026 survey
September-November	Field work for the 2026 survey

4 Recommendations

It is recommended that the content of this report is acknowledged and next steps noted in relation to sharing the results across the Group and developing actions to address areas of concern.

NHS
University Hospitals Tees

Appendix 1 – Regional position against national comparator group average

Organisation	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Benchmark Best	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Benchmark Worst	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Benchmark Average	7.28	5.87	6.6	6.07	5.57	6.22	6.75	6.74	5.84
County Durham and Darlington NHS Foundation Trust	7.17	5.8	6.49	5.98	5.53	6.15	6.67	6.51	5.74
Gateshead Health NHS Foundation Trust	7.18	5.76	6.44	5.95	5.38	5.99	6.55	6.46	5.59
North Cumbria Integrated Care NHS Foundation Trust	7.11	5.79	6.43	6.15	5.31	6.07	6.6	6.49	5.81
North Tees and Hartlepool NHS Foundation Trust	7.41	5.94	6.67	6.17	5.54	6.31	6.78	6.74	5.91
Northumbria Healthcare NHS Foundation Trust	7.71	6.31	7.05	6.58	5.93	6.23	6.97	7.14	6.42
South Tees Hospitals NHS Foundation Trust	7.14	5.63	6.46	5.81	5.25	5.7	6.48	6.55	5.59
South Tyneside and Sunderland NHS Foundation Trust	7.38	6	6.75	6.25	5.76	6.37	6.78	6.8	6.07
The Newcastle upon Tyne Hospitals NHS Foundation Trust	7.25	5.71	6.52	6.07	5.38	6.01	6.51	6.72	5.84

	= Above Group Average
	= Below Group Average
	= Group Best

University Hospitals Tees

Freedom to Speak Up End of Year Report 2025/26

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 3.4

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

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Information
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: People Committee

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

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

Key discussion points and matters to be escalated from the meeting

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

There is nothing to alert.

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

To align the recording and reporting of concerns, it was agreed the Freedom to Speak Up Guardian (FTSU) team would move to Healthcare Guardian (previously Inphase). The initial plan was for this to be implemented in February 2026 however this has been postponed to September 2026.

The closure of the National Guardians Office (NGO) has been extended from 31 March 2026 to 30 June 2026. We are awaiting updates from NHS England regarding future plans.

There has been lower reporting of concerns in Q3 and Q4 2025/26. We have considered this may be linked to the new Clinical Service Unit (CSU) implementation and staff settling into new roles, as well as organisational pressures. Across the year the number of concerns reported has increased by 12.90%.

From the 6 April 2026 sexual harassment will become a "protected disclosure" under UK whistleblowing law. This ensures that reporting sexual harassment in the workplace is directly protected under Public Interest Disclosure Act 1998.

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

It is positive to note there has been a reduction in anonymous reporting at South Tees Hospitals NHS Foundation Trust (South Tees) over the last 12 months as demonstrated in Graph 1.

The FTSU Champion Networks at North Tees & Hartlepool NHS Foundation Trust (North Tees) and South Tees have now aligned as University Hospitals Tees (UHT).

To support effective reporting of concerns and themes the reporting system at South Tees was updated to ensure the process for staff speaking up via the electronic system is streamlined and user friendly whilst capturing essential information.

The FTSUG now have an office at Friarage Hospital Northallerton (FHN), meaning that there is a regular FTSU presence across the main sites for South Tees.

Recommendations:

Members of the Board are asked to:

- Note the content of the paper
- Consider through a Board development session, support the completion of the Freedom to Speak Up (FTSU) Reflection and Planning Tool, to help set the strategic and operational direction of the FTSU service across the new CSU structure.

Freedom to Speak Up
End of Year Report 2025/26
Board of Directors
7 May 2026

1. PURPOSE OF REPORT

The purpose of the report is to provide the end of year position of the work carried out and the themes which are arising from the FTSUGs.

The report provides an overview of the themes and issues raised between 1 April 2025 and 31 March 2026, current actions linked to the group improvement plan and proactive work.

2. Recommendations

Note the content of the report.

Consider, through a Board development session, support the completion of the FTSU Reflection and Planning Tool, to help set the strategic and operational direction of the FTSU service across new CSU structure.

3. BACKGROUND

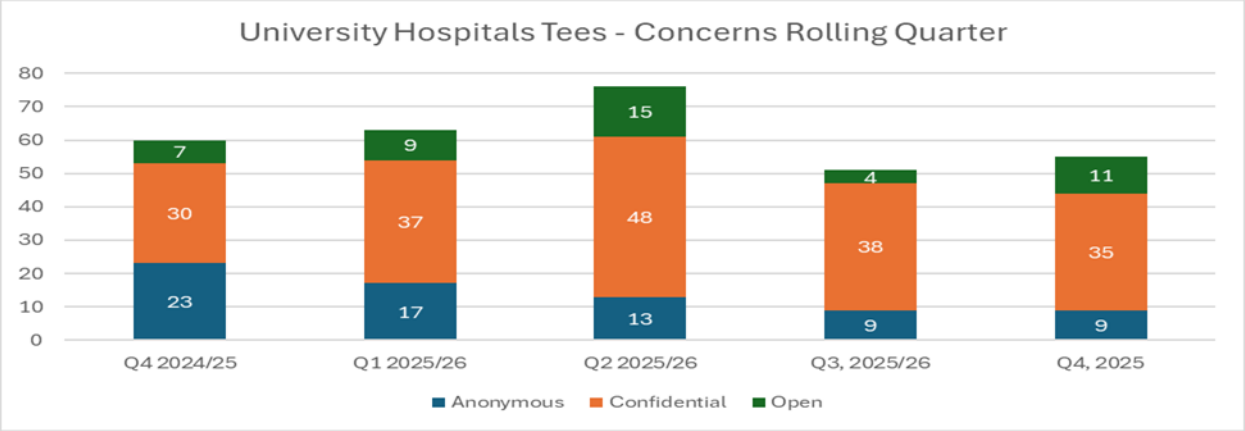
Following recommendations from the Francis Report, FTSUGs were created with the aim of helping to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. At UHT we work to achieve this by supporting colleagues to speak up about concerns, tackling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

4. DETAIL

Assessment of concerns

UHT:
In Q4 2025/26 the FTSUG team received 55 concerns, bringing the total number of concerns raised during 2025/26 to 245 compared to 217 in 2024/25. This is an increase of 12.90%. It is positive to note the number of concerns raised anonymously decreased in 2025/26 to 48 (19.59%) compared to 62 (28.57%) in 2024/25, although this is higher than the national average for anonymous reporting in 2024/25 of 11.6%. There were lower levels of reporting in Q3 and Q4 2025/26. We have considered this may be linked to the new CSU implementation and staff settling into new roles, as well as organisational pressures.

Graph 1



Tables 1 & 2 provide a breakdown of North Tees and South Tees concerns.

Table 1

North Tees

Anonymity	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Anonymous	2	0	0	0	1
Confidential	11	19	21	3	13
Open	3	1	7	0	10

The number of concerns received at North Tees during Q4 2025/26 was 24 bringing the total number of concerns raised in 2025/26 to 75, which is a 15.38% increase compared to 65 concerns in 2024/25. The number of concerns raised anonymously at North Tees remains low at 1 (1.3%0 for 2025/26, which is below the national average for 2024/25 of 11.6%

Table 2

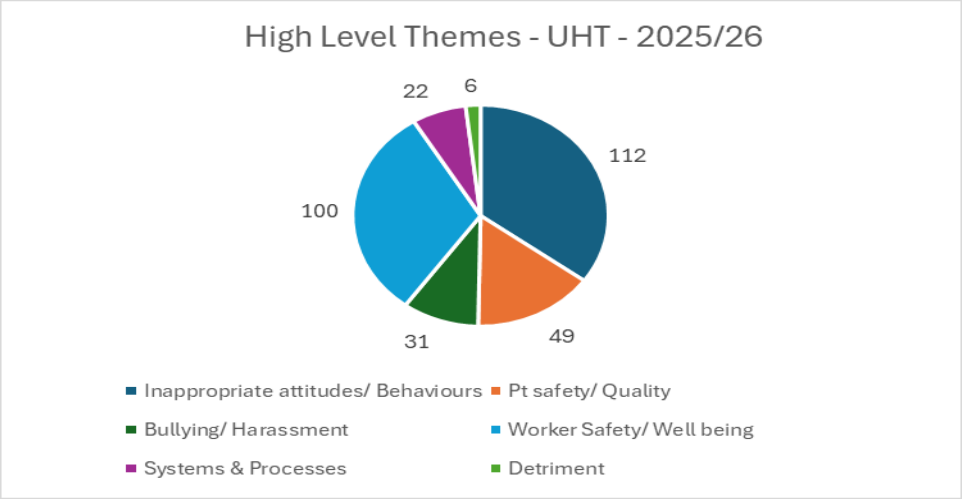
South Tees

Anonymity	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Anonymous	21	18	13	9	8
Confidential	19	18	27	35	22
Open	4	8	8	4	1

The number of concerns raised at South Tees increased from 152 in 2024/25 to 170 in 2025/26 an increase of 11.84%. Anonymous reporting at South Tees decreased from 65 (42.67%) in 2024/25 to 48 (28.07%) in 2025/26, although anonymous reporting at South Tees remains higher than the national average for 2024/25 of 11.6%. Changes were made to the current FTSU system at South Tees in November 2025 which will hopefully further reduce anonymous reporting.

Themes

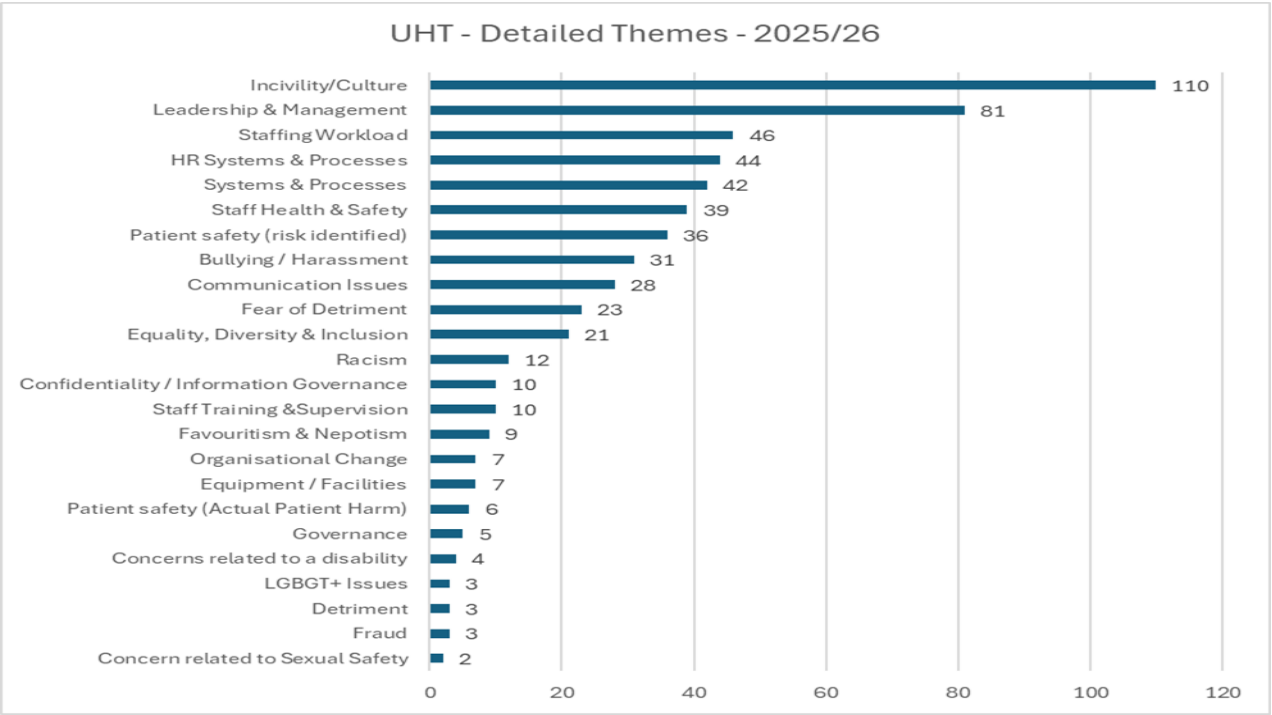
Chart 1 below shows the breakdown of high-level themes identified in 2025/26 for UHT. Now we have moved into our Clinical Service Unit structure, working across UHT, there is no benefit in separating this data between North Tees and South Tees as per previous annual reports. (*please note one concern can have a number of high-level themes*)



Inappropriate attitudes/behaviours was the most reported high-level theme for 2025/26. This mirrors the national picture as this was the highest reported theme nationally in 2024/25 at 39.7%. Worker safety/Wellbeing was the second highest reported theme at UHT. We noted an increase in staff reporting this in Q2 2025/26 and have considered this may be due to uncertainty around the implementation of the new CSU structure. Six concern raisers have reported detriment, and these cases were escalated appropriately to the FTSU NED.

Graph 2 provides a breakdown of the more detailed themes for 2025/26. Leadership and management, Incivility/culture and Staffing Workload feature in the top three detailed themes.

Graph 2



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Learning Identified from Cases:

As an organisation we need to be more curious, invite curiosity and the problem sensors to seek the assurance that we are doing the right thing, including speaking to the experts in the organisation, when we are not sure or need an objective perspective.

In the NHS staff survey results the follow up aspect of staff speaking up is always rated poorly and this is both a local and national picture. We need to improve the relationship of speaking up through good speak up, listen up and follow up, using concepts such as “you said, we did” through our communication streams, and this will help to mitigate the perception of futility within the organisation.

The NGO devised the FTSU Index as an indicator to help build a picture of what speaking up culture feels like for workers. It is a metric for NHS Trusts drawn from five questions in the annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns. The research by the NGO cited that there was a direct corelation with the ratings from staff for these five questions and their organisational CQC rating. Trusts with higher index scores were more likely to be rated ‘good’ or ‘outstanding’ by the CQC. Although the NGO stopped doing the FTSU index, the FTSUG’s would recommend that the same principles be implemented into the new CSU structure.

The completed detriment work now needs to be implemented into the CSUs and staff need to be educated on what it is and that it will not be tolerated by the organisation, if it is reported as a result from speaking up, this will help to mitigate this as a barrier for people speaking up in the first place.

In the current climate of a fast pace changing environment more consideration needs be given in terms of putting people before process, by achieving outputs with clear communication, thought and consideration.

When new systems are put in place, workers should receive advanced adequate training, so staff feel prepared and supported, to mitigate unnecessary stress and anxiety.

When staff are on sick leave, a term of reference should be formulated with the worker regarding check in calls, so staff are not off for long periods of time without this support offering, which can further impact wellbeing.

When staff have spoken up to the Senior Management Team about a concern or an improvement, they should be followed up and assured that their concern has been listened to and responded to within the scope of possibility.

The highest number of concerns continue to be around relationships and behaviours, a more robust holistic approach, to improve the culture in the organisation, needs to be considered, looking at the culture more curiously and working toward an open, transparent and psychologically safe working environment.

As an organisation we need to be receptive and resilient to receiving constructive and fair feedback, when there are suggestions of improvement, rather than come for a place of defensiveness and retaliation.

National Guardian Office Annual Report Headlines 2024/25, presented to Parliament November 2025.

During 2024/25 FTSUG's handled more cases than ever before. The increase in speaking up is the result of FTSUG's working to foster trust and break down barriers to speaking up.

There were 38,158 cases raised with FTSUG's in 2024/25, which makes a total of 171,814 cases in total.

The 38,158 cases reported in 2024/25 was the highest number of cases to be reported in a year and a 18.6 % increase from 2023/24.

The percentage of cases that were raised anonymously increased to 11.6%, up from 9.5% in 2023/24.

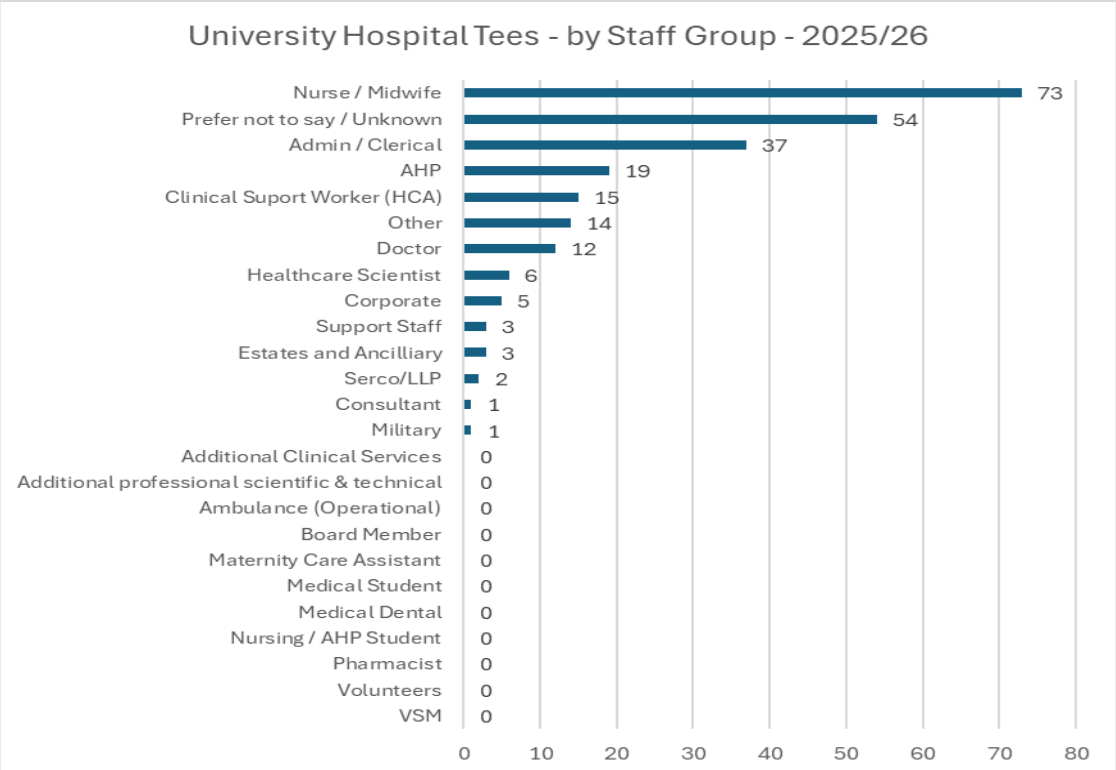
The 79.9% of concern raisers who gave feedback, said they would speak up again.

Detriment for speaking up was indicated in 2.9% of cases, a decrease of 1.1% from 2023/24.

Staff Groups

Graph 3 below shows the staff groups who have raised concerns at UHT. These are the job titles used by the NGO. Nurses/Midwives are the largest reported staff category for 2025/26 which mirrors the national picture. Prefer not to say/unknown was the largest staff group for 2024/25. It is considered changes to the reporting system at South Tees has encouraged concern raisers to provide this detail when raising a concern.

Graph 3



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Equality, Diversity and Inclusion (EDI)

UHT have jointly been collecting EDI data since Q1 2025/26, prior to this date North Tees did not capture EDI data. It is worth highlighting, at North Tees, there is no IT system for workers to complete their EDI information online, so the FTSUG collects this data manually. This will be reviewed at the point the new group IT system is implemented in Q2 2026/27.

Table 3 shows the breakdown of concerns raised by sex, ethnicity, sexuality and disability at UHT.

Table 3

EDI Information 2025/26					
Male	26	Female	100	Prefer not to say: Not stated	31 88
Ethnic Origin of Concern Raisers					
White					57
Asian					<5
Mixed					<5
Black					<5
Other					5
Prefer not to say					78
Not stated					98
Sexuality of Concern Raiser					
Heterosexual / Straight					53
Gay Man / Woman					<5
Bisexual					<5
Prefer not to say					65
Not stated					123
Do you consider yourself to have a disability?					
Yes					73
No					55
Prefer not to say					58
Not stated					59

The FTSUGs continue to work alongside the various EDI staff groups and meet regularly with the EDI lead to triangulate any issues and themes.

Table 4 shows the concerns linked to protected characteristics at UHT.

Table 4

Concerns linked to reported protected characteristics 2025/26 -			
No. of concern raisers who self-reported being from a BAME background	12	No. of concerns raised related to ethnicity or racism	12
No. of Concern Raisers who self-reported having a disability	73	No. of staff who raised concerns related directly to disability	4

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No. of Concern Raisers who self-reported being from the LGBTQ+ community	<5	No. of staff who raised concerns related directly to sexuality or gender identity	3

Freedom to Speak Up Training

All modules of the FTSU e-learning “Speak Up”, “Listen Up” and “Follow Up” are available via ESR. The modules aim to promote a consistent and effective FTSU culture which enables workers to speak up and be confident they will be listened to, and action taken.

Additionally, UHT continues to promote and deliver speaking up workshops, for all three training modules, using each of the modules as a framework, whilst also using evidence-based research from podcasts, webinars, case reviews and inquiries.

FTSU Promotional Platforms

All staff welcome events	Schwartz Round Steering Group
Care Certificate	T-Level Students
Preceptorship training	Undergraduate Medical Students
Teesside University	NTH Solutions
UHT People Group	Community Forum
Individual CSU quarterly meetings	Quarterly UHT People Committee
Bi-annual UHT Board	Ward/Team meetings & huddles
People Hub	Staff Networks
Speak Up Week	Hearing it with Stacey Session
FTSU Podcast	UHT Facebook Page

Group Implementation Plan

The FTSUG’s developed an improvement plan which is regularly added to and reviewed. As elements of this are core business of the FTSUGs, some of the actions are ongoing, forming part of their everyday work.

Action	Lead Trust	Due Date	Progress	Status (open, ongoing, completed, to note)
FTSU Workshops	South Tees North Tees	In place In place	Across UHT workshop content has been developed and is actively promoted.	Complete
FTSU training to be made available to all staff across the group	Group	Q3, 2024	Across UHT Speak Up, Listen Up and Follow Up training is available on ELFH for all staff.	Complete
Champion training	Group	Q1-4	Guardians at UHT continue to expand their FTSUC network,	Ongoing

Development of Champion role, awareness and training Network			through a fair recruiting process, as per National Guidance. FTSUC are trained, can attend quarterly network meetings, have informal bi –annual 1-2-1 and are asked to support staff and signpost and collect high level themed data for triangulation.	
Detriment Work	Group	Q4, 2025	The Detriment presentation and standard operational procedure on how to manage concerns about detriment has been developed.	Complete
Staff survey to be used to develop focussed work in each area.	Group	Q1, 2025	Annual staff survey published and reviewed by the FTSUG's, supporting focused walkabouts across sites focusing on those areas who have scored higher and lower than average.	Ongoing
Data Peer Review	Group	Q1-4	As part of the Group reflection work the FTSUG's at North and South Tees thematically peer review two cases each.	Ongoing
Triangulation of Data	Group	Q1-4	FTSUG attend current cases, staff side, patient safety meetings/steering group, STACQ monthly meetings attended,	Ongoing
EDI - Guardians to link with EDI Network Meetings	Group	Q1-4	All FTSUG's are members of relevant network meetings across the sites. North Tees has established a weekly People Hub, run by the network leads. The FTSUG uses this as another platform to connect with staff and promote FTSU and work with the network leads.	Ongoing
Walkabouts	Group	Q1-4	Regular walkabouts in respective areas completed.	Ongoing
Group Reporting System	Group	Q2 2026	To align as a group in the recording of concerns, the Healthcare Guardian (previously InPhase) system has been agreed with planned implementation now in September 2026.	Ongoing

Key Achievements

Promotion of FTSU across UHT by a variety of methods.

Recruitment of FTSUC through fair recruitment processes, we currently have approximately 60 FTSUC across UHT.

Targeted FTSU walkabouts from triangulated data and staff survey results.

Attending various meetings to support triangulation of data with patient safety, patient experience, safe and effective care, safeguarding and legal services colleagues.

Regular meetings with the STACQ team again to support the triangulation of data being gathered and to support focused work.

Detriment presentation, SOP and feedback forms have been completed and signed off by People Committee for implementation to the CSU structure.

Draft UHT FTSU policy has been completed for review, to align the FTSU services.

Regular "Keep in Touch" meetings with the Executive Sponsor, Non-Executive Director for FTSU, Chairman and CEO. All other senior leaders have helped create a relational approach to speaking up as well progressing any concerns raised.

From a governance and triangulation perspective, FTSUG's, present quarterly updates to People Group and People Committee and bi-annually to the Board of Directors. FTSUG have started to present and triangulate data to the CSU SMT.

Feedback

The FTSUG team seek feedback from concern raisers, below are some examples of feedback received across UHT during 2025/26:-

"I wanted to reach out to thank you for your support - it truly means a lot, as I feel it's the only support I have right now"

"Thank you for your support, it really has helped me get my head (and my conscience) together.

Thank you again for your time, I feel as if a big weight has been lifted off my shoulders by speaking with you".

"I am utmost grateful for your time and energy you put into this, I cannot thank you enough, I really appreciate you, thank you for the love, thank you for your care, thank you for your time thank you for giving me the chance to speak up".

Thank you for listening, it is hard to know who to talk to, when you need to speak to someone impartial.
"I am concerned that as the FTSUG you cannot attend meetings with me, even if your role is impartial."
"Thank you for being so supportive and a great benefit for all of the team, following your discussions"

"It is good to know I have someone to speak to when I am upset, then puts me at ease and gives me good guidance."

NHS Annual Staff Survey

The NGO devised the FTSU Index as an indicator to help build a picture of what speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from five questions in the Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree that they would be treated fairly if involved in an error, near miss or an incident.

Although the FTSU Index is not calculated anymore, for the purpose of this report it was thought, that it would be useful to use a similar concept to allow comparisons across the two Trusts.

For this paper five questions and responses have been taken from the Annual Staff Survey 2025/26, comparing against previous years and benchmarking against the national average to check progress.

The NGO state that the NHS Staff Survey 2025 results show the raising of concerns (or FTSU) sub-score has fallen to 6.37, which is the sharpest single year decline the survey has recorded. The survey found that six in ten staff feel safe to speak up about anything that concerns them, while just under one in two (47.6%) believe their organisation would act if they did so.

NHS Annual Staff Survey Results

Question	North Tees 2022/23	North Tees 2023/24	North Tees 2024/25	North Tees 2025/26	National Benchmark 2025/26
% of staff "agreeing" or "strongly agreeing" My organisation treats staff who are involved in an error, near miss or incident fairly	60.30%	61.85% (+1.55)	60.82% (-1.03)	**61.44% (+0.62)**	58.69%
% of staff "agreeing" or "strongly agreeing" My organisation encourages us to report	87.66%	87.36% (-0.30)	87.51% (+0.15)	**88.68% (+1.17)**	85.24%

errors, near misses and incidents					
% of staff “agreeing” or “strongly agreeing” I would feel secure raising a concern about unsafe clinical practice	74.34%	73.07% (-1.27)	72.28% (-0.79)	**70.76% (-1.52)**	69.82%
% of staff “agreeing” or “strongly agreeing” I am confident that my organisation would address my concerns	61.91%	61.51% (-0.40)	60.52% (-0.99)	**56.53% (-3.99)**	53.94%
% of staff “agreeing” or “strongly agreeing” I feel safe to speak up about anything that concerns me in this organisation	65.03%	64.23% (-0.80)	63.24% (-0.99)	**61.44% (-1.80)**	58.85%

Question	South Tees 2022/23	South Tees 2023/24	South Tees 2024/25	South Tees 2025/26	National Benchmark 2025/26
% of staff “agreeing” or “strongly agreeing” My					

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organisation treats staff who are involved in an error, near miss or incident fairly	57.85%	57.90% (+0.05)	58.19% (+0.29)	**55.08% (-3.11)**	58.69%
% of staff "agreeing" or "strongly agreeing" My organisation encourages us to report errors, near misses and incidents	87.74%	84.94% (-2.80)	85.02%` (+0.08)	**83.97% (-1.05)**	85.24%
% of staff "agreeing" or "strongly agreeing" I would feel secure raising a concern about unsafe clinical practice	74.35%	71.29% (-3.06)	70.26% (-1.03)	**70.35% (+0.09)**	69.82%
% of staff "agreeing" or "strongly agreeing" I am confident that my organisation would address my concerns	58.45%	54.15% (-4.30)	53.32% (-0.83)	**48.59% (-4.73)**	53.94%
% of staff "agreeing"					

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or “strongly agreeing” I feel safe to speak up about anything that concerns me in this organisation	63.17%	62.89% (-0.28)	61.96% (-0.93)	**57.24% (-4.72)**	58.85%

5. CONCLUSION

As we continue the work towards creating a business-as-usual speaking up culture in the organisation, the delivery of the speak up, listen up and follow up training and workshops and the proactive work on detriment, is pivotal.

The FTSUGs look forward to working with the Board to complete the FTSU Reflection and Planning Tool to support the implementation of FTSU across the CSUs with a more strategic and operational direction in 2026/27.

The FTSUGs would like to express thanks for their ongoing support from all colleagues who have helped promote and embed the FTSU ethos over the reporting period.

University Hospitals Tees

Safe Staffing Monthly Report (Feb 26 data)

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 3.5

Report author: Lindsay Garcia, Group 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: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partner's ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Choose an item.

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

This report provides assurance on inpatient nursing staffing for February 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, registered staff sickness increased marginally by 0.1% to 7.10%.
The largest variances between actual and required CHPPD were observed on Ainderby Ward 9, Rutson and Coronary Care Unit, showing potential misalignment between staffing and patient acuity.
The financial ledger reports a vacancy position of 96.19 WTE for HCSWs.
The highest number of Datix incidents relating to staff shortages and skill mix were reported in Ainderby, CYPED, Ward 12, Eston PCN and Greater Middlesbrough PCN.

At North Tees, the Band 3 HCSW vacancy position across the in-patient wards and clinical departments remains a concern as has increased from -46.24wte in January to -52.5wte in February 2026 with a forecasted increase to -56.3wte in March 2026. At North Tees, the Band 2–3 pipeline programme remains in place, supporting trainee HCSWs to achieve the required competencies through a 12 month fixed term post. This programme, however, is now not able to sustain the rising vacancy position each month. A HCSW B3 advert was released in January with 45 people being shortlisted and now pending interview via centralised recruitment.

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.

Across South Tees, the average proportion of planned nurse shifts filled in February 2026 declined slightly to 97.5%.
Both registered and unregistered staff turnover remained stable, with a small month on month reductions across both staff groups. Overall turnover remains lower than in February 2025, indicating continued year on year improvement in workforce retention.

Total nursing sickness and absence at North Tees has increased slightly from 7.26% in January to 7.68% in February 2026.

In February 2026, the NHSP fill rates for both Registered and Unregistered nurses, at North Tees and Hartlepool have reduced. Registered nurse fill is 76.9% (from 79.2% in Jan26) and Unregistered nurse fill is 80.9% (from 83% in Jan26).

At North Tees the overall CHPPD variance for February 2026 is -0.19, with variances >1 identified in multiple wards, including cardiology, respiratory, gastroenterology, stroke, orthopaedics/frailty and endocrinology. These areas align with findings from the biannual nurse establishment review that was presented to Board in July 2025, reinforcing the need for further establishment reviews as CSU service delivery models are developed.

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

Staff sickness at South Tees continues to be actively managed through Health Improvement Plans, with twice daily Safe Care reviews mitigating the impact of sickness and increased patient acuity on CHPPD compliance. Workforce oversight supports timely redeployment to maintain safe staffing levels.

HCSW vacancies continue to be addressed through centralised recruitment, with a further 19 successful applicants interviewed in February 2026. The registered nurse over establishment position (-6.30 WTE) is proactively managed through Workforce Assurance meetings and vacancy controls to ensure alignment with approved posts and statutory reporting.
Temporary staffing use remains demand led, with redeployment prioritised over NHSP. Weekly and monthly workforce reviews support triangulation of sickness, turnover and establishment data.

At North Tees, the Band 5 RN vacancy position reduced from –29.11wte in January 2026 to –16.25wte in February 2026, with a forecasted position of –4.45wte in March 2026. Plans are in place to move fixed term NQNs into these posts. Full assurance is provided that all Trust home NQNs have been appointed.

Total nursing turnover has reduced from 6.6% in January to 5.58% in February 2026.

Recommendations:

Members of the Board are asked to:

- Note the content of this report;
- Note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout February 2026;
- Note the progress made across both sites in relation to developing and retaining the nursing workforce;
- 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;
- 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.

Nurse Monthly Safer Staffing Report: February 2026 data
Board of Directors
7 May 2026

This exception report provides the People Committee 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 February 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>

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

<u>Night Shifts:</u>

- Maternity Centre Friarage
- Ward 24 HDU – Neurosurgery High Dependency Unit

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- Ward 31 – Short Stay Acute Assessment Unit

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

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

- Low RM and HCSW fill rate during the **day** on delivery suite and ward 22 due to RM vacancies – have been appointed into but not taking up posts till March 2026 and will initially be supernumerary.
- Low HCSW fill rate during **day** in SCBU and Elective Care likely due to occupancy.
- Low HCSW fill rate during the **day** on SDU, 28, 32, 36 due to sickness.
- High HCSW fill rate during the **day** on 26, 41 linked to enhanced care demand.
- High HCSW fill during the **night** in ACU, 26, 27, 32, 40, 41, 42 linked to enhanced care demand.
- Low HCSW fill during the night in Elective Care likely due to occupancy.

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		**February 2026**
	RN/RMs (%) Average fill rate – DAYS	89.5%
	HCA (%) Average fill rate – DAYS	90.8%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	96.3%
	HCA (%) Average fill rate – NIGHTS	103.4%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**97.5%**

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

Overall, Ward Fill Rate		February 2026
	RN/RMs (%) Average fill rate – DAYS	88%
	HCSW (%) Average fill rate – DAYS	90%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	100%
	HCSW (%) Average fill rate – NIGHTS	118%
	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 directly referenced in any concluded PSIRF reviews in February 2026. Future reports will provide nurse sensitive indicators in line with patient safety and quality metrics.

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

During February 2026, a total of **12** staffing-related red flags were raised at South Tees. These included:

- **4** flagged as *Shortfall in Registered Nurse (RN) time*
- **7** flagged as *Missed 'intentional rounding'*
- **1** flagged as *less than 2 RN's on shift*

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

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

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

- **1** flagged by Emergency Assessment Unit – due to a shortfall in RN, mitigation and appropriate staffing plans in place via daily safe staffing meeting.
- **1** flagged by Critical Care due to a shortfall in RN – mitigation and appropriate redeployment in place via daily safe staffing meeting.
- **1** flagged by ward 36 due to a shortfall in RN – mitigation and appropriate redeployment in place via daily safe staffing meeting.

- **1** flagged by ward 25 due to a shortfall in RN – mitigation and appropriate redeployment in place via daily safe staffing meeting.

Datix/In-Phase Submissions

At South Tees during February 26, there were 82 Datix submissions relating to staffing. This is a 59% decrease in comparison month on month. Staff are encouraged to Datix any staffing related issues which are reviewed and discussed as part of workforce assurance and governance meetings. The majority of Datix submissions, highlight a reduction in staffing on Ainderby, CYPED, Ward 12, Eston PCN and Greater Middlesbrough PCN. All shortages raised were managed through the Safe Care process throughout January 26.

At North Tees, in January 2026, there was a total of **18** in-phase reports relating to nurse staffing, an increase from **7** in January 2026. Safe staffing plans maintained via actions at the safer staffing meetings in February 2026.

6 of the reports were submitted from the submitted from the Maternity teams due to the following themes;

- Labour Ward Coordinator not supernumerary due to high levels of activity and acuity
- Low maternity staffing over weekend resulting in long waits in maternity triage
- Delay in maternity care for >6hrs due to lower than planned staffing levels.

12 reports were submitted by the acute in-patient wards/departments due to the following themes;

- RN shortfalls resulting in gaps in basic nursing care and medicine administration
- Gaps in Enhanced Care worker provision resulting on ward staff needing provide 1:1 care.
- High levels of acuity and dependency and staff still being redeployed to other areas to manage safe staffing across all areas.
- HCSW gaps with no ability to fill
- Poor skill mixes due to short term RN sickness

Vacancy & Turnover

The RN vacancy and turnover position across South Tees remains stable, with Newly Qualified Nurses progressing through recruitment for start dates from February 2026. To maintain workforce resilience during a period of zero RN vacancies, UHT has agreed to recruit NQNs on an over establishment basis to provide planned backfill for maternity leave, long term sickness, and natural turnover, reduce reliance on temporary staffing, and protect a sustainable RN pipeline amid anticipated reductions in nursing programme applications. All NQNs commence on 12 month fixed term contracts with planned transition to substantive roles, supported by weekly NQN deployment oversight. Success will be measured through ESR workforce reports.

The South Tees financial ledger for February 2026 reports a net position of –6.30 WTE across registered nursing and midwifery roles, and a total vacancy of 96.19 WTE for Healthcare Support Workers.

At North Tees, the Band 5 RN vacancy position reduced from –29.11wte in January 2026 to –16.25wte in February 2026, with a forecasted position of –4.45wte in March 2026. Plans are in place to move fixed term NQNs into these posts. Full assurance is provided that all Trust home NQNs have been appointed.

At North Tees, the Band 3 HCSW vacancy position across the in-patient wards and clinical departments remains a concern as has increased from -46.24wte in January to -52.5wte in February 2026 with a forecasted increase to -56.3wte in March 2026. At North Tees, the Band 2–3 pipeline programme remains in place, supporting trainee HCSWs to achieve the required competencies through a 12month fixed term post. This programme, however, is now not able to sustain the rising vacancy position each month. A HCSW B3 advert was released in January with 45 people being shortlisted and now pending interview via centralised recruitment.

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 February 2026 can be reviewed in Appendix 2.

Table 2 South Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
December 25	9.26	9.26	0.00
January 26	9.27	8.80	-0.47
February 26	9.38	8.83	-0.55

During February 2026, data showed that 10 inpatient areas exceeded the required average CHPPD. Areas operating below the required CHPPD were primarily affected by increased staff sickness and higher patient acuity. These pressures were actively managed through twice daily Safe Care reviews, supporting timely workforce planning and the redeployment of staff 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 incorporating regular acuity review, professional judgement and escalation processes.

The greatest variance between required and actual CHPPD was observed on Ainderby, Ward 9, Rutson and Coronary Care Unit.

- **Ainderby:** Registered staff sickness decreased by 2.4% to 7.1% in February 2026, while unregistered staff sickness increased by 0.9% to 12.3%. Temporary staffing data is consistent with this position, with 19% of temporary staffing requests attributable to sickness absence. Additional factors contributing to CHPPD variance included increased patient acuity and higher demand for enhanced care, reflected in a rise in NHSP CG47 Level 3 shift requests (24%) and an increase in patients requiring falls watch observations (16%). It is also noted that additional beds remained open throughout February, with 20% of temporary staffing requests required to safely staff these areas.

- **Ward 9:** reported a month-on-month reduction in registered staff sickness during February 2026, decreasing by 3.9% to 4.1%. In contrast, unregistered staff sickness increased by 11.7% to 14.1%. This position is reflected in temporary staffing data, which indicates that 38% of temporary staffing requests were attributable to sickness absence. CHPPD variance was further influenced by substantive unregistered vacancies currently held by the ward, with vacancies accounting for 44% of temporary staffing requests.

- **Rutson:** Overall staff sickness reduced month on month in February 2026. Registered staff sickness decreased by 2.1% to 3.3%, while unregistered staff sickness reduced by 0.8% to 15.3%. Although there has been a slight improvement, unregistered sickness remains significantly above the Trust target. This position is reflected in temporary staffing activity, with 29% of temporary staffing requests attributable to sickness absence. Further demand for temporary staffing was driven by increased patient acuity, with 11% of shifts required to support CG47 Level 3 patients, 14% to provide falls-watch cover, and a further 24% associated with other forms of enhanced observation.

- **Coronary Care Unit:** Registered staff sickness decreased by 6.2% to 0.7% in February 2026, while unregistered staff sickness increased by 40% to 52.9%. Given the small size of the unregistered workforce within this area, relatively small changes in absence result in significant percentage fluctuation. Temporary staffing data is consistent with this position, with 64% of temporary staffing requests attributable to sickness absence. CHPPD variance was further influenced by increased patient acuity, with 34% of temporary staffing requests coded to provide falls watch support.

The reasons for NHSP bookings were consistent with the staffing challenges outlined above **(Appendix 3).**

Table 3 North Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
December 2025	8.97	9.02	+0.05
January2026	8.84	8.33	-0.52
February 2026	8.74	9.11	+0.36

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In February 2026, the total variance is in a slightly positive position. The areas highlighting a higher 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 32 – Orthopaedic Fragility
- Ward 36 - Endocrinology

Many of these areas were highlighted as requiring investment into the nursing workforce models as part of the last bi-annual nurse establishment review. SNCT data collection has been completed throughout March 2026 with the final report and recommendations going to Board in May/Jun 2026.

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 February 2026 decreased by **4.4%** compared to February 2025. Bank filled hours also declined by **6.9%** over the same period. These reductions indicate that ongoing initiatives to optimise workforce deployment and reduce reliance on temporary staffing are delivering measurable and sustainable improvements.

Nursing agency usage at South Tees continues to remain low. In February 2026, a total of **289** nursing agency hours were booked, representing a 20 hour increase month on month. Usage was concentrated within theatre services, with 110 hours in Friarage Theatres, 64 hours in Cardio Theatres, and 115 hours in Orthopaedic Theatres.

ODP agency usage remains present within the Trust. In February 2026, a total of **952** ODP agency hours were utilised, reflecting a 60 hour increase month on month. This usage was primarily within Orthopaedic Theatres (645 hours), with additional use in Friarage Theatres (180 hours) and Cardio Theatres (127 hours).

An exit strategy is in place to reduce reliance on agency staffing, aligned with the training matrix and competency progression of Newly Qualified Nurses and ODPs.

In February 2026, bank staffing spend increased by £8,821 (**+0.6%**) compared to February 2025. Conversely, agency staffing spend for nursing increased by £10,582 year on year while agency ODP spend saw a reduction of £2,502.

During this reporting period, overall expenditure has increased despite a reduction in demand. This is primarily attributable to a higher proportion of hours being worked at enhanced rates, reflecting increased unsocial hours, and a greater share of bank shifts being covered by higher band staff.

The overall fill rate for bank and agency staffing in February 2026 was 81%, representing a 1% month-on-month increase. This improvement is consistent with established seasonal trends and provides assurance that temporary staffing demand continues to be effectively managed.

At North Tees and Hartlepool, all temporary staffing spends (NMAHP, Medical and Dental, Health Care Scientist and Admin and Clerical) is reviewed monthly via the Temporary Staffing Focus Group (TSFG). This meeting was stood down in April 2026 due to reduced attendance levels. The next meeting is planned to go ahead on the 5 May 2026.

The key priorities and agreed actions from this group have recently been mapped over to new or existing meetings, already in place at South Tees / UHT, allowing for a potential reduction in duplication and a clearer overview, when managing the use of temporary staffing across UHT.

The following summary provides a breakdown of the North Tees, Nursing only spend;

- Nursing Agency spend for February 2026 was £13,629, a **reduction** from £14,060 in January 2026. A total of **£61,347 lower than last year.**
- Nursing Bank spend for February 2026 was £963,419, a **reduction** from £979,972 in January 2026. A total of **£67,647 higher than last year**.
- Nursing overtime spend for February 2026 was £66,259, an **increase** from £53,779 in January 2026. A total of **£18,715 lower than last year**.

Key Priorities

Following the Group workforce assurance meeting in February 2026, priorities identified for alignment include:

- Strengthen and Retain the Newly Qualified Workforce
- Maintain weekly oversight of progression against the training matrix.
- Reduce Reliance on Temporary Staffing
- Continue to shift activity from agency to bank where clinically appropriate.
- Deliver the planned agency exit strategy aligned with competency progression.
- Enhance rota efficiency through demand led rostering and improved forecasting of gaps (maternity, sickness, turnover).
- Continue monitoring sickness trends and implement targeted support in high-pressure specialties.
- Close monitoring of temporary staffing expenditure through CSU and finance reporting.

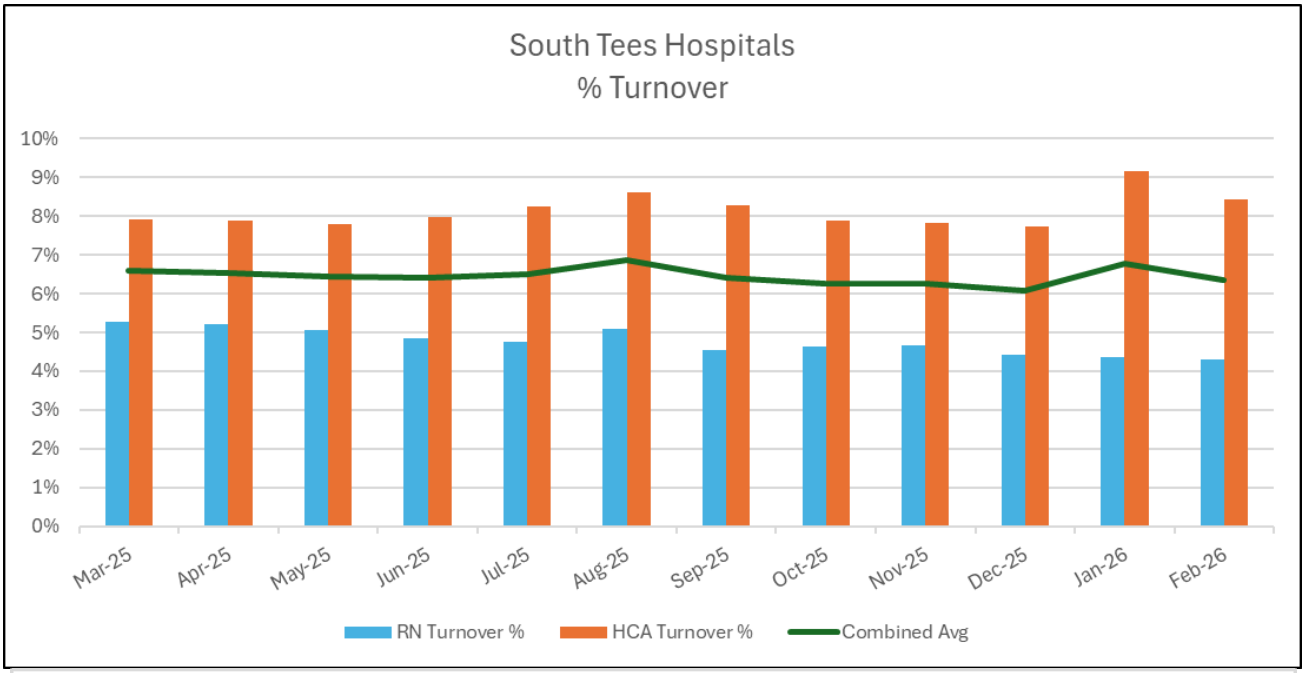
Recommendations

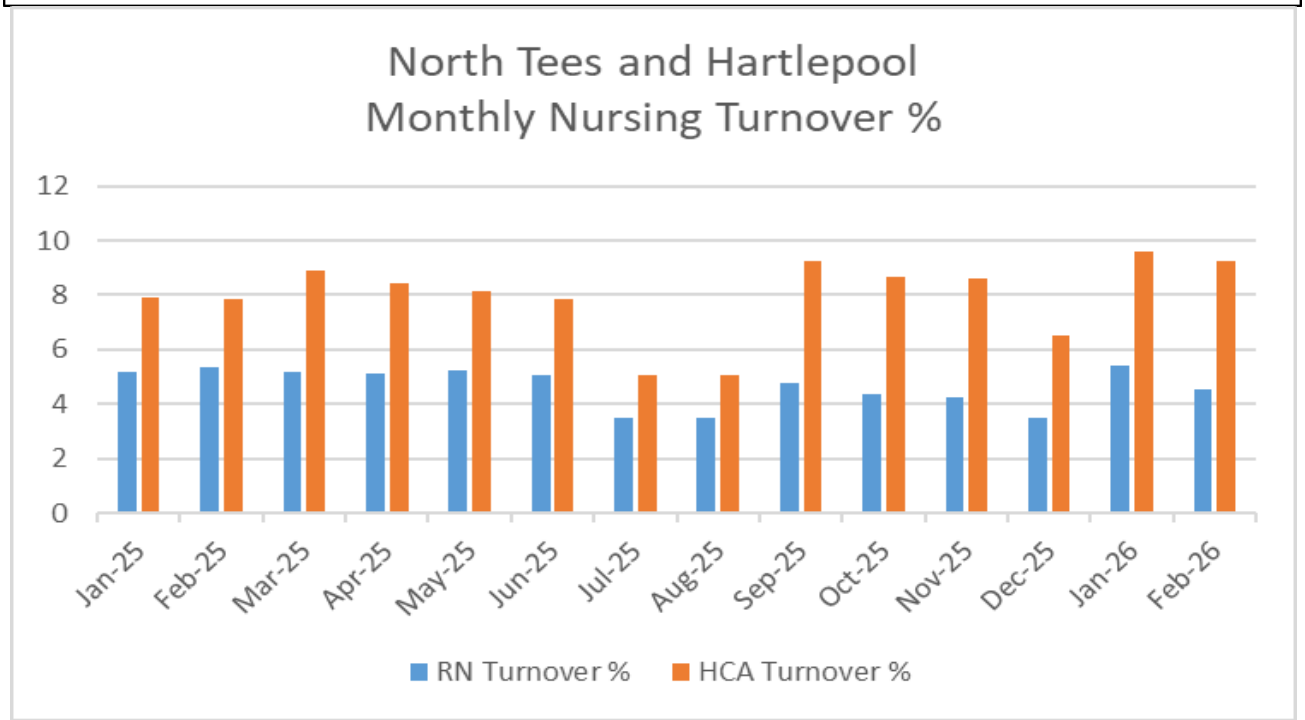
Members of the Board are asked to:

- Note the content of this report;
- Note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout February 2026;
- Note the progress made across both sites in relation to developing and retaining the nursing workforce;
- 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;
- 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 February 2026





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Appendix 2

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

Ward	Average of Required CHPPD	Average of Actual CHPPD	CHPPD Variance
Ainderby Ward	11.31	6.14	-5.17
Cardio HDU	11.14	12.58	1.43
Cardio MB	7.00	8.52	1.52
CCU JCUH	15.02	11.18	-3.84
CDU FHN	8.22	7.82	-0.40
CICU	22.75	23.33	0.58
Critical Care	18.09	25.77	7.68
Friary Ward	8.42	7.35	-1.07
Gara Ward	7.37	13.14	5.78
NNU	14.81	14.21	-0.60
PCCU	14.06	21.31	7.25
Romanby Ward	7.28	6.20	-1.08
Rutson Rehab Ward	11.21	7.43	-3.78
Spinal Injuries Ward	10.97	8.81	-2.16
Tocketts Ward	7.21	6.29	-0.92
Ward 01	8.35	7.89	-0.47
Ward 02	6.46	4.56	-1.89
Ward 03	7.98	5.32	-2.65
Ward 04	8.69	6.41	-2.27
Ward 05	7.28	5.35	-1.93
Ward 06	5.08	5.38	0.30
Ward 07	6.06	5.35	-0.71
Ward 08	5.56	4.96	-0.60
Ward 09	8.85	4.39	-4.45
Ward 11	7.80	5.80	-2.00
Ward 12	8.99	6.27	-2.72
Ward 14	6.07	5.75	-0.32
Ward 21	9.10	12.67	3.57

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Ward 22	12.72	14.40	1.68
Ward 24	8.62	6.75	-1.87
Ward 24 HDU	10.82	18.99	8.17
Ward 25	10.28	7.20	-3.08
Ward 26	10.34	7.06	-3.28
Ward 27	8.21	12.15	3.94
Ward 28	8.66	5.88	-2.78
Ward 29	5.74	4.82	-0.92
Ward 31	9.93	6.79	-3.14
Ward 32	7.17	5.82	-1.35
Ward 33	7.65	6.87	-0.78
Ward 34	7.48	5.62	-1.86
Ward 35	7.97	7.15	-0.82
Ward 36	6.93	6.15	-0.78
Ward 37	11.26	8.19	-3.07
Zetland Ward	8.88	7.58	-1.30
Grand Total	**9.38**	**8.83**	**-0.55**

North Tees Average CHPPD Breakdown by Ward (February2026):

Row Labels	Average of Required CHPPD	Average of Actual CHPPD	Variance
Acute Cardiology Unit	7.93	5.99	-1.94
Critical Care North Tees	17.83	26.88	9.05
Elective Care Unit	4.96	13.66	8.69
Emergency AMB	7.49	7.78	0.29
Neonatal Unit	10.83	19.46	8.63
Paediatrics	9.93	12.36	2.43
SDU	8.81	9.92	1.11
Ward 24 (Respiratory)	9.20	6.37	-2.83
Ward 24 RSU	13.00	9.91	-3.09
Ward 25 (Respiratory)	8.50	6.92	-1.59
Ward 25 RSU	11.06	10.41	-0.65
Ward 26	8.34	6.15	-2.19
Ward 27 (Gastroenterology)	7.92	6.14	-1.77
Ward 28 (Surgery)	6.54	5.96	-0.57
Ward 31 (Surgical Observation Unit)	7.67	7.60	-0.07

Ward 32 (Fragility Fracture)	8.92	7.34	-1.58
Ward 33 (Orthopaedic & Spinal)	6.52	6.15	-0.38
Ward 36	8.31	6.63	-1.67
Ward 37 (Resilience)	6.42	7.18	0.76
Ward 38	6.55	5.78	-0.77
Ward 40 (Acute Elderly)	8.35	6.68	-1.67
Ward 41 (Stroke Unit)	7.99	7.12	-0.87
Ward 42 (Elderly Rehabilitation)	8.05	7.09	-0.95
Grand Total	**8.74**	**9.11**	**0.36**

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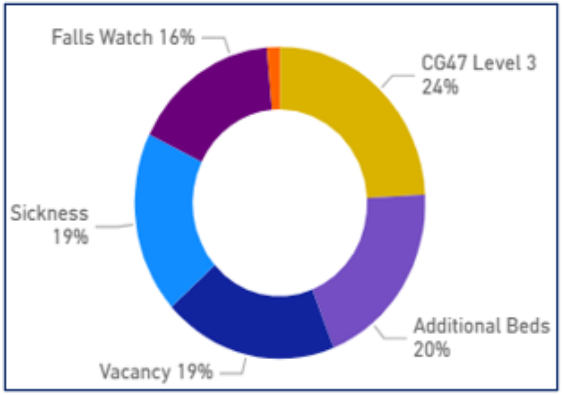
Appendix 3

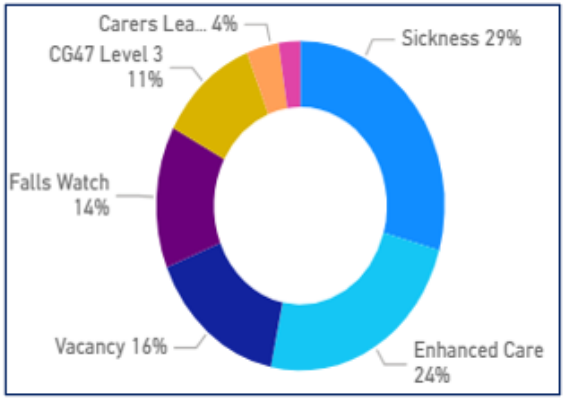
University Hospitals Tees

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

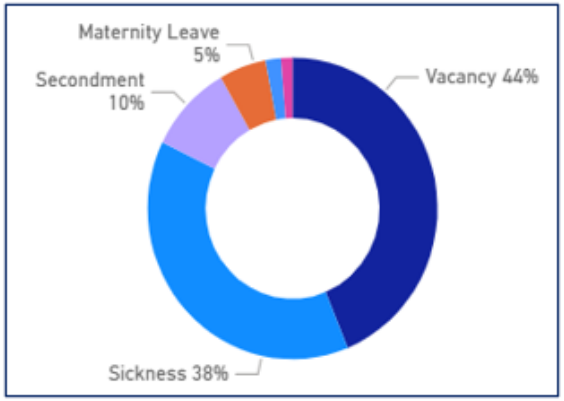
Ainderby



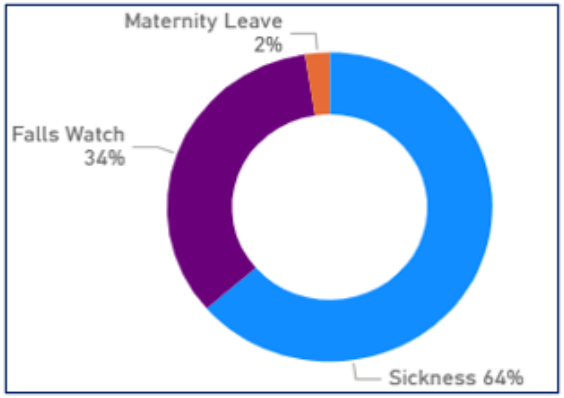
Rutson



Ward 9



CCU



NHS
University Hospitals Tees

Resources Committee

25 March 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

For NTHFT, the following performance metrics remain as Alert, with one further RESPONSIVE metric regraded to Alert in January 2026:

- Readmission rate - (New - regraded from Advise)
- Cancer 62 Day Standard
- 12-Hour ED Breaches Rate (%)
- RTT Incomplete Pathways (%)
- RTT time to first appointment (%)

For STHFT, the following performance metrics remain as Alert, with one further RESPONSIVE metric regraded to Alert in January 2026:

- Cancer 31 Day Standard – (New - regraded from Advise)
- Diagnostic 6 Week standard
- RTT Incomplete Pathways (%)
- RTT time to first appointment

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2026/2027 Annual Plan Update

The Committee received an update on the annual plan and submission process for 2026/2027. A further paper on budget setting principles was received, including assumptions made in the plan.

Finance

Month 11 position: The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.5m ICS deficit support for STH).

The financial position for Month 11 2025/26 is a deficit of £9.7m for the Group, which is a favourable variance of £21k against the year-to-date plan.

Continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTE and expenditure run-rates will be essential throughout the remainder of the financial year to ensure delivery of the financial control total.

NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

A stronger cash flow forecast position for STH for the remainder of the financial year, means that an application to access revenue cash support is no longer required.

CIP

NHSE expect strong Board oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

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

Performance

Whilst the majority of performance metrics are ‘Advise’, there have been no newly graded items for either trust.

Finance

The Committee was advised of the ongoing position in relation to WTEs. Variations to the previous month, previous year and the 2019/2020 position were described. Some increases over time relate to the response to CQC safety and quality concerns and also to deliver additional commissioner funded services.

Reductions in premium pay expenditure continue, with Agency spend £1.8m (21%) less and Bank spend £3.5m (12% less) than that incurred at the same point in the previous year (adjusted for inflation).

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission.

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

Performance

There have been no newly graded ‘Assure’ items for either trust.

Resources Committee Effectiveness annual review for 2025/2026

The Committee has met in line with its terms of reference and items scheduled in line with its cycle of business. Escalation reports have been received by Board.

Resources Committee

29 April 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

For NTHFT, the following four performance metrics within the Responsive domain remain as Alert.

- 12-Hour ED Breaches Rate
- Cancer 62 Day Standard
- RTT Incomplete Pathways (%)
- RTT time to first appointment (%)

In addition,

- Cancer faster Diagnosis is regraded to Alert from Advise
- RTT 52 Week Waiters (%) is regraded from Advise to Alert
- Ambulance Handovers within 45 Minutes (%) is regraded from Advise to Alert
- The 4-Hour A&E Standard consistently fails to meet plan and is regraded from Advise to Alert

For STHFT, the following three performance metrics within the Responsive domain remain as Alert assurance:

- Diagnostic 6 Week standard (%)

- RTT time to first appointment (%)
- Cancer 31 Day Standard

In addition,

- Community UCR 2 Hour Response % is regraded to Alert from Advise.

Performance within the Alert category will be explored further with the CSUs.

Productivity

Lower quartile performance is reported in the following operational productivity measures:

- NTHFT DNA rates
- NTHFT ratio of follow up to first appointments
- STHFT ratio of follow up to first appointments
- STHFT proportion of outpatient attendances resulting in PIFU
- STHFT day case rate overall
- NTHFT BADS day case benchmark (British Association of Day Surgery)
- STHFT BADS day case benchmark
- NTHFT capped theatre utilisation

Across UHT, further improvement in productivity, along with new approaches to demand management, and waiting list management, will be essential to support achievement of agreed performance plans within the available resources.

Finance

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.8m ICS deficit support for STH).

At the end of Month 12 2025/26 the Group is reporting a year-to-date favourable variance of £8.2m, with a variance of £3.3m relating to NTH and £4.9mk relating to STH. This largely relates to the decision made by NHSE to redistribute Deficit Support Funding.

The reported position includes additional non-recurrent measures totalling £16.4m year-to date across the Group. The Group has received a fair share allocation of national pressures funding for industrial action totalling £2.9m.

Estates

At NTHFT, as identified in the Trust wide 6-facet survey in 2022 Trust buildings no longer meet the required standards to provide healthcare services, and are not compliant with current Health Building Notes and other standards in specific locations.

At STHFT three landlord assurance letters from NHSPS (NHS Property Services) relating to contracts from 3rd party owners, are missing. Regular discussions are taking place between

the landlord and NHS Property Services to gather compliance documentation, however there is a lack of assurance due to the documentation/certification not being shared sufficiently.

The impact of these are other issues for NTHFT and STHFT were further described in the Capital update report to the Committee. The Committee has requested a deep dive into Estates issues in the May or June 2026 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.

Performance

For NTHFT:

- Cancelled Operations not rebooked in 28 days is regraded from Assure to Advis

For STHFT:

- RTT Incomplete Pathways (%) regraded from Alert

Finance

The Committee was advised of the ongoing position in relation to WTEs. Variations to the previous month, previous year and the 2019/2020 position were described. Some increases over time relate to the response to CQC safety and quality concerns and also to deliver additional commissioner funded services.

Reductions in premium pay expenditure continue, with Agency spend £2.2m (24%) less and Bank spend £3.5m (10% less) than that incurred at the same point in the previous year (adjusted for inflation).

The Resource Committee, People Committee and Quality and Compliance Committee will work to ensure a joined-up focus on WTEs in 2026/2027.

CIP

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission. Across the Group, overall year-to-date reported CIP delivery is £73.1m (100% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £12.9m behind plan at the end of Month 12.

Capital

The Group's capital expenditure to the end of Month 12 amounted to £98.9m. Across the Group, UHT has managed to maximise the use of available CDEL and the benefit of additional national PDC allocations to support additional capital expenditure of £30.2m ahead of plan.

Estates

A new CAFM (Computer Aided Facilities Management) system being developed to improve system of contractor management and service delivery asset management – this is being developed to incorporate compliance monitoring of all South Tees premises in a PAM (Premises Assurance Model) format.

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

Performance

For both NTHFT and STHFT, assurance continues for one metric within the Responsive domain:

- Community 52-week waits (%)

Productivity

Top quartile performance is seen in headline productivity measures as follows:

- NTHFT overall productivity in 25/26 compared to 24/25
- STHFT overall productivity in 25/26 compared to 19/20
- NTHFT cost per weighted activity unit

Amongst the operational productivity metrics presented, top quartile performance is seen in the following:

- NTHFT utilisation of specialist advice and guidance
- NTHFT elective length of stay
- NTHFT % non-elective admissions with zero or one-day length of stay
- NTHFT non-elective length of stay

Both Trusts are delivering activity levels in excess of 24/25 in outpatients, elective day cases, and same day emergency care; STHFT is providing care to increased numbers of A&E attendances.

Estates

The Northern & Yorkshire Apprentice Assessment Centre (NYAC) is progressing with its Main Provider application. Once in place the NYAC will continue to develop young local talent, as difficulties in regional recruitment continues, the Estates department is committed to following a ‘grow your own’ philosophy.

Procurement

Achievement of Procurement CIP savings targets for 2025/2026 and plans in place for 2026/2027, the Committee will receive regular updates on progress.

Month 12: 2025-26 Finance Report

Meeting date: *7 May 2026*

Reporting to: Board of Directors

Agenda item No: 4.2

Report author: *Chris Hand, Chief Finance Officer*

Executive director sponsor: *Chris Hand, Chief Finance Officer*

Action required: *Information*

Delegation status: *Jointly delegated item to Group Board*

Previously presented to: *Resources Committee*

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to the Board Assurance Framework Finance domain

Key discussion points and matters to be escalated from the meeting

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

NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.8m ICS deficit support for STH).

At the end of Month 12 2025/26 the Group is reporting a year-to-date (YTD) favourable variance of £8.2m, with a variance of £3.3m relating to NTH and £4.9mk relating to STH.

This largely relates to the decision made by NHSE to redistribute Deficit Support Funding (DSF) foregone by systems to those providers that did so, as long as those providers are part of a system that delivered plan and have also submitted a balanced plan for 2026/27.

The reported position includes additional non-recurrent measures totalling £16.4m year-to-date across the Group. The Group has received a fair share allocation of national pressures funding for industrial action totalling £2.9m.

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 12 shows a net overall increase of 76.06 WTE worked across the Group, compared to the previous month.

Compared to the same period last year (Month 12 2024/25) WTEs were lower by 274.61wte. WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,492.44wte (19%). 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

Reductions in premium pay expenditure continue, with Agency spend £2.2m (24%) less and Bank spend £3.5m (10% less) than that incurred at the same point in the previous year (adjusted for inflation).

Across the Group, overall year-to-date reported CIP delivery is £73.1m (100% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £12.9m behind plan at the end of Month 12.

The Group's capital expenditure to the end of Month 12 amounted to £98.9m. Across the Group, UHT has managed to maximise the use of available CDEL and the benefit of additional national PDC allocations to support additional capital expenditure of £30.2m ahead of plan.

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

No Revenue Cash PDC support was required during 2025/26.

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 received monthly assurance reports on the financial performance throughout the year, and closely monitored the risk and assumptions within the plan.

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 12 2025/26.

Board of Directors
7 May 2026
Month 12: 2025/26 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 12 of 2025/26.

2. BACKGROUND

For 2025/26, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single Integrated Care System (ICS). Both North Tees and Hartlepool NHS Foundation Trust (NTH) and South Tees Hospitals NHS Foundation Trust (STH) and are aligned to the North Cumbria (NENC) Integrated Care System (ICS).

The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH.

This includes non-recurrent deficit support provided by NHSE to systems with an agreed deficit plan, to deliver break-even for the 2025/26 financial year. NENC ICB received an allocation of £33.3m (reduced from £49.9m in 2024/25), which has been allocated to deficit trusts including a revised allocation of £11.8m for STH. The planned deficit excluding non-recurrent deficit support funding is £20.6m.

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

3. MONTH 12 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 12 2025/26, 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	442,978	454,675	11,697	1,008,320	1,019,576	11,256	**1,451,298**	**1,474,251**	**22,953**
Other operating income	34,764	35,191	427	71,900	78,388	6,488	**106,664**	**113,579**	**6,915**
Employee expenses	(326,544)	(342,496)	(15,952)	(648,025)	(657,172)	(9,147)	**(974,569)**	**(999,668)**	**(25,099)**
Operating expenses excluding employee expenses	(149,447)	(158,678)	(9,231)	(412,925)	(460,134)	(47,209)	**(562,372)**	**(618,812)**	**(56,440)**
OPERATING SURPLUS/(DEFICIT)	**1,751**	**(11,308)**	**(13,059)**	**19,270**	**(19,342)**	**(38,612)**	**21,021**	**(30,650)**	**(51,671)**
FINANCE COSTS									
Finance income	2,252	2,510	258	1,674	3,429	1,755	**3,926**	**5,939**	**2,013**
Finance expense	(703)	(704)	(1)	(21,662)	(23,167)	(1,505)	**(22,365)**	**(23,871)**	**(1,506)**
PDC dividends payable/refundable	(3,204)	(2,687)	517	0	0	0	**(3,204)**	**(2,687)**	**517**
NET FINANCE COSTS	**(1,655)**	**(881)**	**774**	**(19,988)**	**(19,738)**	**250**	**(21,643)**	**(20,619)**	**1,024**
Other gains/(losses) including disposal of assets	0	829	829	0	6	6	**0**	**835**	**835**
Corporation tax expense	(96)	(42)	54	(13)	(19)	(6)	**(109)**	**(61)**	**48**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**0**	**(11,402)**	**(11,402)**	**(731)**	**(39,093)**	**(38,362)**	**(731)**	**(50,495)**	**(49,764)**
Add back all I&E impairments/(reversals)	0	14,623	14,623	7,625	54,647	47,022	**7,625**	**69,270**	**61,645**
Remove capital donations/grants I&E impact	0	57	57	(7,447)	(12,695)	(5,248)	**(7,447)**	**(12,638)**	**(5,191)**
Remove net impact of consumables donated from other DHSC bodies	0	2	2	0	0	0	**0**	**2**	**2**
Remove PFI revenue costs on an IFRS 16 basis	0	0	0	64,427	66,360	1,933	**64,427**	**66,360**	**1,933**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(72,934)	(73,357)	(423)	**(72,934)**	**(73,357)**	**(423)**
Adjusted financial performance surplus/(deficit)	**0**	**3,280**	**3,280**	**(9,060)**	**(4,138)**	**4,922**	**(9,060)**	**(858)**	**8,202**
Less Non-Recurrent Deficit Funding	0	(3,276)	(3,276)	(11,858)	(16,773)	(4,915)	**(11,858)**	**(20,049)**	**(8,191)**
Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding	**0**	**4**	**4**	**(20,918)**	**(20,911)**	**7**	**(20,918)**	**(20,907)**	**11**

At the end of Month 12 2025/26 the Group is reporting a year-to-date (YTD) favourable variance of £8.2m, with a variance of £3.3m relating to NTH and £4.9mk relating to STH.

This largely relates to the decision made by NHSE to redistribute any Deficit Support Funding (DSF) foregone by systems that did not deliver their plans this year to those providers that did so, as long as those providers are part of a system that delivered plan and have also submitted a balanced plan for 2026/27.

Because the funding from which the bonus will be paid was originally intended to fund system deficits, the money has to be flowed to the bottom line creating a surplus to make sure that the NHS overall meets its financial targets, and so cannot be spent. However, the DSF bonus will be cash-backed, so still provides trusts in the UHT Group with additional cash.

The main drivers of the **NTH Month 12 position** are:

- Clinical Income is ahead of plan by £11.7m. This is mainly due to £3.3m of DSF bonus funding, £1.4m breast services funding for increased activity; £1.2m of industrial action funding, £1.1m variable drugs & devices income; £2.5m sexual health service funding, and other non-recurrent commissioner funding. This has been offset by net-neutral reclassifications of income for hosted services (relating to lead contract arrangements for UTC and Speech & Language Therapy services).

- Other operating income is £0.4m ahead of plan, largely relating to the reclassification of Speech & Language Therapy income to Clinical Income, offset by education income.
- Interest receivable is ahead of plan by £0.3m, reflecting current interest rates and cash balances.
- Pay is £16.0m behind plan due to increased demand for Enhanced Care, weekend working linked to activity, industrial action, pay award pressures and slippage on targets for unidentified CIP at initial plan submission.
- Non-Pay is overspent by £9.2m, largely relating to fixed asset impairments (which are excluded from the financial control total calculation).
- Overspends on in clinical supplies and drugs and the costs of the newly commissioned sexual health service, are largely offset by the net-neutral reclassification of the hosted UTC contract.
- The position includes the impact of additional non-recurrent measures of £3.2m ahead of plan.

The main drivers of the **STH Month 12 position** are:

- Clinical Income is ahead of plan by £11.3m. The position includes additional DSF bonus funding of £4.9m, £1.7m additional national pressure funding received for strikes, and funding for 'winter surge' and Quarter 4 sprint activity.
- The position includes the impact of net neutral reclassification of income for activity delivered under sub-contract arrangements (UTC at James Cook and CDC Stockton Hub). Variable income for High-cost Drugs and Devices is also ahead of plan.
- Other Operating Income is £6.5m ahead of plan, largely relating to the net neutral reclassification of CDC income and non-recurrent income adjustments.
- Pay is overspent by £9.1m, including the YTD pressure from a funding shortfall for the national pay award, the costs of industrial action, winter surge and Quarter 4 sprint activity. Bank staff underspends continue to offset an adverse variance on agency expenditure.
- Non-Pay is £47.2m overspent, largely relating to fixed asset impairments (which are excluded from the financial control total calculation).
- Overspends on clinical supplies and drugs, and the impact of the net-neutral reclassification of UTC income, are part offset by underspends against energy and premises. The position also includes additional expenditure for winter surge and Quarter 4 sprint activity.
- Interest receivable is ahead of plan by £1.8m, reflecting higher than plan cash balances.
- The position includes the impact of additional non-recurrent measures of £13.2m, ahead of the phased plan.

Agency and Bank Expenditure

Reductions in temporary staffing and premium pay costs are a national priority set by NHSE. The 2025/26 planning guidance included requirements to reduce agency spend by at least 30% from the prior year and to reduce bank spend by at least 10%.

The tables below show the position on agency and bank expenditure for the Group to the end of Month 12, comparing the year-to-date expenditure with the same period in the previous financial year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,075	116	(959)	1,939	(1,823)	-94%
AHP and Sci&Tech	323	712	389	807	(95)	-12%
Other Clinical	0	0	0	0	0	-
Consultants	683	1,281	598	1,807	(526)	-29%
Career/staff grades	0	80	80	6	74	1173%
Trainee grades	0	31	31	36	(5)	-13%
Non Clinical	0	93	93	14	79	583%
TOTAL	**2,081**	**2,313**	**232**	**4,610**	**(2,297)**	**-50%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	4,679	5,641	962	5,404	237	4%
AHP and Sci&Tech	665	702	37	630	72	11%
Other Clinical	4,665	5,720	1,055	5,439	281	5%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	636	581	(55)	870	(289)	-33%
TOTAL	**10,645**	**12,644**	**1,999**	**12,343**	**301**	**2%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	206	280	74	284	(4)	-1%
AHP and Sci&Tech	252	849	597	424	425	100%
Other Clinical	41	0	(41)	1	(1)	-100%
Consultants	2,707	3,431	724	3,876	(445)	-11%
Career/staff grades	0	0	0	9	(9)	-100%
Trainee grades	0	0	0	0	0	-
Non Clinical	55	223	168	97	126	129%
TOTAL	**3,261**	**4,783**	**1,522**	**4,691**	**92**	**2%**

BANK YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	8,850	7,962	(888)	9,836	(1,874)	-19%
AHP and Sci&Tech	214	242	28	242	0	0%
Other Clinical	7,522	6,562	(960)	8,169	(1,607)	-20%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	1,687	1,148	(539)	1,496	(348)	-23%
Non Clinical	871	1,041	170	975	66	7%
TOTAL	**19,144**	**16,955**	**(2,189)**	**20,719**	**(3,764)**	**-18%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,281	396	(885)	2,223	(1,827)	-82%
AHP and Sci&Tech	575	1,561	986	1,232	329	27%
Other Clinical	41	0	(41)	1	(1)	-100%
Consultants	3,390	4,712	1,322	5,683	(971)	-17%
Career/staff grades	0	80	80	16	64	409%
Trainee grades	0	31	31	36	(5)	-13%
Non Clinical	55	316	261	111	205	185%
TOTAL	**5,342**	**7,096**	**1,754**	**9,301**	**(2,205)**	**-24%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	13,529	13,603	74	15,240	(1,637)	-11%
AHP and Sci&Tech	879	944	65	872	72	8%
Other Clinical	12,187	12,282	95	13,608	(1,326)	-10%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	1,687	1,148	(539)	1,496	(348)	-23%
Non Clinical	1,507	1,622	115	1,845	(223)	-12%
TOTAL	**29,789**	**29,599**	**(190)**	**33,062**	**(3,463)**	**-10%**

Across the Group, **YTD agency** expenditure was £7.1m. This was £1.8m higher than plan, largely relating to Consultant agency (which was £0.6m over at NTH and at £0.7m over at STH), and £1.0m on Scientific staff across the Group. However, total agency expenditure was £2.2m (24%) less than the agency expenditure incurred at the same

point in the previous year (adjusted for inflation), largely relating to nursing agency reductions at NTH.

Across the Group, **YTD bank** expenditure was £29.6m. This was £0.2m less than plan, largely relating to Nursing and HCA Bank at STH which was under by £1.8m overall, offset by increased usage at NTH (partly linked to agency reductions). Total bank expenditure was £3.5m (10%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

Workforce

Growth in workforce remains an area of significant national and regional scrutiny, linked to the reductions in productivity and growth in non-clinical roles that has been noted across the NHS.

The table below shows the WTE actual worked in Month 12 (split between Substantive, Bank, and Agency staff) compared to each of:

- the average monthly WTE worked in 2019/20 (the pre-Covid baseline),
- the average monthly WTE worked in 2023/24,
- the average monthly WTE worked in 2024/25 (the previous financial year),
- the wte worked in Month 12 of 2024/25; and
- the previous month.

WTE worked data has been used (taken directly from the General Ledger), to ensure consistency between different reporting periods and to provide the best correlation to the actual pay costs incurred.

WTE Worked	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	YTD Avg 25/26	Q1 Avg 25/26	Q2 Avg 25/26	Q3 Avg 25/26	Mth 12 25/26	Q4 Avg 25/26	Change from prior month	Change from M12 24/25	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg
NTH														
Agency	20.38	63.89	35.17	14.64	16.66	15.30	13.90	13.37	12.72	1.42	(12.97)	(7.01)	(50.52)	(21.80)
Bank	186.45	234.11	247.00	248.00	240.89	248.10	238.13	301.22	264.89	54.53	21.76	114.77	67.11	54.22
Substantive	4,659.47	5,130.23	5,325.94	5,259.15	5,293.57	5,227.35	5,276.35	5,242.04	5,239.33	(19.98)	(141.35)	582.57	111.81	(83.90)
Sub Total	**4,866.30**	**5,428.23**	**5,608.11**	**5,521.80**	**5,551.11**	**5,490.75**	**5,528.38**	**5,556.63**	**5,516.94**	**35.97**	**(132.56)**	**690.33**	**128.40**	**(51.48)**
STH														
Agency	25.51	34.62	18.73	22.04	15.84	20.35	27.71	20.58	24.27	(5.72)	3.99	(4.93)	(14.04)	1.85
Bank	198.01	393.05	347.40	287.84	275.69	293.62	276.38	315.70	305.67	8.25	(37.56)	117.69	(77.34)	(31.70)
Substantive	7,836.68	9,235.07	9,492.43	9,558.58	9,597.58	9,557.95	9,574.44	9,526.03	9,504.36	37.56	(108.48)	1,689.35	290.96	33.60
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,868.47**	**9,889.11**	**9,871.92**	**9,878.53**	**9,862.31**	**9,834.29**	**40.09**	**(142.05)**	**1,802.11**	**199.57**	**3.75**
UHT GROUP														
Agency	45.89	98.51	53.90	36.69	32.50	35.66	41.61	33.95	36.98	(4.30)	(8.98)	(11.94)	(64.56)	(19.95)
Bank	384.46	627.16	594.40	535.84	516.58	541.72	514.52	616.92	570.56	62.78	(15.80)	232.46	(10.23)	22.52
Substantive	12,496.15	14,365.30	14,818.37	14,817.73	14,891.14	14,785.30	14,850.78	14,768.07	14,743.69	17.58	(249.83)	2,271.92	402.77	(50.30)
Grand Total	**12,926.50**	**15,090.97**	**15,466.68**	**15,390.26**	**15,440.23**	**15,362.67**	**15,406.91**	**15,418.94**	**15,351.23**	**76.06**	**(274.61)**	**2,492.44**	**327.97**	**(47.73)**

Month 12 shows a net overall increase of 76.06wte worked across the Group, compared to the WTE worked reported in the previous month. The in-month change in WTE was a 35.97wte increase at NTH and a 40.09wte increase at STH.

Compared to the same period last year (Month 12 2024/25) WTEs were lower by 274.61wte.

WTEs worked in month were 47.73wte lower than the average of the previous financial year. The average of WTEs worked across the whole of 2025/26 was 15,390.26 which is 76.41wte less than the average across 2024/25, mainly apparent at NTH.

WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,492.44wte (19.3%). 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	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	YTD Avg 25/26	Q1 Avg 25/26	Q2 Avg 25/26	Q3 Avg 25/26	Mth 12 25/26	Q4 Avg 25/26	Change from prior month	Change from M12 24/25	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg
NTH														
Nursing & Midwifery	1,381.12	1,607.51	1,682.30	1,709.85	1,698.86	1,698.04	1,712.72	1,751.52	1,729.76	23.30	24.47	370.40	144.01	69.22
Medical & Dental	535.14	555.47	585.95	597.51	600.51	586.73	608.99	596.21	593.81	4.33	(18.49)	61.07	40.74	10.26
AHP, Sci., Ther.&Tech.	540.32	588.28	603.99	564.65	562.54	566.28	567.43	564.58	562.36	2.77	(31.73)	24.26	(23.70)	(39.41)
HCAs & Support Staff	949.52	1,051.64	1,050.01	1,040.04	1,021.43	1,019.66	1,053.61	1,079.80	1,065.46	14.54	22.04	130.28	28.16	29.79
Non Clinical	1,460.20	1,625.34	1,685.87	1,609.75	1,667.77	1,620.03	1,585.64	1,564.52	1,565.55	(8.97)	(128.85)	104.32	(60.82)	(121.35)
Sub Total	**4,866.30**	**5,428.24**	**5,608.11**	**5,521.80**	**5,551.11**	**5,490.75**	**5,528.38**	**5,556.63**	**5,516.94**	**35.97**	**(132.56)**	**690.33**	**128.39**	**(51.48)**
STH														
Nursing & Midwifery	2,506.06	2,958.13	3,095.50	3,158.08	3,145.89	3,151.02	3,158.50	3,192.75	3,176.91	17.08	8.57	686.69	234.62	97.25
Medical & Dental	1,242.76	1,318.94	1,376.28	1,400.17	1,392.44	1,395.16	1,409.77	1,425.64	1,403.29	30.73	24.87	182.88	106.70	49.36
AHP, Sci., Ther.&Tech.	1,225.20	1,484.76	1,570.58	1,600.95	1,574.89	1,596.20	1,618.48	1,607.01	1,614.24	(12.39)	11.29	381.81	122.25	36.43
HCAs & Support Staff	1,424.35	1,755.65	1,672.69	1,636.21	1,642.68	1,638.32	1,636.74	1,622.73	1,627.09	(4.03)	(39.78)	198.38	(132.92)	(49.96)
Non Clinical	1,661.83	2,145.27	2,143.50	2,073.06	2,133.21	2,091.23	2,055.05	2,014.18	2,012.76	8.70	(147.00)	352.35	(131.09)	(129.32)
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,868.47**	**9,889.11**	**9,871.92**	**9,878.53**	**9,862.31**	**9,834.29**	**40.09**	**(142.05)**	**1,802.11**	**199.57**	**3.75**
UHT GROUP														
Nursing & Midwifery	3,887.18	4,565.64	4,777.80	4,867.92	4,844.75	4,849.06	4,871.21	4,944.27	4,906.67	40.38	33.04	1,057.10	378.63	166.47
Medical & Dental	1,777.90	1,874.41	1,962.23	1,997.68	1,992.95	1,981.89	2,018.76	2,021.85	1,997.10	35.06	6.38	243.95	147.44	59.62
AHP, Sci., Ther.&Tech.	1,765.52	2,073.04	2,174.57	2,165.61	2,137.43	2,162.48	2,185.91	2,171.59	2,176.60	(9.62)	(20.44)	406.07	98.55	(2.98)
HCAs & Support Staff	2,373.87	2,807.29	2,722.71	2,676.24	2,664.11	2,657.98	2,690.34	2,702.53	2,692.55	10.51	(17.74)	328.66	(104.76)	(20.18)
Non Clinical	3,122.03	3,770.61	3,829.37	3,682.81	3,800.99	3,711.26	3,640.69	3,578.70	3,578.31	(0.27)	(275.85)	456.67	(191.91)	(250.67)
Sub Total	**12,926.50**	**15,090.98**	**15,466.68**	**15,390.26**	**15,440.23**	**15,362.67**	**15,406.91**	**15,418.94**	**15,351.23**	**76.06**	**(274.61)**	**2,492.44**	**327.96**	**(47.74)**

The Month 12 position includes a reduction of 274.61wte Non-Clinical staff compared to the same period last financial year, with an in-month decrease of 0.27wte across the Group.

Efficiency

The plan assumed delivery of an overall efficiency target for the Group of £73.1m. The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 12 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	15,803	10,367	-5,436	66%	16,491	16,321	-170	99%	32,294	26,688	-5,606	83%
Non Pay	7,336	10,434	3,098	142%	25,436	27,084	1,648	106%	32,772	37,518	4,746	114%
Income	1,434	3,772	2,338	263%	6,573	5,096	-1,477	78%	8,007	8,867	861	111%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,074**	**1**	**100%**
Recurrent	14,453	15,133	680	105%	41,148	27,581	-13,568	67%	55,601	42,714	-12,887	77%
Non-recurrent	10,120	9,440	-680	93%	7,352	20,919	13,567	285%	17,472	30,359	12,887	174%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,073**	**0**	**100%**
Recurrent %	59%	62%	3%	-	85%	57%	-28%	-	76%	58%	-18%	-

Across the Group, overall year-to-date delivery is £73.1m (100% of target). However, this position includes a number of non-recurrent schemes. Delivery of recurrent savings is £12.9m behind plan at the end of Month 12, constituting 58% of YTD delivery across the Group.

Capital

The Group's gross capital expenditure plan for the 2025/26 financial year totalled £66.8m at the start of the financial year.

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2025/26 totals £37.8m, including ICS approved Constitutional Standards/Estates Safety schemes (that are funded through additional national PDC). The plan also includes expected PFI lifecycle costs of £8.0m (the cost of which sits outside the ICS CDEL limit).

The capital programme also included externally funded schemes for RAAC eradication and replacement of Linear Accelerators (funded by Public Dividend Capital (PDC) of £6.6m, and de-carbonisation schemes, supported with Salix grant funding of £13.9m across the Group.

Since plan submission, NTH received an additional £4m of bonus CDEL resource in relation to urgent and emergency care performance in 2024/25; however, this is not cash-backed. The Group has also received significant additional national PDC funding for equipment, diagnostics and digital during the financial year.

The Group's capital expenditure to the end of Month 12 amounted to £98.9m, as detailed in the table below.

	NTH			STH			Group		
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Equipment	6,066	9,595	3,529	8,012	26,848	18,836	**14,078**	**36,443**	**22,365**
Digital	5,117	7,467	2,350	2,080	5,454	3,374	**7,197**	**12,921**	**5,724**
Estates	10,211	12,561	2,350	3,844	5,963	2,119	**14,055**	**18,524**	**4,469**
PFI	0	0	0	8,163	7,945	(218)	**8,163**	**7,945**	**(218)**
Decarbonisation	1	0	(1)	13,928	13,622	(306)	**13,929**	**13,622**	**(307)**
RAAC	1,300	2,846	1,546	2,900	2,900	0	**4,200**	**5,746**	**1,546**
IFRS 16	2,825	2,050	(775)	4,313	1,686	(2,627)	**7,138**	**3,736**	**(3,402)**
Total Gross Capital	**25,520**	**34,519**	**8,999**	**43,240**	**64,418**	**21,178**	**68,760**	**98,937**	**30,177**

Across the Group, UHT has managed to maximise the use of available CDEL and the benefit of additional national PDC allocations to support additional capital expenditure of £30.2m ahead of plan.

Liquidity

The cash balance at the end of Month 12 stood at £144.4m for the Group. The month end revenue cash balance at NTH was £58.0m (equating to 31 operating expenditure days) and £86.4m at STH (equating to 22 operating expenditure days).

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

Better Payment Practice Code	NTH		STH		GROUP	
	YTD Number	YTD Value £000	YTD Number	YTD Value £000	YTD Number	YTD Value £000
Total bills paid in the year	70,791	206,586	105,783	725,575	176,574	932,161
Total bills paid within target	69,443	202,761	103,419	688,231	172,862	890,992
Percentage of bills paid within target	**98.1%**	**98.1%**	**97.8%**	**94.9%**	**97.9%**	**95.6%**

Statement of Financial Position

The table below shows the draft balance sheet position for the two Trusts as at the end of Month 12:

	NTH £000	STH £000
Non-current assets		
Intangible assets	2,873	10,055
On-SoFP IFRIC 12 assets	0	143,167
Other property, plant and equipment (excludes leases)	150,612	156,538
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	16,271	33,860
Receivables: due from NHS and DHSC group bodies	512	1,123
Receivables: due from non-NHS/DHSC Group bodies	1,448	2,783
Credit Loss Allowances		(685)
Total non-current assets	**171,716**	**346,841**
Current assets		
Inventories	6,701	15,416
Receivables: due from NHS and DHSC group bodies	13,659	30,911
Receivables: due from non-NHS/DHSC Group bodies	15,600	36,164
Credit Loss Allowances	(4,515)	(4,057)
Other Assets	0	
Cash and cash equivalents: GBS/NLF	57,964	83,458
Cash and cash equivalents: commercial/in hand/other	8	2,945
Total current assets	**89,417**	**164,837**
Current liabilities		
Trade and other payables: capital	(2,590)	(33,983)
Trade and other payables: non-capital	(62,845)	(160,089)
Borrowings	(4,421)	(23,624)
Other financial liabilities	0	0
Provisions	(1,988)	(1,357)
Other liabilities: deferred income including contract liabilities	(5,098)	0
Total current liabilities	**(76,942)**	**(219,053)**
Total assets less current liabilities	**184,191**	**292,625**
Non-current liabilities		
Borrowings	(28,723)	(249,605)
Provisions	(1,405)	(1,304)
Total non-current liabilities	**(30,128)**	**(250,909)**
Total net assets employed	**154,063**	**41,716**
Financed by		
Public dividend capital	215,015	507,294
Revaluation reserve	12,835	25,628
Other reserves	0	26,476
Income and expenditure reserve	(73,787)	(517,682)
Total taxpayers' and others' equity	**154,063**	**41,716**
Debtor Days	**23.3**	**23.6**
Creditor Days	**191.0**	**187.2**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 12 2025/26

University Hospitals Tees

Integrated Performance Report (reporting to end February 2026)

Meeting date: 7 May 2026

Reporting to: Board of Directors

Agenda item No: 4.3

Report author: Lucy Tulloch, Director Planning & Intelligence and Lynsey Atkins, Associate Director Planning, Performance & Improvement

Executive director sponsor: Neil Atkinson, Managing Director

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	Finance
People	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 February 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 nine performance metrics remain as Alert.

- *E. coli* infections
- MSSA infections
- *Klebsiella* infections
- Readmission rate
- 12-Hour ED Breaches Rate
- Cancer 62 Day Standard
- RTT Incomplete Pathways (%)
- RTT time to first appointment
- Sickness Absence (%)

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

In addition, **breast feeding at first** is regraded to Alert from Advise as following positive outliers in previous months there is a declining trend, and plan is not statistically in range of current performance. Collaboration between NTHFT and STHFT continues to support an increase in breast feeding.

Cancer faster Diagnosis is regraded to Alert from Advise as performance is close to lower expected variation; there is a continued focus on improvement in urology and respiratory pathways.

RTT 52 Week Waiters (%) is reporting close to the limit of expected variance over recent months and is regraded from Advise to Alert. There is a continued focus on returning to plan through productivity and efficiency measures.

Ambulance Handovers within 45 Minutes (%) is regraded from Advise to Alert, following deteriorating performance. There is a continued focus on ED patient flow to minimise ambulance delays.

The 4-Hour A&E Standard consistently fails to meet plan and is regraded from Advise to Alert. Validation in line with NHSE spring reset opportunities and weekend discharges QI is ongoing; a custody pathway is planned in partnership with police.

For STHFT, the following 11 performance metrics remain as Alert assurance:

- Never Events
- *Klebsiella* infections
- *Pseudomonas* infections
- Breast feeding at first feed
- Still birth rate rolling 12 months per 1000 births
- Diagnostic 6 Week standard (%)
- RTT time to first appointment (%)
- Cancer 31 Day Standard
- Sickness Absence (%)
- Mandatory Training (%)
- Annual Appraisal (%)

In addition, **MRSA Infections** regraded from Advise to Alert, as one new case reported in February 2026.

Neonatal Mortality Rate (rolling 12 months, per 1000 births) is regraded to Alert from Advise, triggered as reporting one incidence above the peer group average in a rolling 12 months. All neonatal deaths are reviewed by a multidisciplinary team and reported using the perinatal mortality review tool.

Inpatient Experience (%) regraded from Advise as recent months close to the lower limit of expected variation.

In addition, **Community UCR 2 Hour Response %** is regraded to Alert from Advise. Performance in this standard has deteriorated with in a stepped change below the average. Clinical prioritisation across caseloads and a continued focus on clock stops will positively impact and improve this 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.

The majority of IPR metrics remain graded Advise, for both Trusts.

For NTHFT, one metric has been regraded to Advise in February 2026.

Cancelled Operations not rebooked in 28 days is regraded from Assure to Advise performance is no longer statistically assured. A daily review of all cancellations is in place with a focus on reappointing patients.

For STHFT, two metrics have been regraded to Advise in February 2026.

Still birth rate (rolling 12 months, per 1000 births) regraded from Alert as the recent higher rate has stabilised. Perinatal losses are reported using the perinatal mortality review tool.

RTT Incomplete Pathways (%) regraded from alert as performance is better than expected variance in February 2026. There is a wider strategic focus in reducing long waits through proactive mutual support, services have undertaken additional activity as part of the NHSE Q4 sprint

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 five metrics:

- *C. difficile* infections
- Discharge Delay average days
- Community 52-week waits (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

In addition, **A&E Experience %** regraded from Advise, as consistently exceeds the national average and is assured.

Neonatal Mortality Rate (rolling 12 months per 1000 births) is consistent since July 2005 and below peer group average. Regular in-depth reporting on maternity services takes place through Quality Assurance Committee and The Local Maternity and Neonatal System Board.

For STHFT, assurance continues for four metrics:

- Summary Hospital-Level Mortality Indicator
- Discharge Delay average days
- Community 52-week waits (%)
- Staff Turnover (%)

No further metrics have been regraded to Assure for STHFT in February 2026.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for the reporting period February 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: February 2026

Caring Better Together

Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. The IPR is underpinned by a broader range of metrics and evidence for clinical governance and operational management.

SAFE: The rate of incidents reported per 1000 bed days is below the NTHFT longer-term average. Clinical Service Units have been asked to examine and promote reporting, and with the implementation of Healthcare Guardian in March, we may start to see an improvement. In February no Never Events were reported across UHT. The Patient Safety Incident Response Framework is embedded across UHT and thematic reviews are used to derive learning from incidents and near misses. The focus on reducing health care acquired infections continues, centred on antimicrobial stewardship and medical leadership and aligned to the national focus on prescribing. Maternity metrics are reviewed against regional and national audit and peer group benchmarks.

EFFECTIVE: Standardised mortality is 'as expected' for both Trusts. Readmissions rates differ across UHT and relative to the national average. A recent readmissions audit focused on patients with a diagnosis of COPD; monitoring improvement will be embedded into Quality and Performance Reviews, with oversight via the Audit and Clinical Effectiveness Council. Better than national average performance in the discharge delay metric for both Trusts highlights the effective processes for patient flow and providing care in the most appropriate environment. There is a focus on utilisation of Home First in cases of delays.

RESPONSIVE: Whilst the NHS constitutional standards remain, each Trust has an agreed plan for recovery towards the 25/26 operational standard or improvement ‘stretch’ trajectory relative to 24/25 performance in each metric. This contributes to the regional performance position.

Ambulance handover delays are reported against a 45-minute standard, STHFT performance remains stable, NTHFT has reported increased delays in recent months, however, >95% compliance is maintained. 12-hour breach performance is challenged to meet a significant improvement trajectory at NTHFT. The 4-hour standard performance is stable at both trusts, however NTHFT is no longer assured to consistently meet plan in February 2026. Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. For RTT, there is ongoing focus on ensuring the very longest waiters receive their treatment and there is not yet consistent improvement/achievement across the core metrics. Productivity improvements such as driving up theatre utilisation to create more capacity for patients awaiting surgery, waiting list validation and specialty specific recovery plans are in place. From November 2025, NTHFT joined STHFT in receiving additional performance scrutiny and support for improvement in cancer treatment waiting times under the NHS England performance management regime (Tier 2). Cancer action plans are in place and for STHFT, there is clear evidence of improvement in the cancer 62-day standard arising from planned actions in diagnostic pathways.

CARING: The IPR demonstrates that both Trusts perform well in patient feedback surveys, around or above national average feedback scores across care settings. This includes evidence of recent improved A&E experience at STHFT. Managing complaints to a timely closure at STHFT is being addressed with senior leadership support.

WELL LED: The improvement of working lives, staff retention and attendance is a focus for the People Directorate. The national People Promise is implemented as part of the Group People Plan. Reduced staff turnover, assured below target, is embedded at both Trusts. Sickness absence and mandatory training remain improvement priorities. An in-depth absence plan and focus on whole time equivalent reduction (e.g. non-essential bank and agency work, scrutiny of recruitment requests) supports our obligation to deliver the agreed financial position. At month 11 NTHFT reported a small positive variance to plan and STHFT is on plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

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.

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.

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

Provider Performance Summary

	Urgent & Emergency Care						Elective care												Cancer			
Provider	A&E 4 hour standard	12 hour delay from DTA	% A&E Type 1 Attendances >12hrs from arrival	Ambulance handovers 30-60 mins	Ambulance handovers 45+ mins	Ambulance handovers 60+ mins	RTT - 18 week standard	RTT - 52+ ww %age of WL	RTT - Time to 1st Appt	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 25/26 v 24/25	1st OP - YTD growth 25/26 v 24/25	Total elective - YTD growth 25/26 v 24/25	Diagnostic activity 25/26 v 24/25	Diagnostic 6 week waits	Cancer 62 day	Cancer 62 day backlog	Cancer treatments (first and subsequent)	Cancer 28 day FD
Data period	Feb-26	Feb-26	Feb-26	Feb-26	Feb-26	Feb-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Jan-26	Feb-26	Jan-26	Jan-26
25/26 Ambition	78%	Zero	25/26 Plan				25/26 Plan	< 1%	25/26 Plan	25/26 Plan	Zero	Zero	Zero	25/26 Plan					<=5%	75%			80%
North Tees & Hartlepool NHSFT	83.0%	39	6.0%	178	52	18	70.7%	1.1%	79.1%	250	3	0	0	21,898	107%	108%	103%	95%	4.5%	54.8%	131	206	78.1%
South Tees Hospitals NHSFT	77.6%	35	5.6%	324	200	108	62.0%	1.8%	64.8%	996	29	1	0	55,924	105%	102%	104%	114%	14.3%	68.5%	127	783	74.0%
NENC ICS Provider level *(including IS providers)*	76.8%	535	5.9%	2,154	1,236	653	69.5%	1.1%	74.7%	4,046	88	3	0	365,242	102%	105%	102%	103%	17.2%	68.5%	866	3,707	67.1%
North East & Yorkshire	75.3%		7.5%				65.1%												26.5%	67.6%			69.8%
National	74.1%		11.3%				61.4%												24.7%	68.4%			72.8%

For urgent and emergency care metrics, NTHFT demonstrated good comparative performance for the 4-hour standard in February in relation to regional and national benchmarks, and in the context of demand and acuity. Although STHFT performed better than regional benchmarks, the 4-hour standard remains a strategic risk for the organisation, with actions reviewed weekly by the operational team. Reducing ambulance handover delays and the longest department waits are a priority, whilst improving patient experience by developing alternatives to ED pathways.

Elective care metrics show an RTT 18-week standard at both NTHFT and STHFT fell below plan, however noting NTHFT exceeded the national and regional average and STHFT performing in line with the national average. Both trusts committed to improving RTT compliance by 5% in 25/26. Achievement of this standard is a strategic risk for both trusts, with actions focusing on increasing outpatient productivity. NTHFT focus is on ensuring patients wait no longer than 52 weeks whilst STHFT services are working to eliminate waits above 65 weeks and have entered tiered support with NHS England to provide assurance of action plans to achieve this. This remains very challenging whilst demand and capacity imbalances in several specialties are addressed.

Cancer 62-day standard is a strategic risk for both Trusts. STHFT has been in tiered support with NHS England for the 62-day standard since February 2025. Actions and progress are discussed fortnightly, providing NHSE with assurance that all relevant actions are in hand. These focused on reducing delays in specific tumour pathways, whilst investment in cancer navigators in focus specialties helps to ensure individual cases are proactively pursued through the diagnostic and treatment steps. An improvement trend in STHFT 62-day standard is now evident and exceeds the agreed improvement trajectory. NTHFT performance shows the impact of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025 on cancer standard compliance. NTHFT commenced tiering support with NHS England from November 2025.

Index of metrics

SAFE DOMAIN
Responsibility: Quality Assurance Committee

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
Falls with Harm per 1000 Bed Days
C. difficile infections
MRSA infections
E. coli infections
MSSA infections
Klebsiella infections
Pseudomonas infections
Total births
Still Births Rate (Rolling 12 months, per 1000 Births)
Neonatal Mortality Rate (rolling 12 months, per 1,000 births)
Breast Feeding at First Feed (%)
PPH >= 1500ml Rate per 1,000 births
3rd/4th Degree Tear (%)

EFFECTIVE DOMAIN
Responsibility: Quality Assurance Committee

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)
Discharge Delays Average (days)

RESPONSIVE DOMAIN
Responsibility: Resources Committee

NEAS Handovers – Over 45 mins (%)
4-Hour A&E Standard (%)
12-Hour ED Breaches Rate (%)
Community UCR 2 Hour Response (%)
Cancelled Operations Not Rebooked in 28 Days
Cancer Faster Diagnosis Standard (%)
Cancer 31 Day Standard (%)
Cancer 62 Day Standard (%)
Diagnostic 6 Weeks Standard (%)
RTT Incomplete Pathways (%)
RTT 52 Week Waiters (%)
Community over 52-week Waiters (%)
RTT Time to First Appointment (%)

CARING DOMAIN
Responsibility: Quality Assurance Committee

A&E Experience (%)
Inpatient Experience (%)
Maternity Experience (%)
Outpatient Experience (%)
Community Experience (%)
Feedback Acknowledged in 3 Days (%)
Complaints Closed Within Target (%)

WELL LED DOMAIN
Responsibility: People Committee, *Resources Committee (Finance only)

Sickness Absence (%)
Staff Turnover (%)
Annual Appraisal (%)
Mandatory Training (%)
*Cumulative YTD Financial Position (£Millions)

North Tees & Hartlepool assurance summary

No change in assurance

- *E. coli* infections
- MSSA Infections
- *Klebsiella* infections
- Readmission Rate
- 12-Hour ED Breaches Rate (%)
- Cancer 62 Day Standard
- RTT Incomplete Pathways (%)
- RTT time to first appointment (%)
- Sickness absence (%)

ALERT

- **Cancer Faster Diagnosis** performance is close to lower expected variation in February 2026, regraded from advise.
- **RTT 52 Week Waiters (%)** Reporting close to the limit of expected variance January and February 2026. Regraded from advise.

New ALERT indicators

- **Breast feeding at first feed** demonstrates a declining performance trend and plan is not in range of current performance, regraded from advise.
- **Ambulance handover within 45 minutes** deteriorating performance which is not assured to meet plan consistently, regraded from advise.
- **4 Hour A&E Standard** performance has deteriorated, and is consistently below plan, regraded from advise.

No change in assurance

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- MRSA Infections
- *Pseudomonas* infections
- Still Births Rate (Rolling 12 months, per 1000 Births)
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- Summary Hospital-Level Mortality Indicator

ADVISE

- Community UCR 2 Hour Response (%)
- Cancer 31 Day Standard
- Diagnostic 6 Week Standard
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Annual Appraisal (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

New ADVISE indicators

- **Cancelled operations not rebooked in 28 days** regraded from assure as performance is no longer assured to consistently meet plan.

No change in assurance

- *C. difficile* Infections
- Discharge Delay average days
- Community 52-week waits (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

ASSURE

- **A&E Experience (%)** regraded from advise as consistently exceeding national average

New ASSURE indicators

- **Neonatal Mortality Rate (rolling 12 months per 1,000 births)** is consistent since July 2005 and below peer group average, regraded from advise.

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South Tees Hospitals assurance summary

No change in assurance	ALERT	New ALERT indicator
• Never Events • *Klebsiella* infections • *Pseudomonas* infections • Breast feeding at first feed • Cancer 31 Day Standard • Diagnostic 6 Weeks Standard (%) • RTT time to first appointment (%) • Sickness absence (%) • Mandatory training (%) • Annual Appraisal (%)	• **Inpatient Experience (%**) has deteriorated in recent months, close to the lower limit of expected variation, regraded from advise. • **MRSA infections** regraded from advise as one new case reported in February 2026.	• **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** regraded from advise, reporting one incidence above the peer average in a rolling 12 months. • **Community UCR 2 Hour Response (%)** regraded from advise following continued declining performance.

No change in assurance	ADVISE	New ADVISE indicator
• Incidents per 1000 Bed Days • Patient Safety Incident Investigations • Falls with Harm per 1000 Bed Days • *C. difficile* infections • MRSA infections • *E. coli* infections • MSSA infections • 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 (%)	• Complaints Closed Within Target • Cancelled operations not rebooked in 28 days • Cancer Faster Diagnosis • Cancer 62 Day Standard • RTT 52 Week Waiters (%) • A&E Experience (%) • Maternity Experience (%) • Outpatient Experience (%) • Community Experience (%) • Feedback Acknowledged in 3 Days (%) • Cumulative YTD Financial Position (£Millions)	• **RTT Incomplete Pathways (%)** regraded from alert as performance better than expected variance in February 2026. • **Still birth rate (Rolling 12 months per 1000 Births)** regraded from alert, higher rate in previous months has now stabilised.

No change in assurance	ASSURE	New ASSURE indicator
• Summary Hospital-Level Mortality Indicator • Discharge delay average days	• Community over 52-week Waiters (%) • Staff Turnover (%)	

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SAFE DOMAIN SUMMARY

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

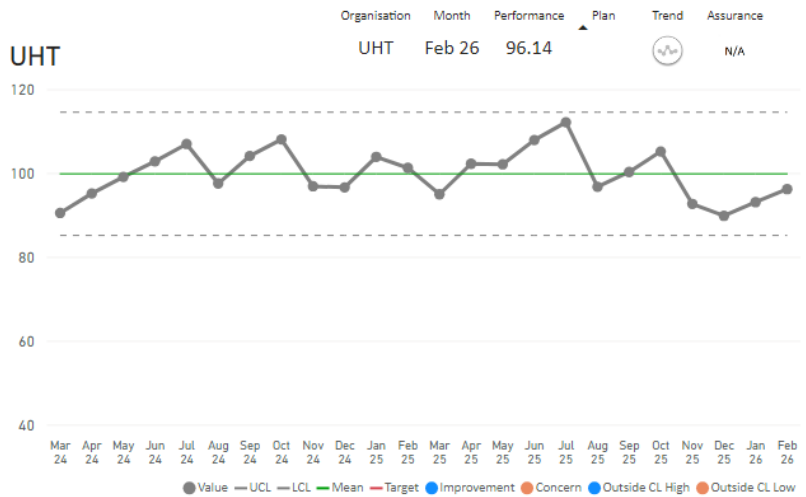
An external evaluation of the Group's implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These form the measures within one of the Group's Quality Priorities and will be used to support the development of the UHT PSIRF plan and policy. The reporting of incidents is seen as a positive indicator of a safety culture; with the move from Datix to Healthcare Guardian for STHFT, this will be monitored closely as there is a known risk of reporting being temporarily impacted by a change in reporting systems.

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 aligned to the Trust Quality Priorities for 2025/26. 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.

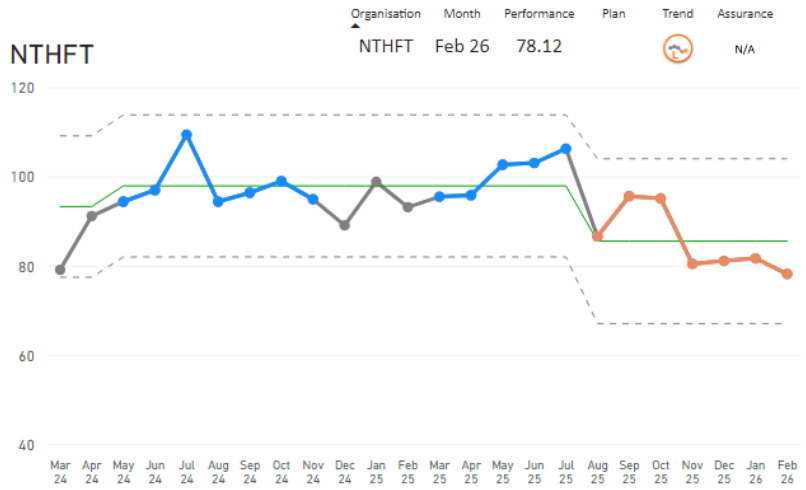
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Incidents Per 1000 Bed Days		95.44	95.77	102.61	103.01	106.22	86.51	95.56	95.05	80.38	81.04	81.61	78.12
Patient Safety Incident Investigations		1	0	1	1	3	1	2	0	0	0	0	0
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.27	0	0.28	0.29	0.14	0.21	0.07	0.21	0.07	0.21	0.19	0
C-Difficile	6	7	6	1	4	4	6	8	2	8	5	4	4
MRSA	0	0	0	0	0	0	0	1	1	0	0	0	0
E-Coli	7	4	8	10	6	12	12	10	9	6	12	7	6
MSSA	3	1	3	3	4	3	5	5	6	1	3	5	3
Klebsiella	3	5	4	4	4	2	0	2	3	2	4	3	5
Pseudomonas	2	2	4	3	1	2	0	1	0	0	1	0	0

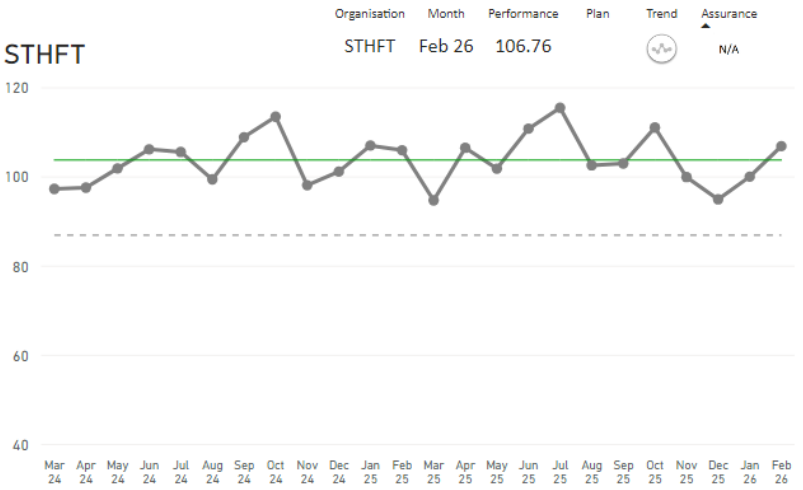
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Incidents Per 1000 Bed Days		94.61	106.4	101.73	110.69	115.38	102.47	102.88	110.94	99.83	94.85	99.93	106.76
Patient Safety Incident Investigations		0	1	0	1	2	1	1	0	0	1	1	0
Never Events	0	0	0	0	0	2	0	0	0	0	1	1	0
Falls With Harm Rate (Per 1000 Bed Days)		0.28	0.33	0.12	0.17	0.21	0.08	0.25	0.08	0.21	0.12	0.19	0.21
C-Difficile	11	10	13	11	11	9	8	13	13	12	7	12	13
MRSA	0	3	0	0	1	1	1	0	2	1	0	0	1
E-Coli	11	17	16	11	14	14	14	14	8	11	13	10	11
MSSA	7	11	3	10	5	8	11	6	7	5	6	9	7
Klebsiella	4	2	4	2	3	4	5	9	9	5	7	8	7
Pseudomonas	1	3	3	3	1	4	1	1	3	1	3	0	2

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: Lower level of incidents reported between November and February. STHFT: No trend.
Assurance: n/a.
Action taken: The fluctuation in incident reporting across both trusts is noted; the notable drop in the NTHFT reporting has been analysed. The CSU structure was introduced in November; it is possible that this change has impacted on reporting. CSUs have been asked to examine all areas of their reporting and to implement actions to further promote reporting. The implementation of the joint reporting system in March, where CSUs only are used, should aid in further understanding the reasons for the reduction.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



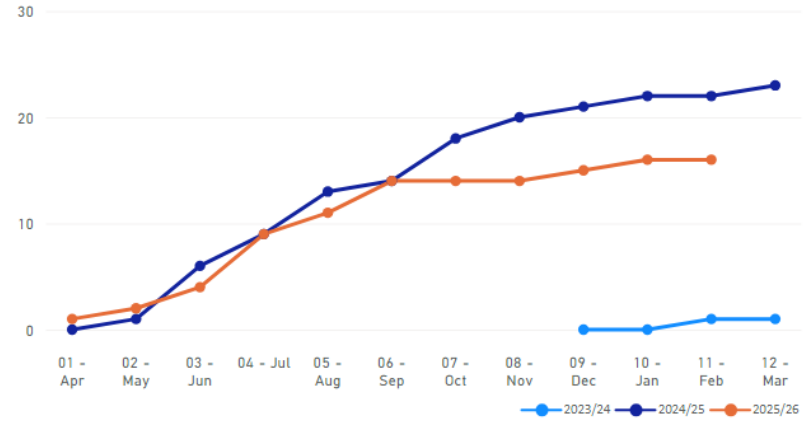


Caring Better Together

SAFE Patient Safety Incident Investigations (YTD)

UHT

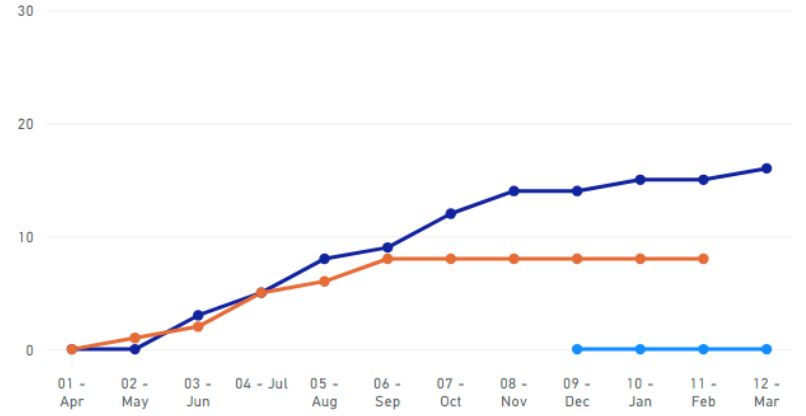
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	16		N/A	N/A



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: No new PSIIs recorded in February, 8 PSIIs YTD. STHFT: No new PSII in February, 8 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

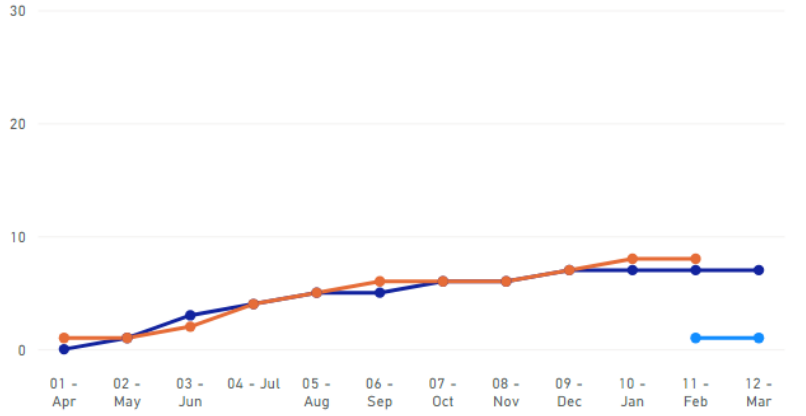
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	8		N/A	N/A

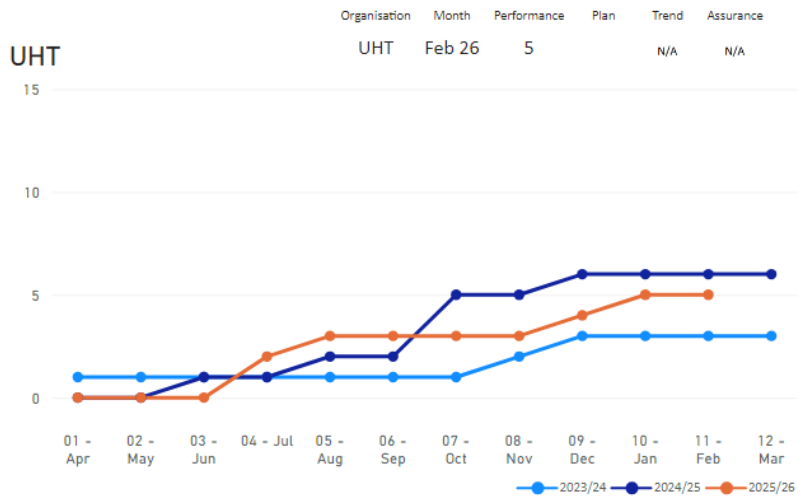


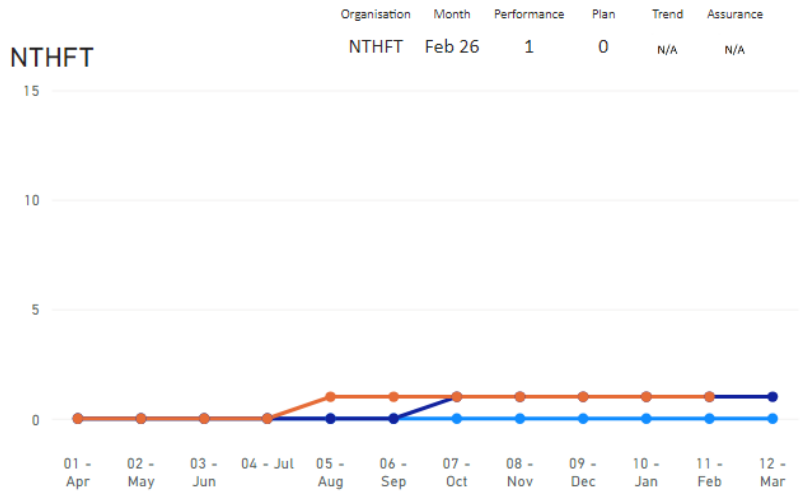
STHFT

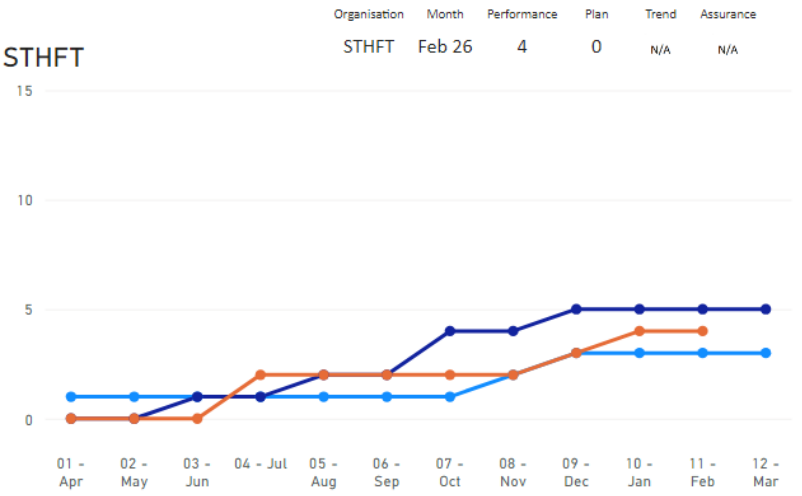
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	8		N/A	N/A



SAFE Never Events (YTD)

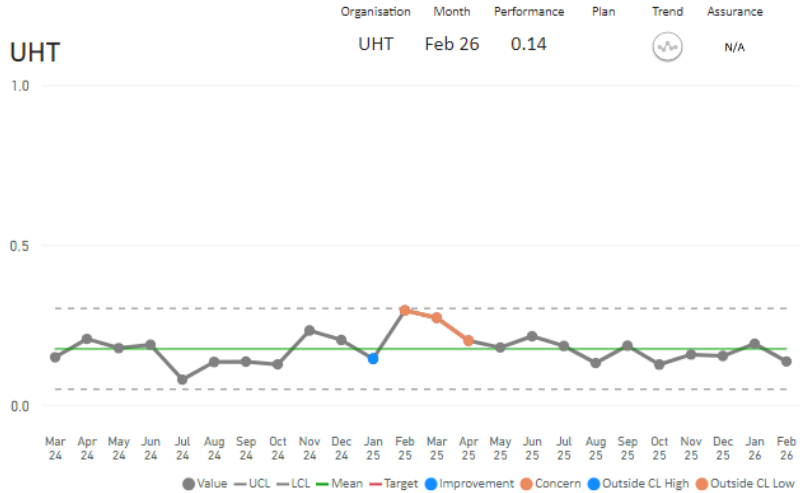




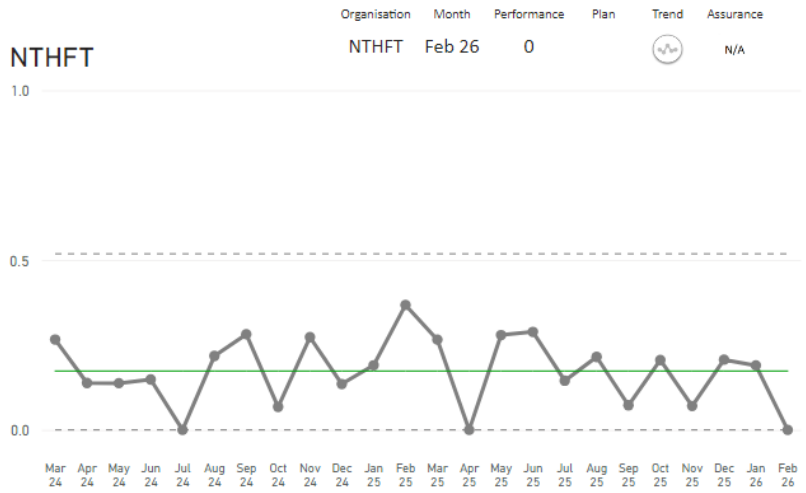


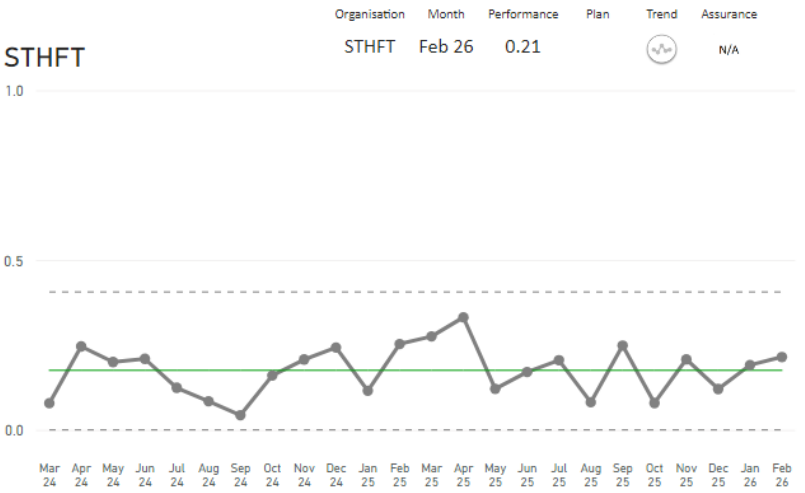
Metric: Never Events (a defined list of serious preventable errors), cumulative annually from April.
Plan: Zero.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 months without a Never Event. STHFT: One new event recorded in January 2026.
Assurance: NTHFT: Advise, a Never Event reported for August 2025. STHFT: Alert, two Never Events in July 2025, two new events in December 2025 and January 2026; 4 YTD.
Action taken: Work is underway to promote the involvement of patients in safety checks prior to procedures in addition to strengthening the UHT's approach to using national and local safety standards for invasive procedures. NHSE consultation has been completed; further workshops will be held in 2026 to review the future of the Never Event framework.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

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.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



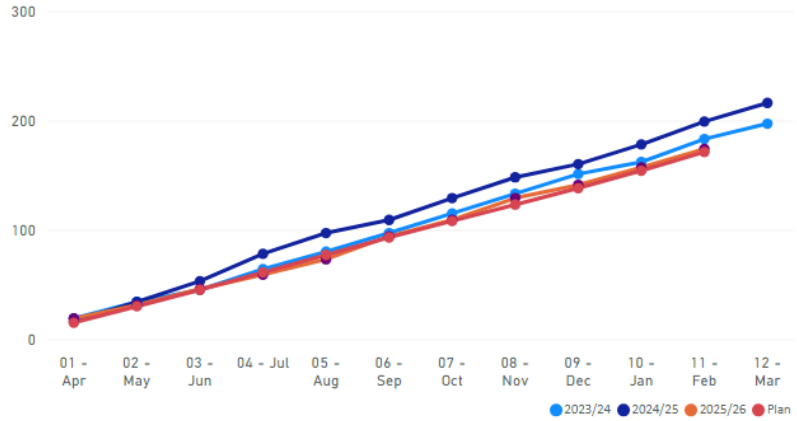


Caring Better Together

SAFE C-Difficile (YTD)

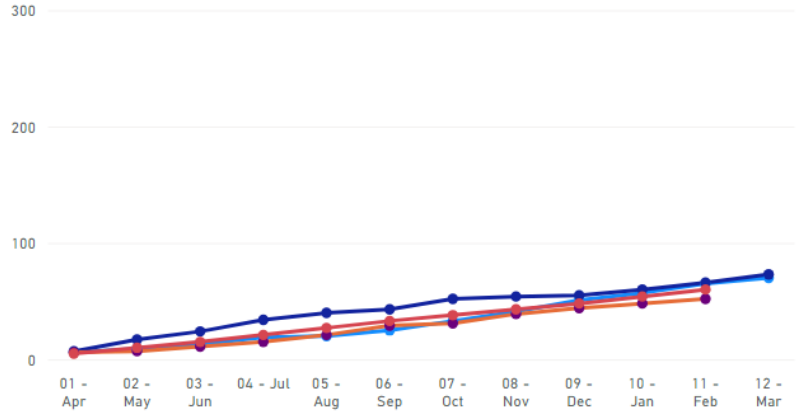
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	174	171	N/A	N/A



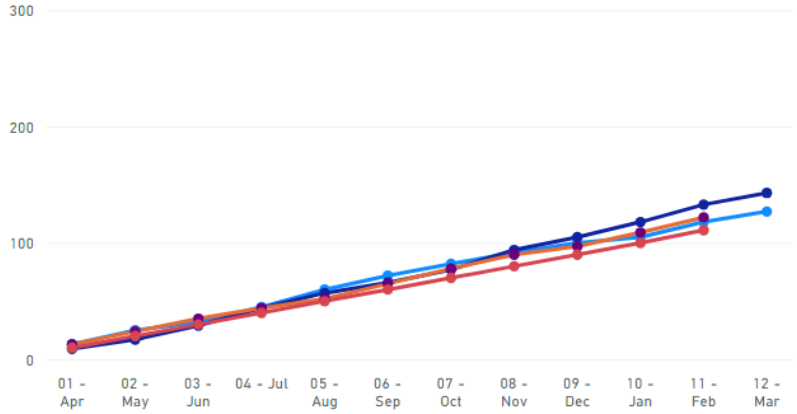
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	52	60	N/A	N/A



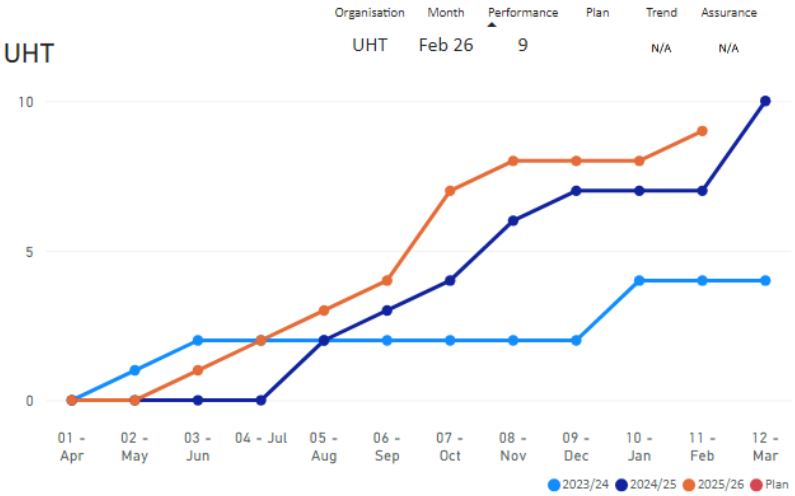
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	122	111	N/A	N/A

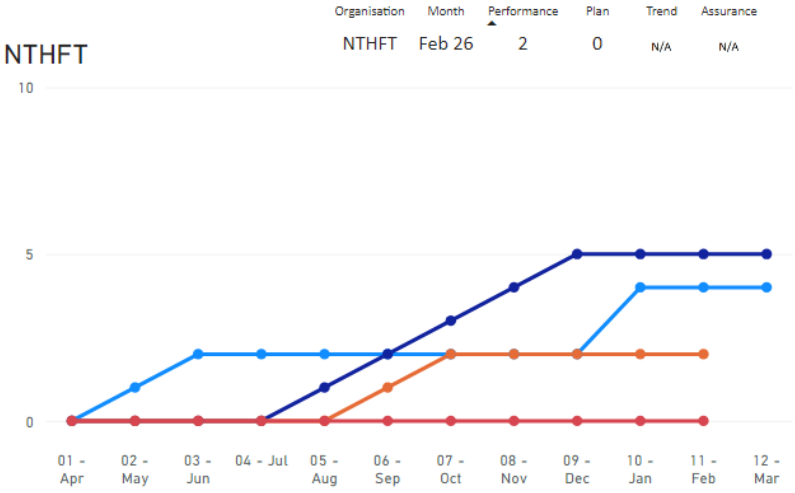


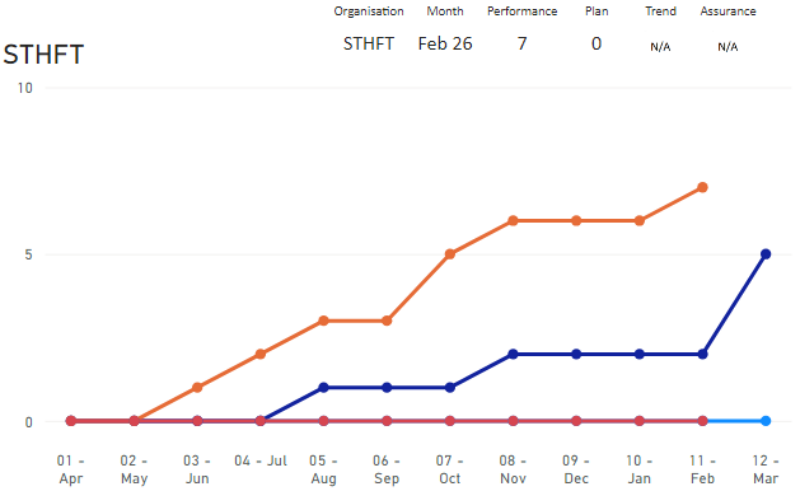
Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in February (trajectory of 6). STHFT: 13 new cases in February (trajectory of 11).
Assurance: NTHFT: Assure; 13%, 8 cases, better than trajectory YTD. STHFT: Advise; 10%, 11 cases, worse than trajectory YTD.
Action taken: Hydrogen peroxide fogging continues after all *C. diffiicile* infections as gold standard, new machines purchased at STHFT, plan for NTHFT. Appropriate decant facility to be established. Improvement in HPV fogging at NTHFT is noted as contributing to a reduction of cases.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MRSA (YTD)



Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT No new cases in February 2026. STHFT 1 New case in February 2026.
Assurance: NTHFT: Advise, no new cases since October, 2 cases YTD. STHFT: Alert, 1 new case in February, 7 cases YTD.
Action taken: Alignment of policies to increase MRSA screening. Increased audit and education. Detailed learning is shared.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

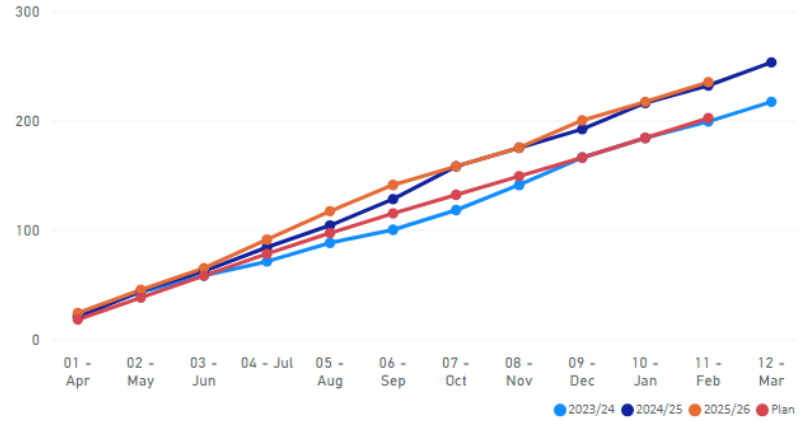




SAFE E-Coli (YTD)

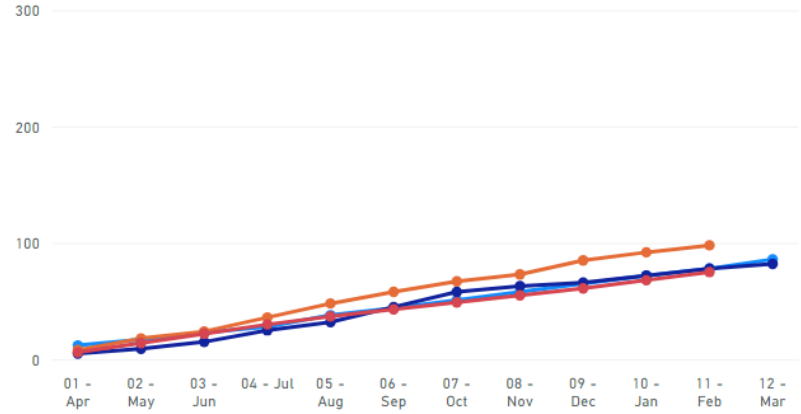
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	235	202	N/A	N/A

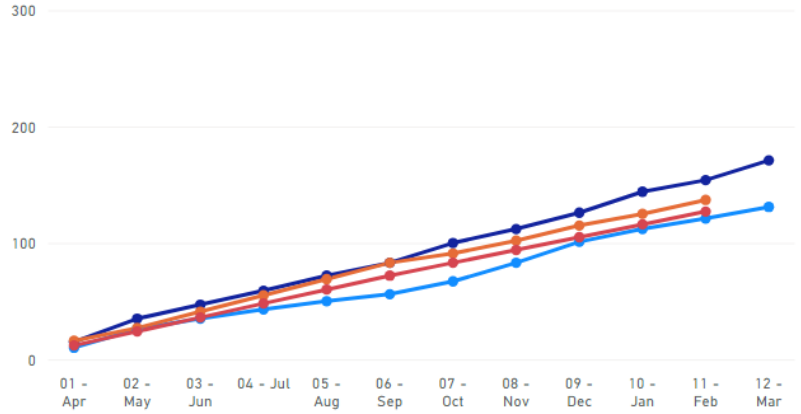


NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	98	75	N/A	N/A



STHFT

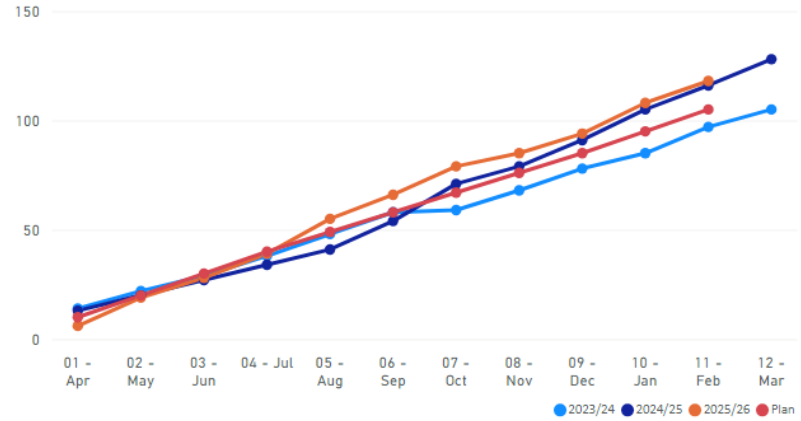


Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 cases in February 2026 (trajectory of 7). STHFT: 12 cases in February 2026 (trajectory of 11).
Assurance: NTHFT: Alert, 23 cases 30% worse than trajectory YTD. STHFT: Advise, 10 cases 8% worse than trajectory YTD.
Action taken: Thematic learning from a catheter prevalence perspective. ICB collaboration for catheters in care homes and hydration. Establishment of UHT catheter group. External support for good practice in audit and education.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MSSA (YTD)

UHT

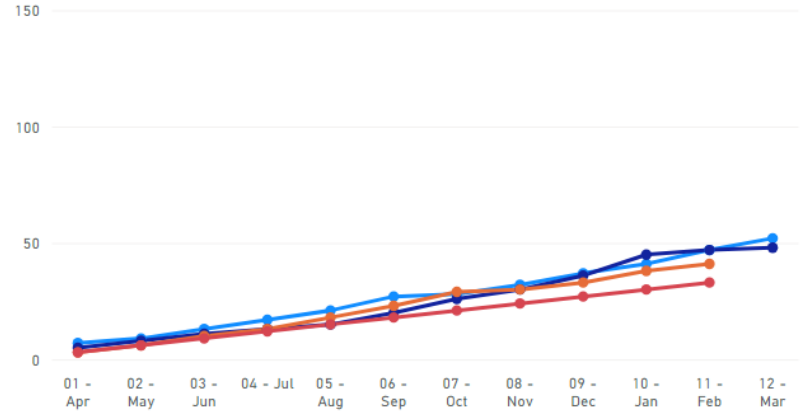
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	118	105	N/A	N/A



Metric: Healthcare associated cases of MSSA annually from April.
Plan: Local plan for 1 case fewer than 2024/25 (no contractual plan).
Rationale: In line with other NHS Contract indicators.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 3 new cases in February 2026 (trajectory of 3). STHFT: 7 new cases in February 2026 (trajectory of 7).
Assurance: NTHFT: Alert, 8 cases, 25% worse than trajectory YTD. STHFT: Advise, 5 cases, 7% 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

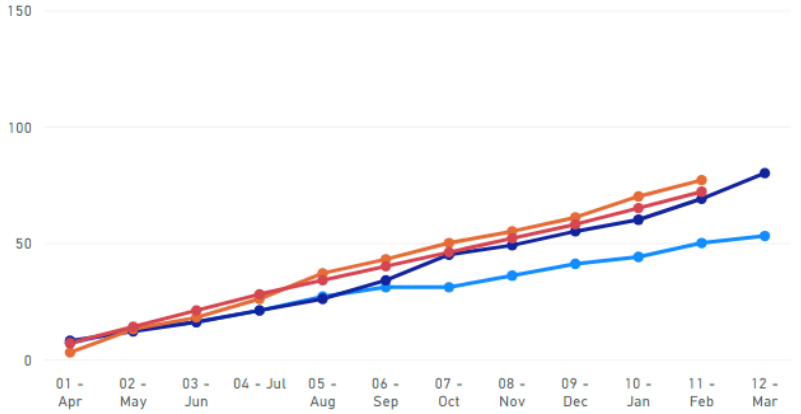
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	41	33	N/A	N/A

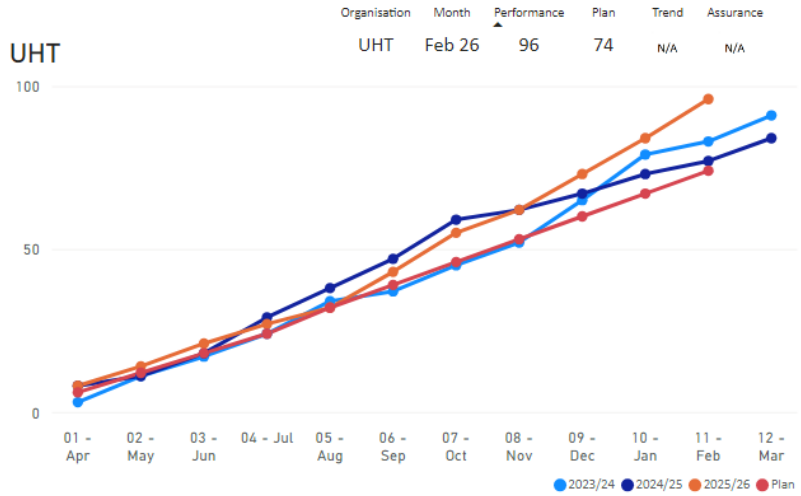


STHFT

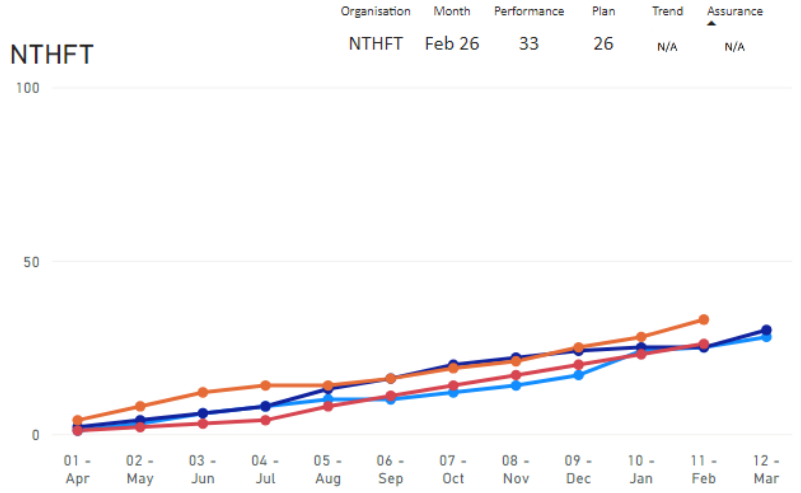
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	77	72	N/A	N/A

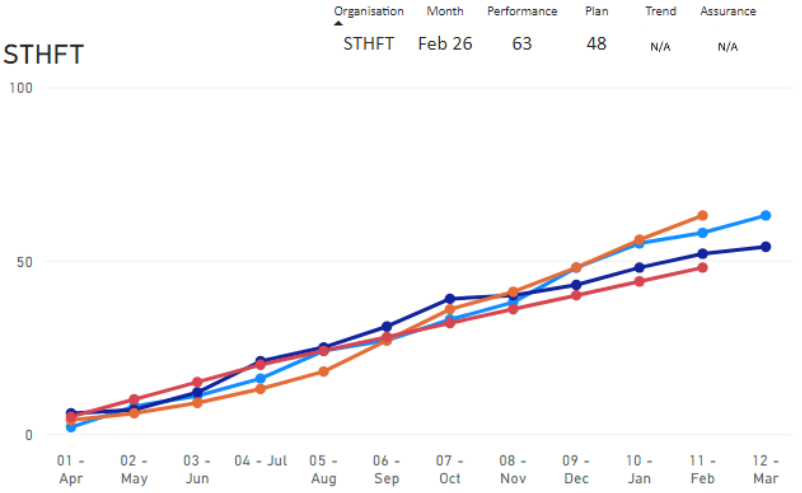


SAFE Klebsiella (YTD)



Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 5 new cases in February 2026 (trajectory of 3). STHFT: 7 new cases in February 2026 (trajectory of 4).
Assurance: NTHFT: Alert, 7 cases more, 27% worse than trajectory YTD. STHFT: Alert, 15 cases, 31% worse than trajectory YTD.
Action taken: Links to health inequalities reviewed with regional focus. Hot gall bladder awareness from hepatobiliary focus. Catheter work in UHT and care homes. Regional input due to increased community prevalence.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

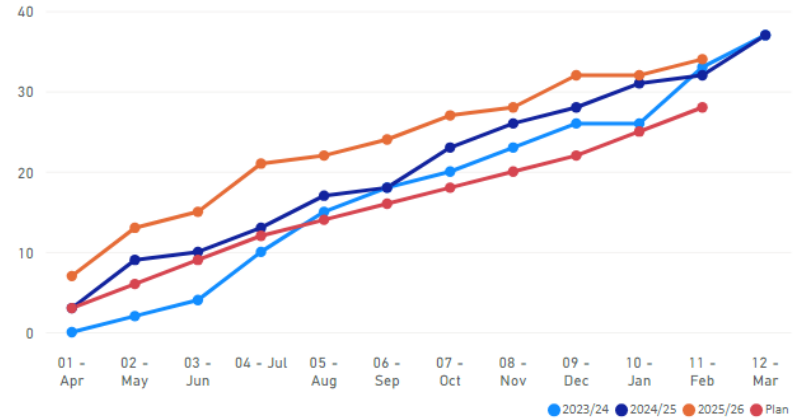




SAFE Pseudomonas (YTD)

UHT

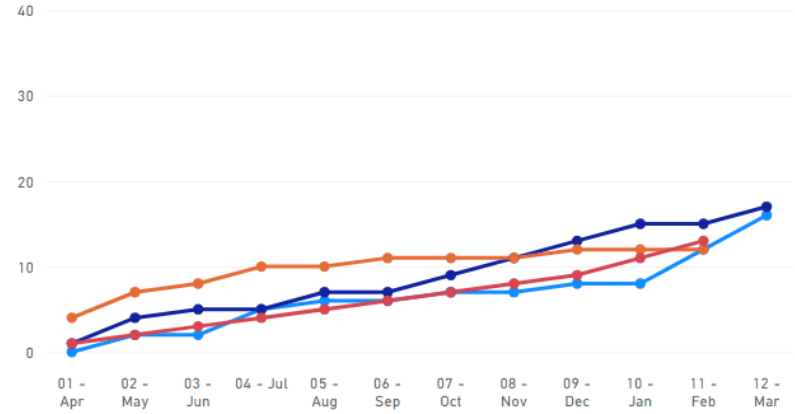
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	34	28	N/A	N/A



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases in February (trajectory of 2). STHFT: Two new cases in February (trajectory of 1).
Assurance: NTHFT: Advise, 1 case better than trajectory YTD. STHFT: Alert, 7 cases, 47%, worse than trajectory YTD.
Action taken: Focus on water safety reporting and governance. Alignment of process across UHT. Sporadic cases across STHFT – no clear links or themes identified.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

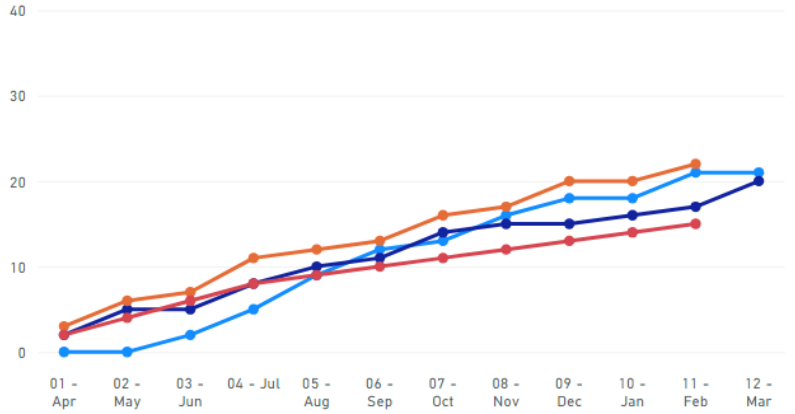
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	12	13	N/A	N/A



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	22	15	N/A	N/A



SAFE MATERNITY SUMMARY

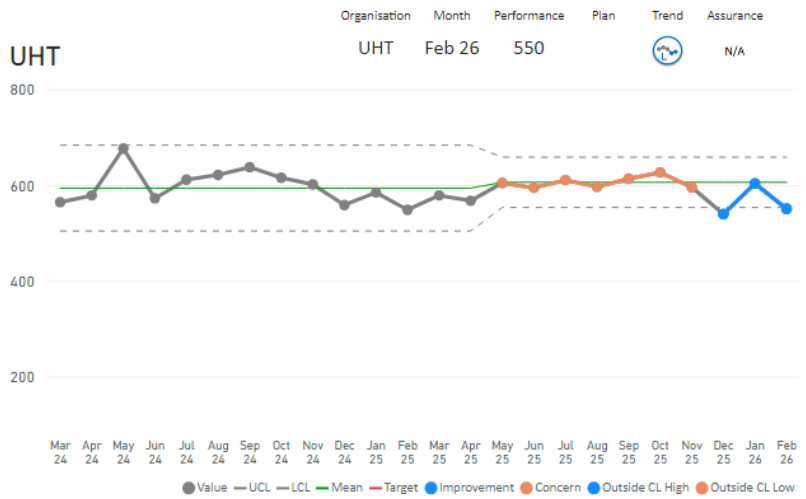
Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

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. Neonatal mortality rate triggers Alert at STHFT due to reporting 1 incidence above the rolling peer average (noting that NTHST and STHFT have different case mix peer groups). Breastfeeding rates are alerted to Board for both Trusts. Infant feeding specialists are providing a continued focus to support and promote breastfeeding. Maternity service across UHT participate in simulation exercises, care bundles and research studies to identify where clinical care can be further improved. Regular in-depth reporting on maternity services takes place through Quality Assurance Committee and the Local Maternity and Neonatal System Board.

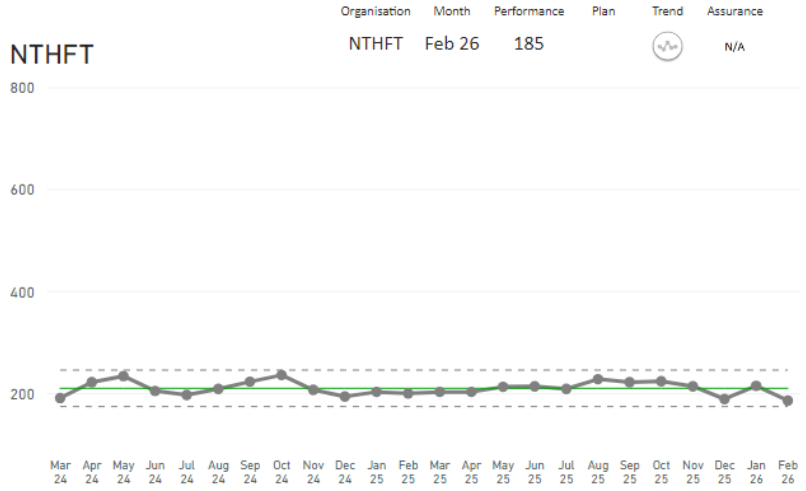
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Total Births		202	202	212	213	208	227	221	223	213	188	214	185
Still Birth Rate (Rolling 12 months, per 1000 births)	2.91	3.97	4	3.63	3.61	4.4	3.97	3.97	3.19	3.18	3.58	3.17	2.79
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	0.99	0	0	0	0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Breast Feeding at First Feed	72.3%	53%	51.5%	50.9%	46.2%	49.5%	46.3%	47.5%	47.3%	52.4%	42.8%	55.1%	46.2%
PPH >= 1500ml Rate per 1000 Births	31	25	30	38	33	24	13	18	41	38	11	9	37
3rd/4th Degree Tear (%)		0.8%	2.7%	5.8%	2.9%	8.9%	3.2%	1%	3%	2.5%	1.2%	3.6%	3%

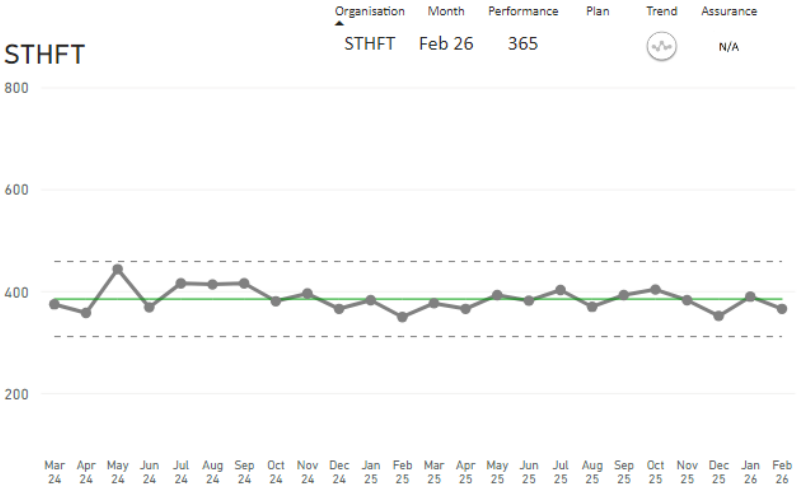
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Total Births		376	365	392	381	402	369	392	403	382	351	389	365
Still Birth Rate (Rolling 12 months, per 1000 births)	3.6	3.22	3.43	3.25	3.24	3.68	3.72	3.52	3.5	3.51	3.52	3.52	3.73
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1.84	1.72	1.71	1.3	1.73	1.73	1.31	1.54	1.53	1.54	1.76	2.2	1.98
Breast Feeding at First Feed	77.1%	68.2%	63.9%	65.3%	64.5%	62.3%	63.5%	69.5%	65.7%	65.7%	68.1%	65.5%	69.4%
PPH >= 1500ml Rate per 1000 Births	31	30	28	29	32	25	28	29	51	32	41	26	22
3rd/4th Degree Tear (%)		5.7%	2.4%	1.3%	3.4%	1.3%	1.8%	2.7%	3.5%	5.2%	1.1%	3.1%	4.3%

SAFE Total Births



Metric: Total births (includes all registerable live and still births) under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: Number of births at NTHFT and STHFT is relatively stable over 2-year timeframe.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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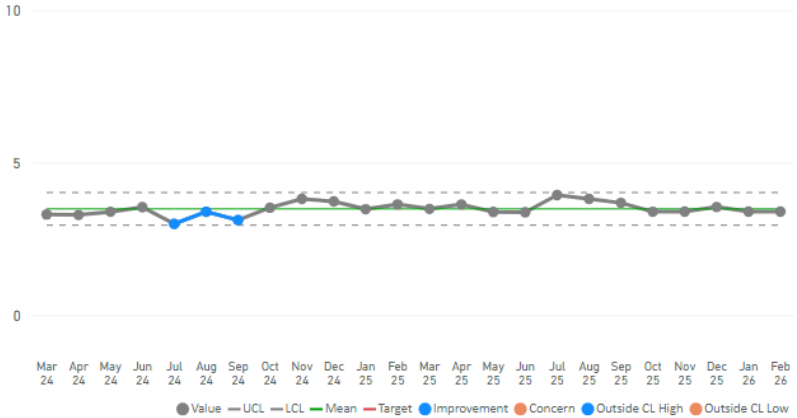
SAFE Still Birth Rate (Rolling 12 months, per 1000 births)

UHT

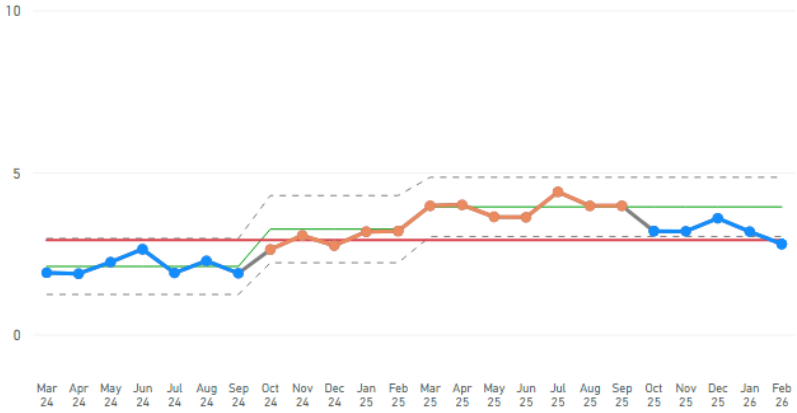
Organisation	Month	Rate	Plan	Trend	Assurance
UHT	Feb 26	3.39			N/A



Metric: Still birth rate (rolling 12 months per 1000 births).
Plan: MBRRACE comparator group crude average 2023.
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: Positive, reduced rates and better than expected variance February 2026. STHFT: Slightly higher rate for the last 9 months compared to first half of 2025.
Assurance: NTHFT: Advise. STHFT: Advise, recent higher rate has stabilised.
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

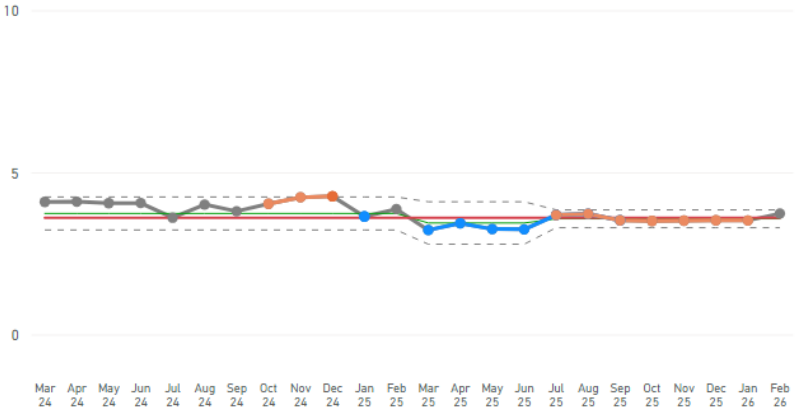
NTHFT

Organisation	Month	Rate	Plan	Trend	Assurance
NTHFT	Feb 26	2.79	2.91		



STHFT

Organisation	Month	Rate	Plan	Trend	Assurance
STHFT	Feb 26	3.73	3.6		



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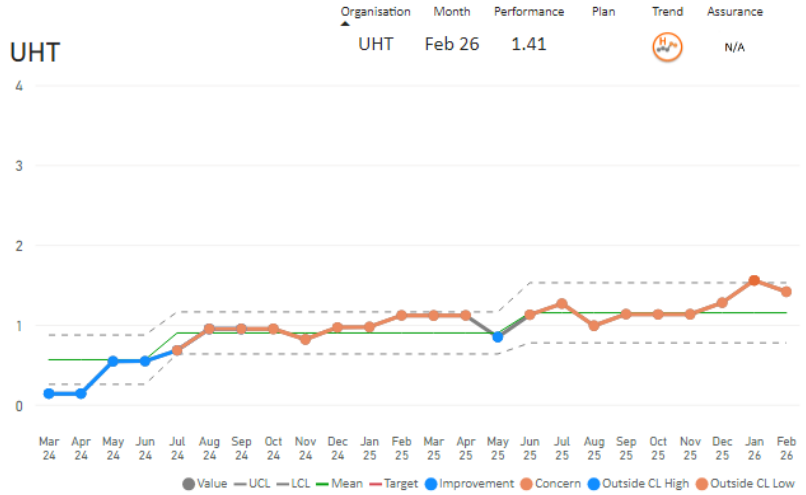
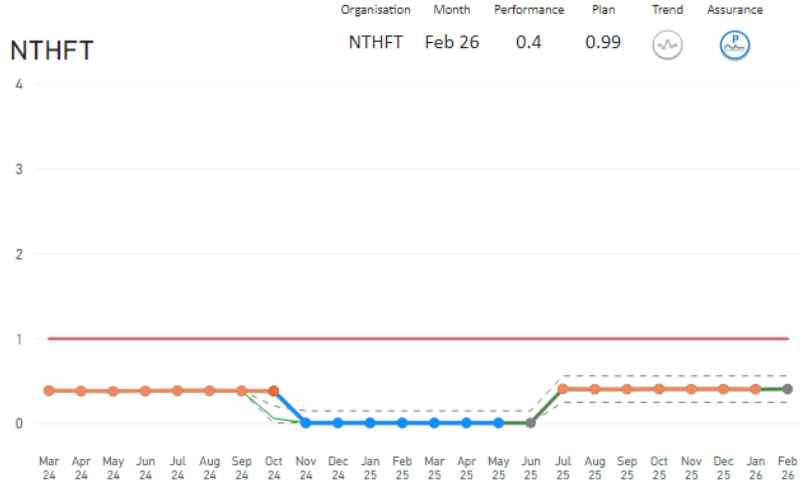
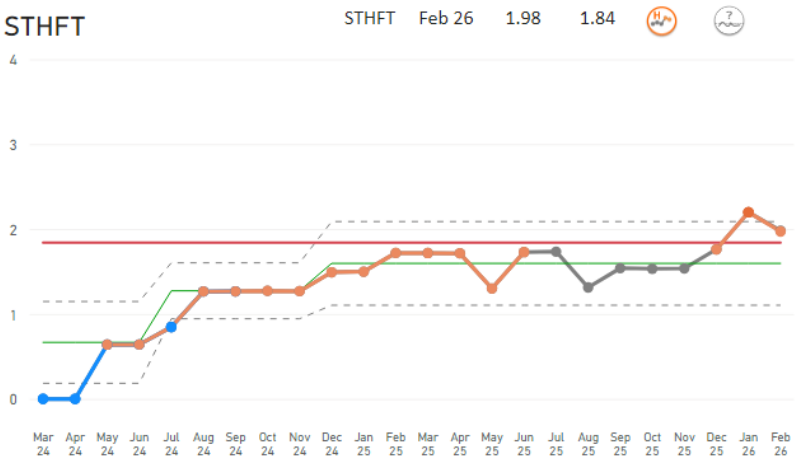
SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)



Metric: Neonatal mortality rate**,** rolling 12 months per 1,000 births.
Plan: Local plan 25/26, MBRRACE audit peer group average.
Rationale: National Maternity Indicator.
Data quality: Assured, validated crude data, not case-mix adjusted.
Trend: NTHFT: No trend, neonatal mortality rate is consistent since July 2005. STHFT: Reporting 1 incidence above the peer average in a rolling 12 months, high outliers January and February 2026.
Assurance: NTHFT: Assure. STHFT: Alert.
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





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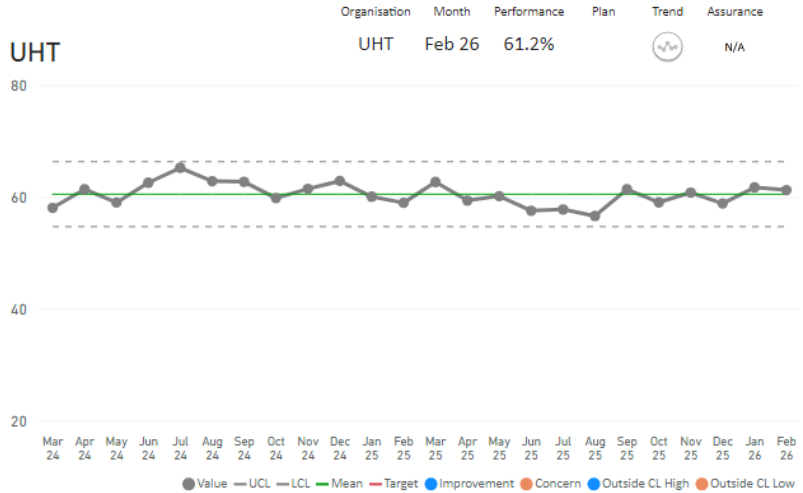
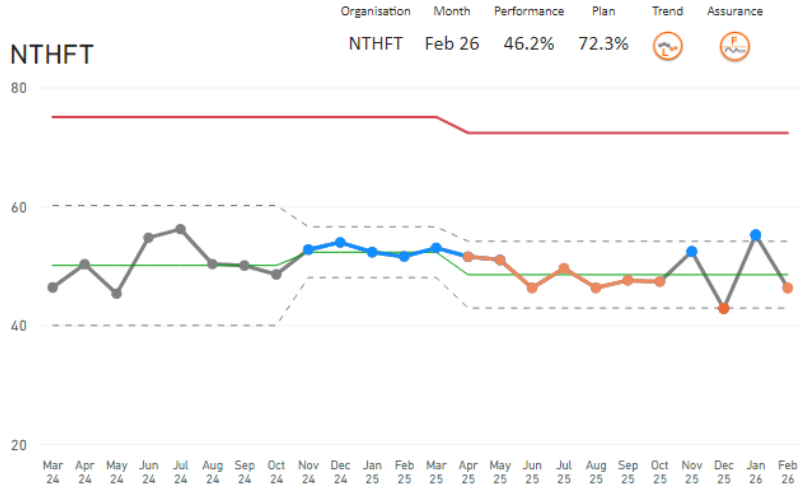
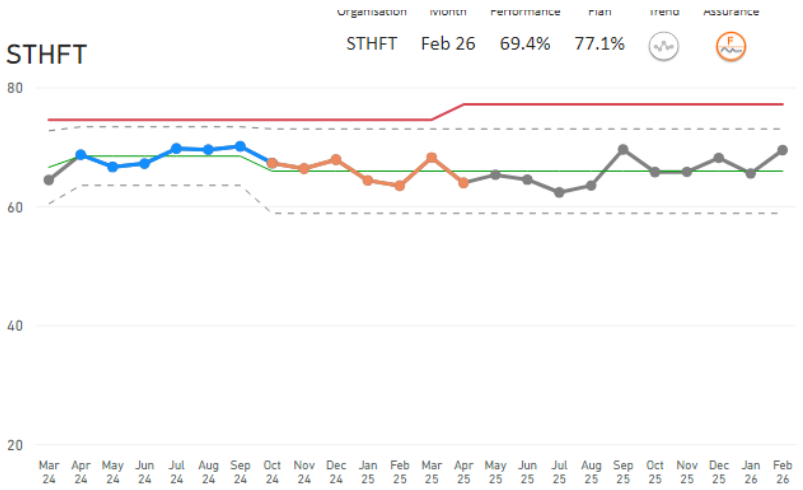
SAFE Breast Feeding at First Feed

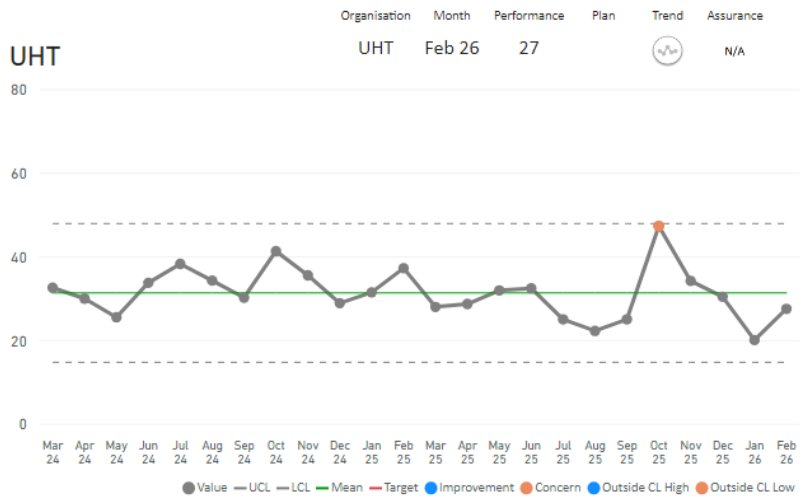


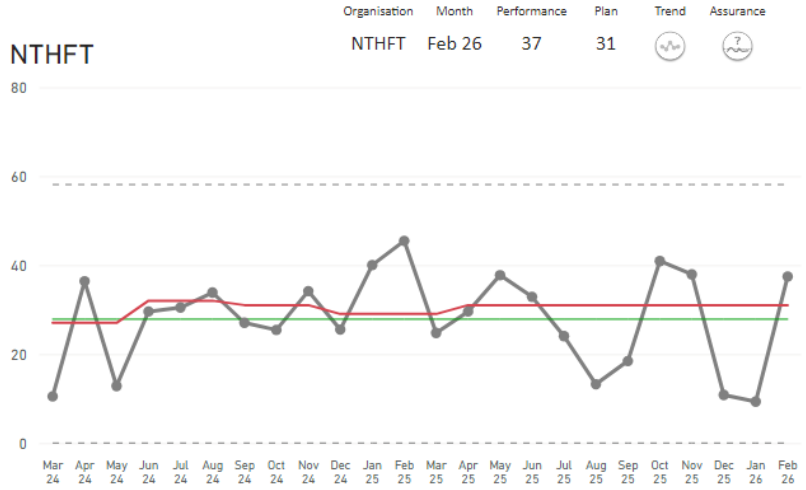


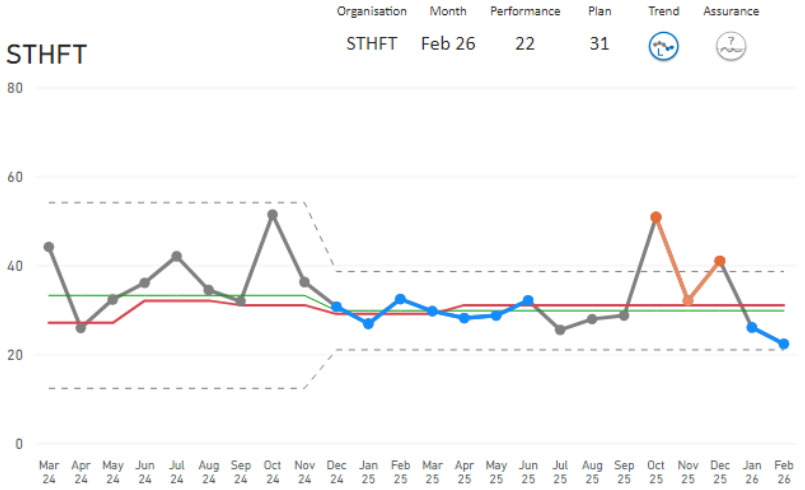


Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 25/26 to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: National maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: Positive outliers November 2025 and February 2026, however, declining trend, plan is not statistically in range of current performance. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: NTHFT are collaborating with STHFT infant feeding team, as a learning opportunity to support an increase in breast feeding.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE PPH >= 1500ml Rate per 1000 Births

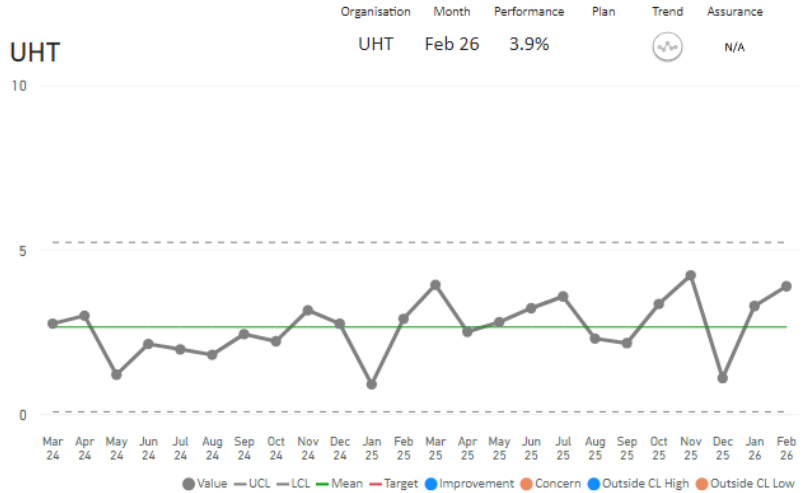




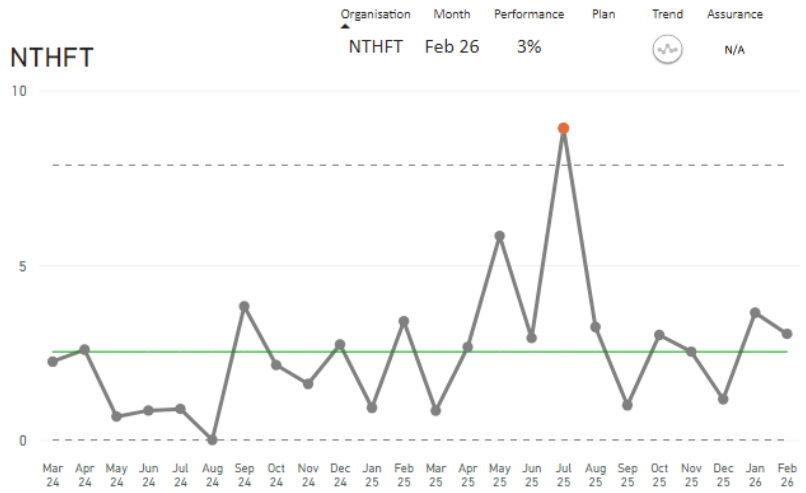


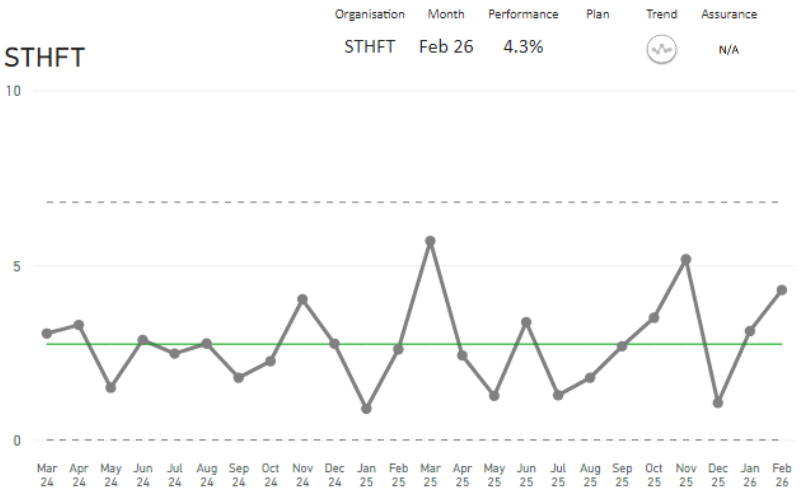
Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births.
Plan: North East and North Cumbria ICB regional average.
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Recent high outliers in October and again in December 2025, but lower rates in January and February 2026.
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 amended to reflect national descriptor, from July 2025, new rate close to limits of previous range of variation.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: All cases have a joint review to identify any learning points; no common themes have emerged.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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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.

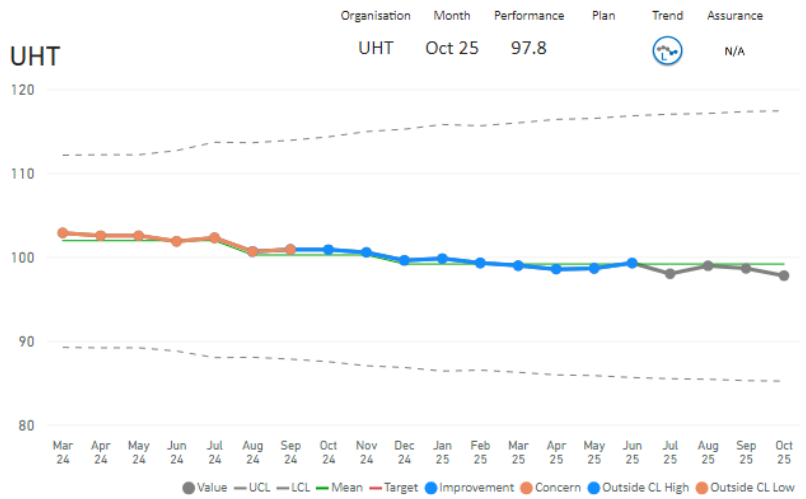
Both trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. This is focusing initially on readmissions of patients 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 national average for 24/25.

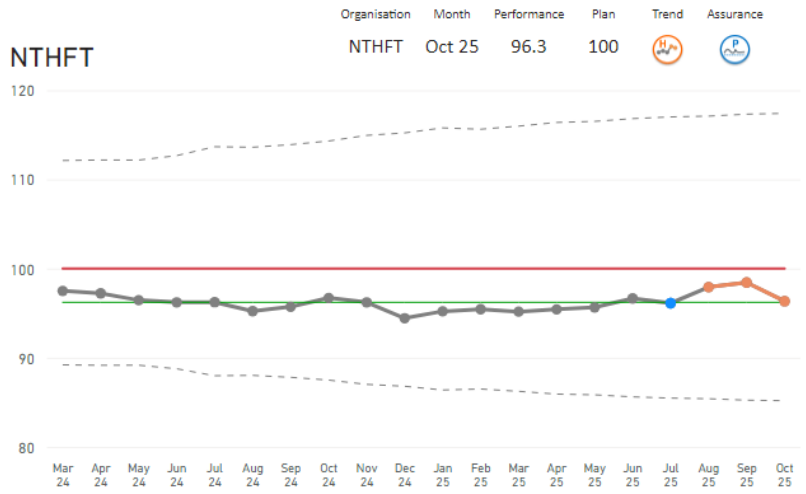
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Summary Hospital-Level Mortality Indicator	100	95.2	95.4	95.6	96.6	96.1	97.9	98.4	96.3			
Readmission Rate (%)	8.4%	11.6%	11.3%	10.5%	10.3%	10.5%	10.1%	10.2%	11%	10.2%		
Discharge Delay Average (days)	0.825	0.577	0.626	0.623	0.559	0.681	0.67	0.574	0.553	0.632	0.709	0.619

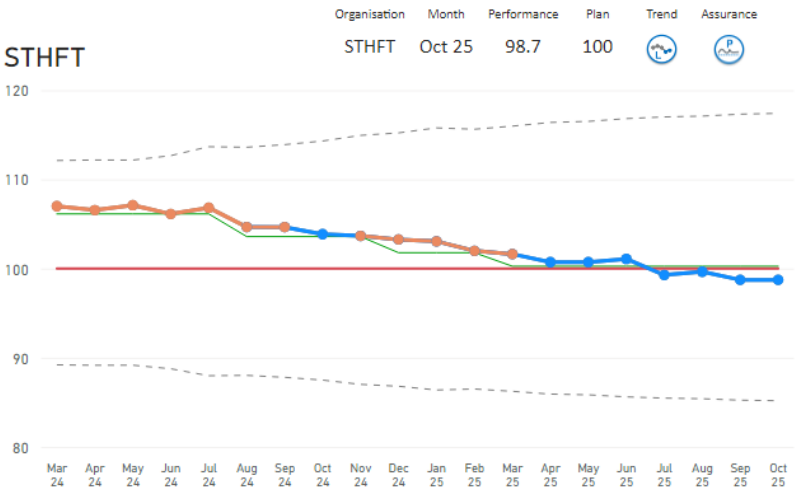
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Summary Hospital-Level Mortality Indicator	100	101.6	100.7	100.7	101.1	99.3	99.6	98.7	98.7			
Readmission Rate (%)	8.4%	8.8%	8.8%	8.4%	9.1%	8.6%	8.4%	8.6%	8.6%	8%		
Discharge Delay Average (days)	0.825	0.652	0.534	0.626	0.594	0.617	0.601	0.688	0.671	0.594	0.635	0.738

EFFECTIVE Summary Hospital-Level Mortality Indicator

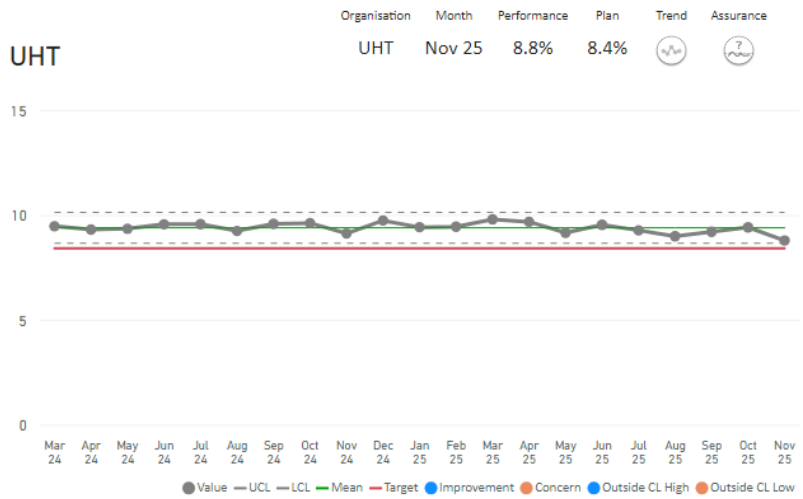


Metric: Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: Higher rates August to October 2025. STHFT: Improving.
Assurance: 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

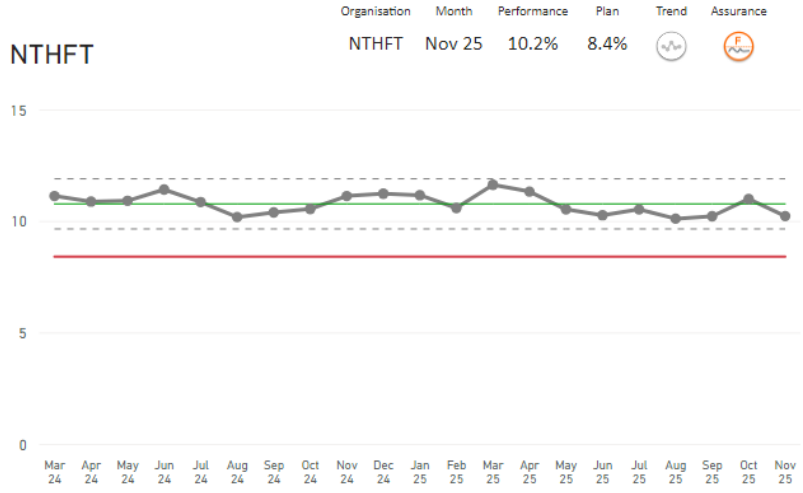


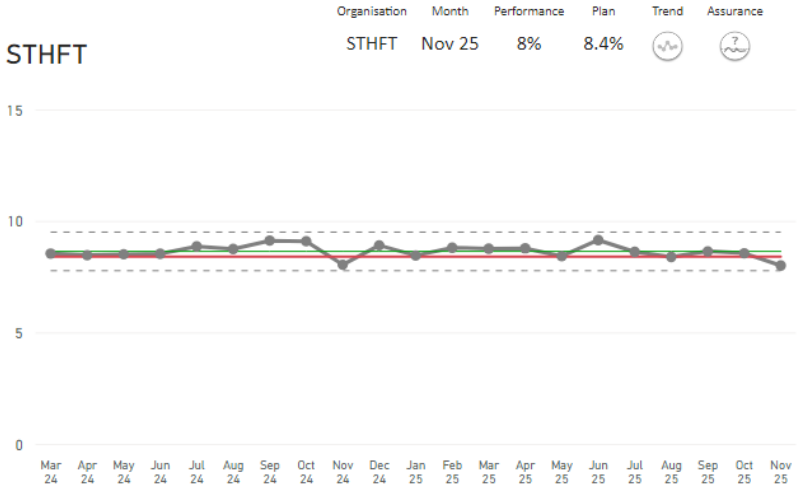


EFFECTIVE Readmission Rate (%)

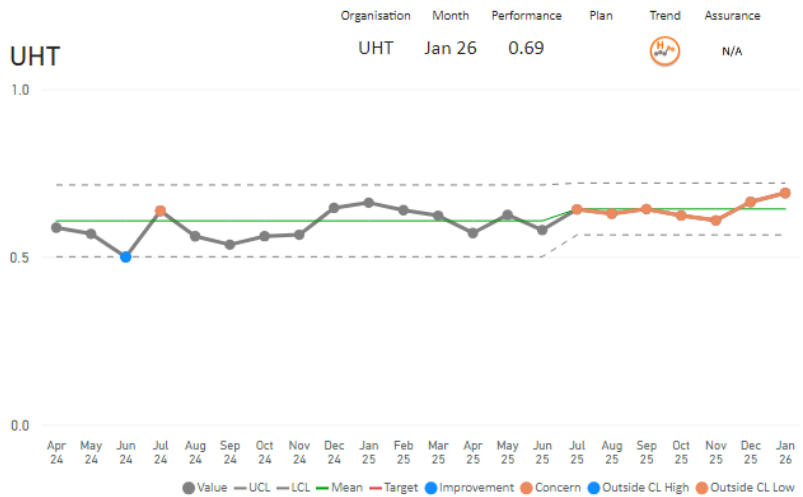


Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Alert. Readmission 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

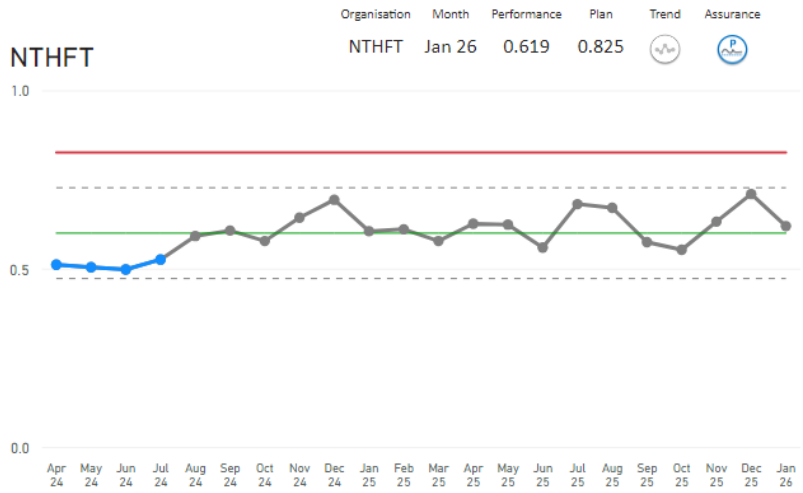


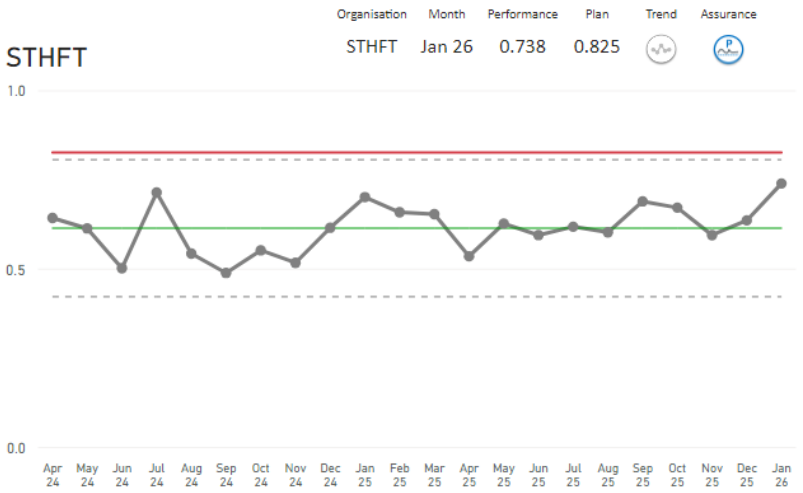


EFFECTIVE Discharge Delay Average (days)



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 24/25.
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





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RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **Accountable to: Resources Committee**

Urgent and emergency care

Ambulance handover performance compliance at NTHFT has shown the effects of increased seasonal demand and acuity from December onwards. Handovers within 45 minutes are usually assured at >95% outside of peak winter demand. Similarly, STHFT performance reflects the same heightened demand and improved resilience following improvements made in 2025.

A&E 4-hour standard performance fell below the agreed trajectory for NTHFT, however noting that at NTHFT, the national recovery standard of 78% has been exceeded throughout the year as one of the top performing trusts nationally. There is continued focus at STHFT to secure delivery to trajectory, including implementing a rapid assessment and treatment model. To date, compliance demonstrates good resilience to seasonal demand compared to last year.

12-hour breaches in ED show seasonal variation with patient acuity and are lower than the national planning guidance standard of fewer than 10%, but delivery of agreed plans is not assured. This remains an operational focus.

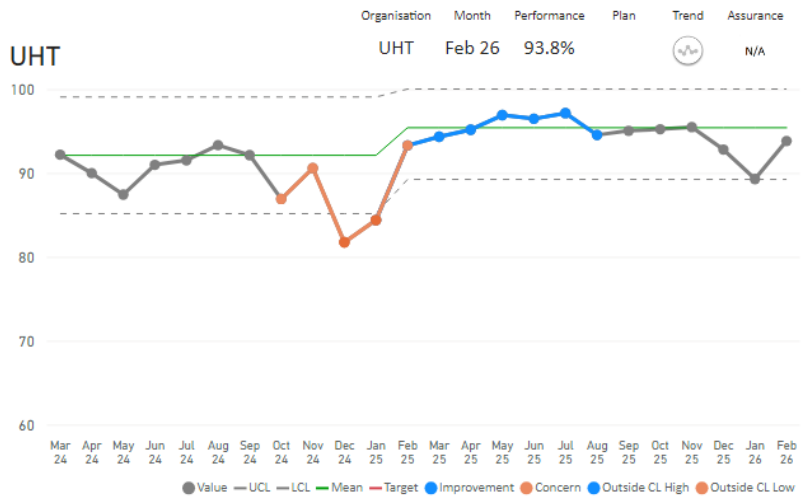
Above-standard performance in the community urgent 2-hour response reflects the continued focus on supporting urgent and emergency care pathways, caring for patients in the most appropriate setting. The introduction of a UHT care co-ordination centre in November supports making optimal use of community resources to avoid unnecessary admissions during the seasonal increase in demand for care.

Elective operations cancelled on the day not rebooked within 28 days is consistently less than 5 per month at NTHFT, at STHFT this metric has stabilised after re-invigorating focus on re-booking through collaborative performance meetings and the Surgical Improvement Group.

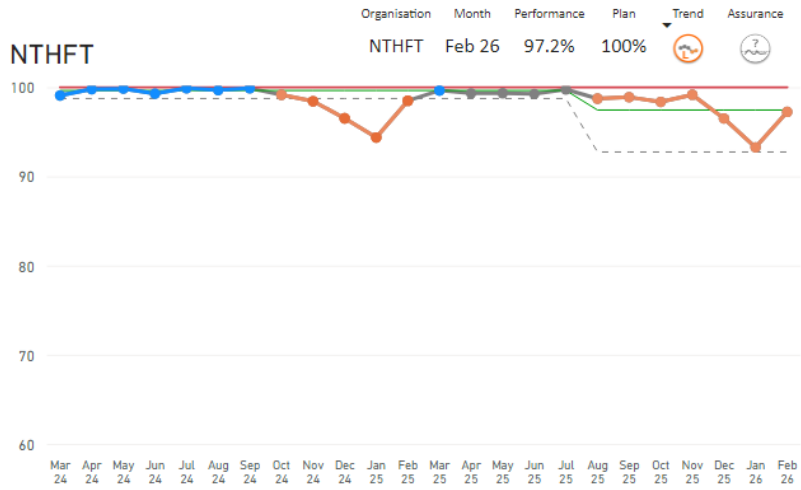
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
NEAS Handovers - Within 45 Mins (%)	100%	99.6%	99.3%	99.3%	99.2%	99.7%	98.7%	98.9%	98.4%	99.2%	96.5%	93.3%	97.2%
4-Hour A&E Standard	86.5%	85.6%	83.7%	86.4%	84.6%	84.9%	84.6%	83.4%	82%	82%	83.3%	80.4%	83%
12-hour ED breaches rate	0.9%	1.7%	2.2%	1.4%	3.2%	1.5%	1.4%	4.5%	6.4%	5.5%	6.9%	9.5%	5.7%
Community UCR 2hr Response Rate (%)	70%	74%	70%	75%	75%	76%	80%	76%	73%	75%	74%	76%	
Cancelled Ops - Not Rebooked Within 28 days	0	0	3	4	5	1	0	3	4	2	2	4	3

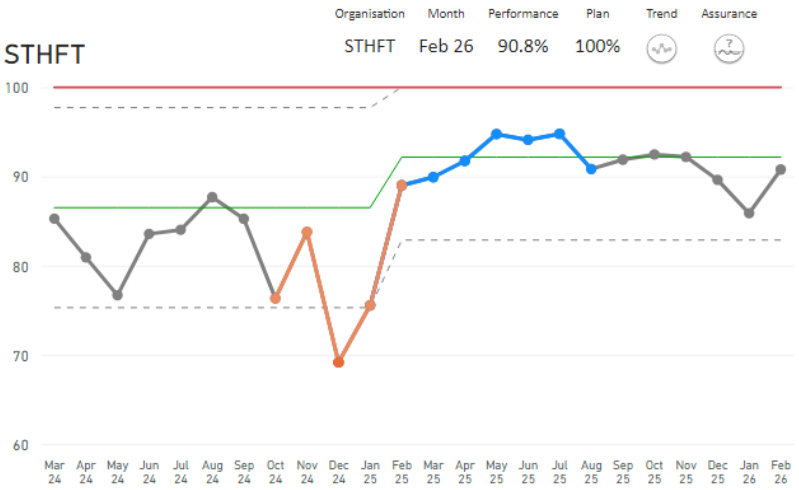
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
NEAS Handovers - Within 45 Mins (%)	100%	89.9%	91.7%	94.7%	94.1%	94.8%	90.8%	91.9%	92.5%	92.2%	89.6%	85.9%	90.8%
4-Hour A&E Standard	77.6%	75.7%	77%	77%	76.6%	78.5%	78%	76.7%	77.3%	77.7%	78.5%	75.6%	77.6%
12-hour ED breaches rate	4.7%	4.1%	4.4%	2.8%	3.2%	2.7%	4.6%	5.6%	5.2%	5.5%	5.5%	8.4%	5.6%
Community UCR 2hr Response Rate (%)	70%	86%	82%	81%	78%	76%	77%	71%	76%	76%	77%	76%	
Cancelled Ops - Not Rebooked Within 28 days	0	16	10	6	11	10	10	9	16	10	16	20	13

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: Deteriorating performance. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT continue focus on full compliance. Handover SOP in place and use of corridor and ambulatory area in surge to provide timely release of crews. STHFT reinforce the handover escalation SOP with clinical teams. ED patient flow will become the primary source of escalation to minimise ambulance delays.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



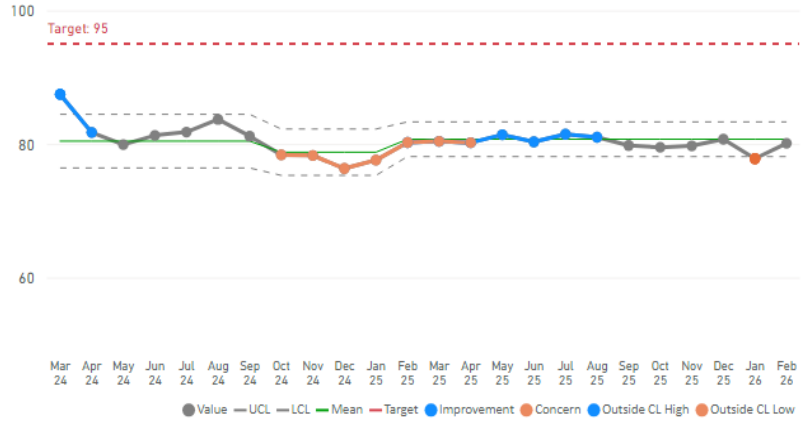


RESPONSIVE 4-Hour A&E Standard

Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, agreed operational plan to achieve 90% NTHFT, 78% STHFT by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend, consistently fails to meet plan. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT: Review of breaches to identify themes as well as validation process in line with NHSE spring reset opportunities; improvement of weekend discharges and discharge after 5pm; liaison with Police regarding the custody suite pathway. STHFT: Ongoing alternative to ED work; validation process review and SOP agreed to align processes across Group; review of 'ready to proceed' status and underpinning data.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

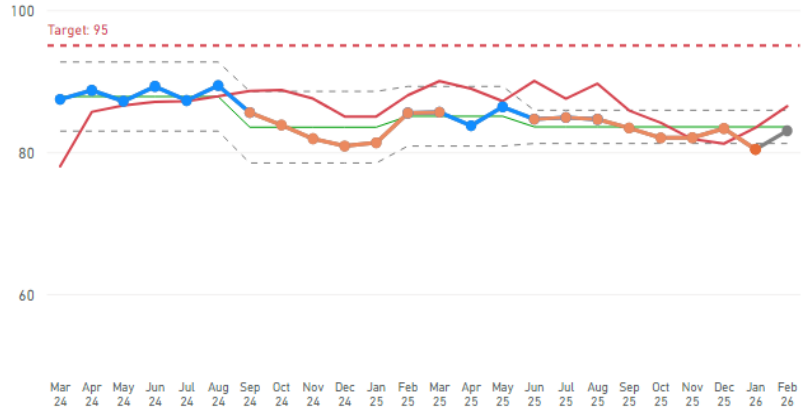
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	80.1%			N/A



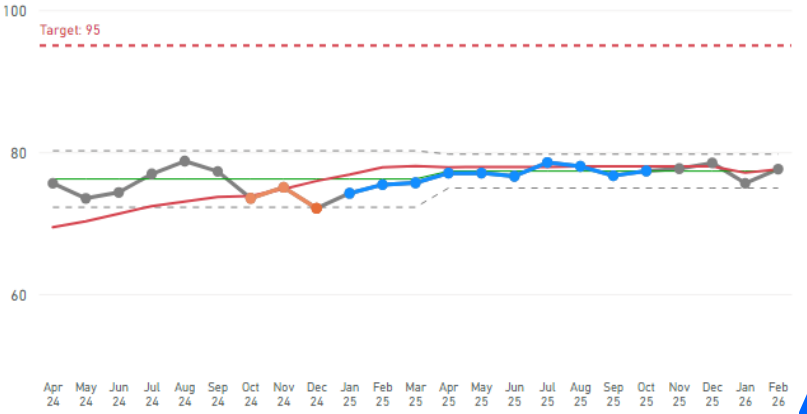
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	83%	86.5%		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	77.6%	77.6%		

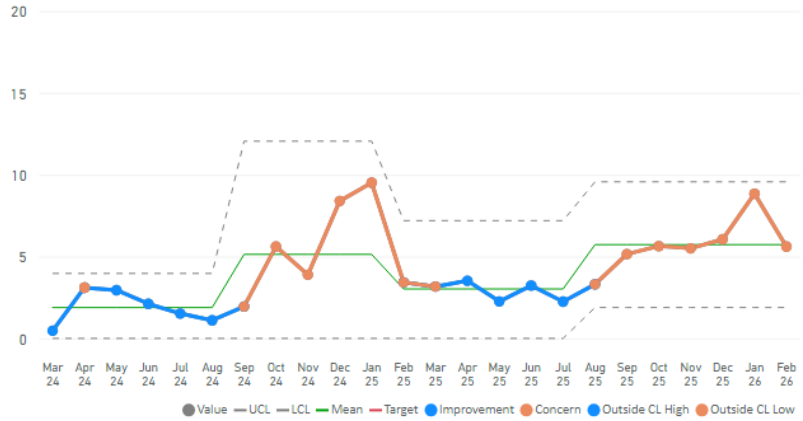


RESPONSIVE 12-hour ED breaches rate

Metric: Percentage of patients admitted or discharged from Type 1 Emergency Department after 12 hours.
Plan: Seasonalised operational plan for 25/26 submitted by each Trust: NTHFT to achieve 1.93% in March 2026; STHFT to achieve 3.22%. National planning guidance standard 10%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Declining performance in recent months. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT: Ongoing audit of breaches to identify key themes, with patient transport highlighted. STHFT: Continued focus on interventions at 10-hours to avoid 12-hour breaches. Full capacity protocol enacted when required to support admitted patient flow.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

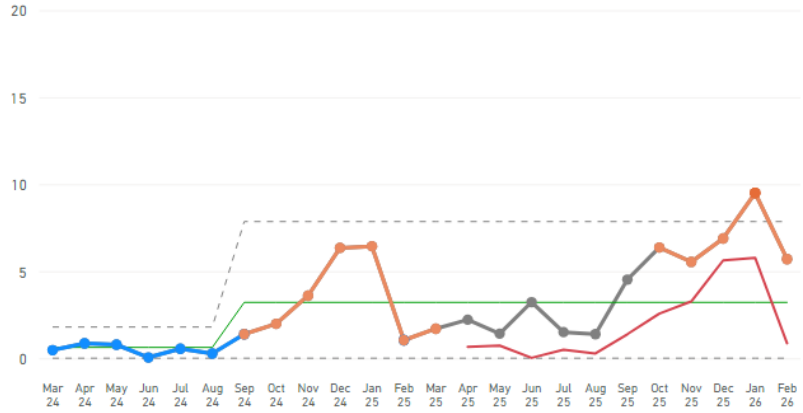
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	5.6%			N/A



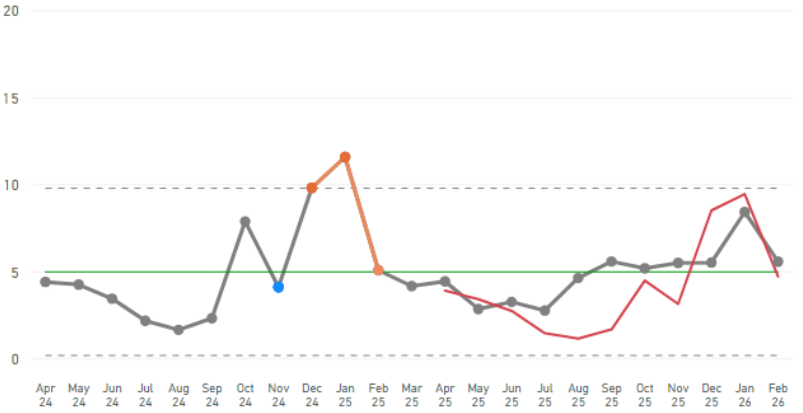
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	5.7%	0.9%		



STHFT

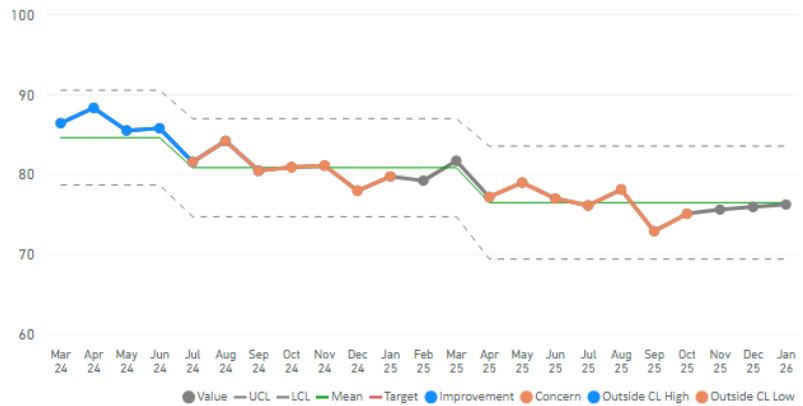
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	5.6%	4.7%		



RESPONSIVE Community UCR 2hr Response Rate (%)

UHT

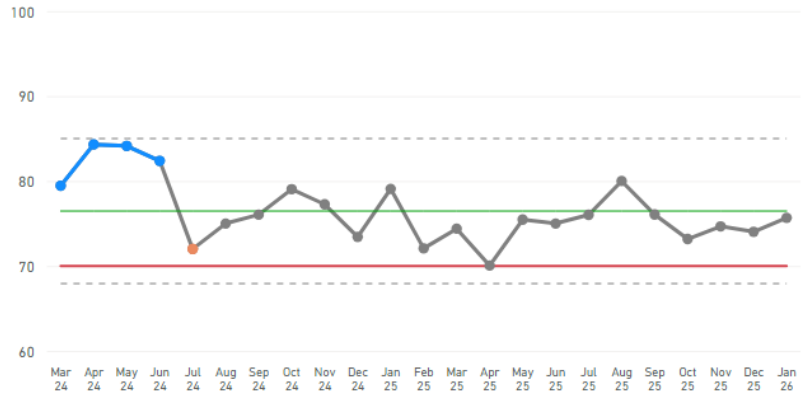
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jan 26	76%			N/A



Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, available one month in arrears. A review of UCR reporting across NENC is planned to ensure consistency.
Trend: NTHFT: No trend. STHFT: deteriorating performance.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: An integrated UHT care coordination centre pilot during peak winter demand has helped to optimise use of community resources to avoid unnecessary admissions. As a result, UCR activity has increased with performance maintained above the national standard. Clinical prioritisation of responses across UCR and Hospital@Home caseloads continues. A continued focus on clock stops will positively impact. **Executive lead:** Chief Delivery Officer
Accountable to: Resources Committee

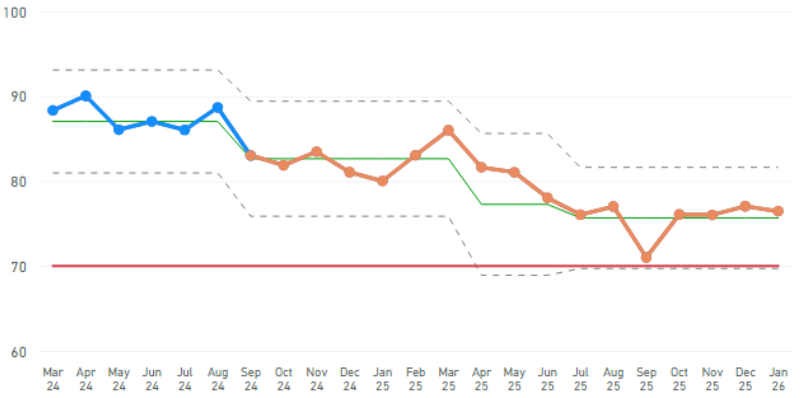
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jan 26	76%	70%		

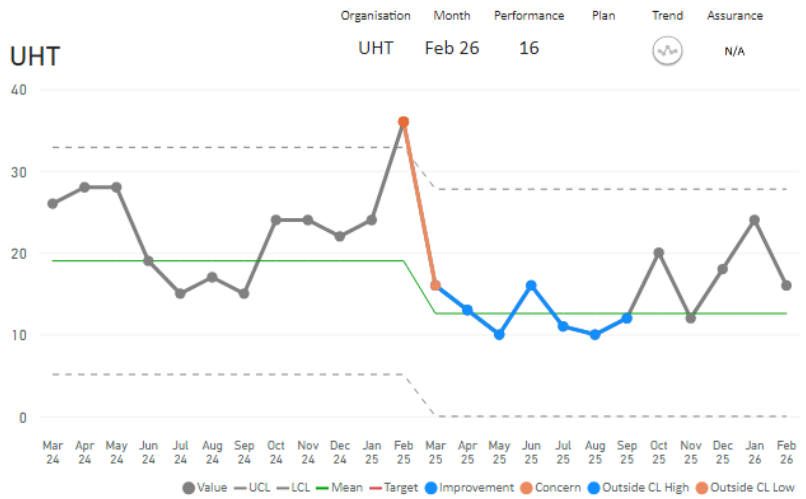


STHFT

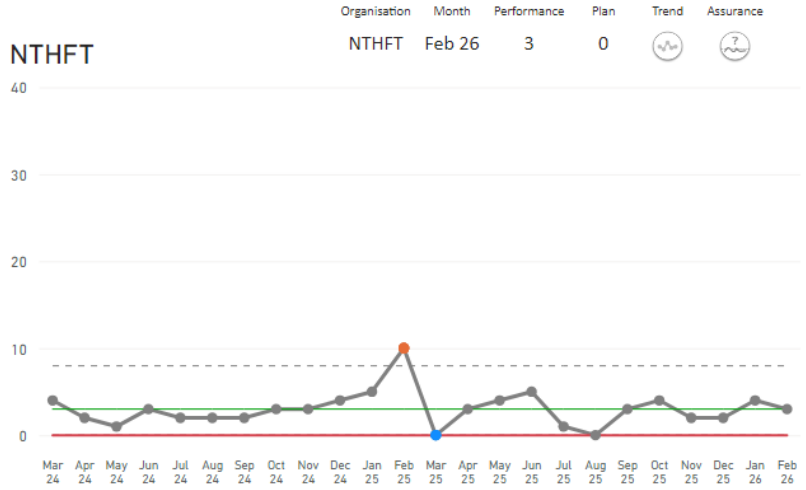
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jan 26	76%	70%		

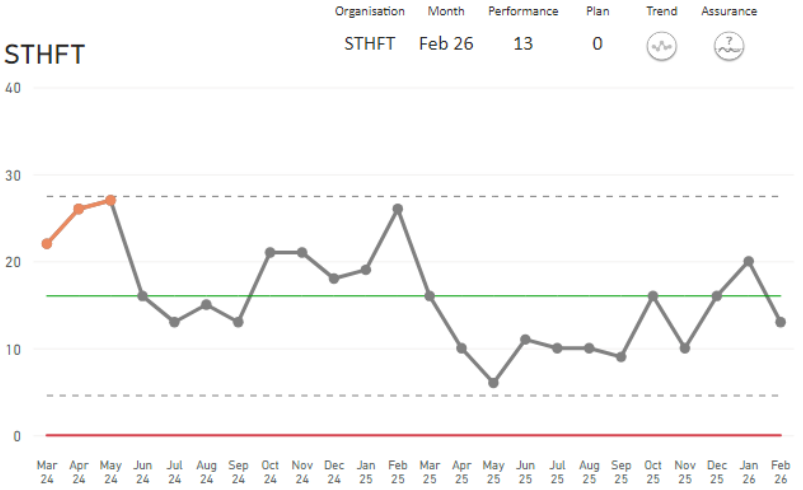


RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days



Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Daily review of all cancellations is in place at NTHFT, and services remain focussed and committed to reappointing patients within the timeframe. At STHFT renewed focus on rebooking is monitored via Clinical Service Units performance and Surgical Improvement Group meetings.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **Accountable to: Resources Committee**

Elective, diagnostic and cancer care

Achievement of key access targets continues to be challenging and logged as strategic risks for both trusts.

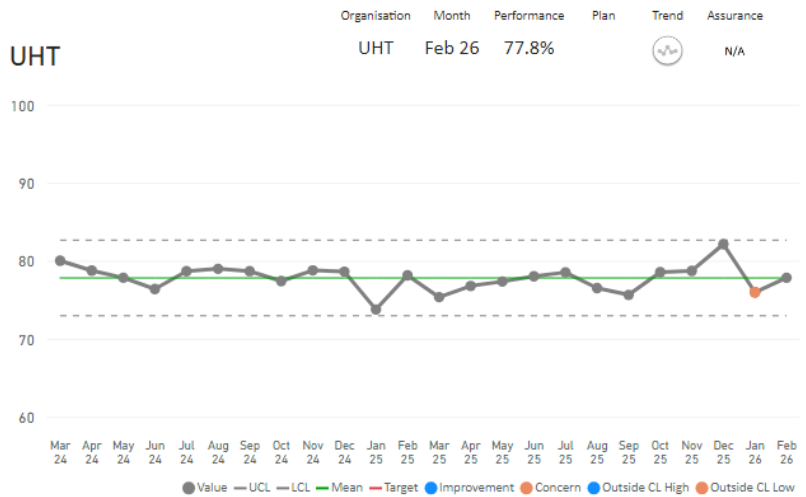
Cancer faster diagnosis standard is not assured for NTHFT or STHFT and is alerted for NTHFT in February 2026, 31-day compliance at STHFT throughout 2025 was lower than in 2023/24, largely driven by increased demand for subsequent radiotherapy treatments. STHFT compliance with 62-day standard continues to track ahead of plan, demonstrating a significant improvement trend . Tiered support from NHS England continues. 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. The team are working closely with CDDFT and the Cancer Care Alliance to support a collaborative approach to service delivery in the short / medium term and longer-term models of delivery across the system. Specific interventions are being put in place to reduce pathway delays across respiratory and urology services, as the next two pathways with lower performance against the standard. Tumour specific pathway improvements are driven by the clinically-led Cancer Delivery Groups with oversight from the Performance Recovery Oversight Group.

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 performing close to the NHS operational standard for 52-week waits each month. For STHFT, 52-week waits is demonstrating the start of an improvement trend although still exceeds the planned trajectory. STHFT entered tiered support arrangements with NHS England in November 2025 with the aim of eliminating 65 week waits.

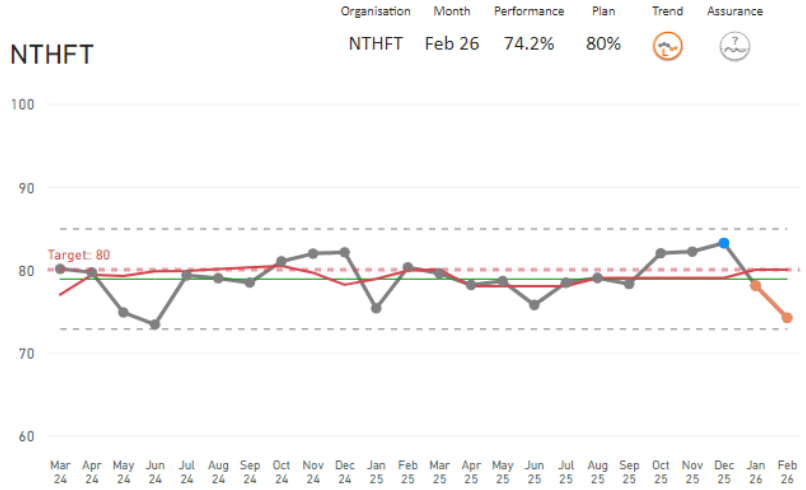
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Cancer Faster Diagnosis Standard (%)	80%	79.5%	78.2%	78.6%	75.7%	78.4%	79%	78.3%	82%	82.2%	83.2%	78.1%	74.2%
Cancer 31 Day Standard (%)	96.2%	93.8%	97.2%	94.8%	97.1%	92.5%	88.8%	92.4%	94.2%	93.3%	97.2%	92.7%	96.6%
Cancer 62 Day Standard (%)	74.1%	67%	64.3%	58%	56.7%	52.3%	51.7%	56.7%	61%	63%	62.1%	54.8%	52.9%
Diagnostic 6 Weeks Standard (%)	95%	96.7%	95.1%	96.3%	95.8%	96.6%	94.5%	96.1%	94.9%	95.5%	95%	95.5%	98.3%
RTT Incomplete Pathways (%)	76%	75.5%	74.5%	74.5%	73.9%	74.2%	72.7%	73.3%	73.8%	72.8%	71.3%	70.7%	70.1%
RTT 52 Week Waiters Rate	0.9%	0.8%	1%	1%	1.2%	0.9%	0.8%	0.7%	0.9%	0.8%	1%	1.1%	1.1%
Community Over 52 Week Waiters Rate	7.1%	0.1%	0.6%	1.5%	2.9%	3%	3.4%	3.2%	1.5%	3.1%	2.9%	1.7%	0.7%
RTT Time to First Appointment (%)	83.1%	82.2%	81.7%	82.3%	81.1%	81%	79.9%	79.5%	80.5%	80.7%	78.6%	78.8%	78.3%

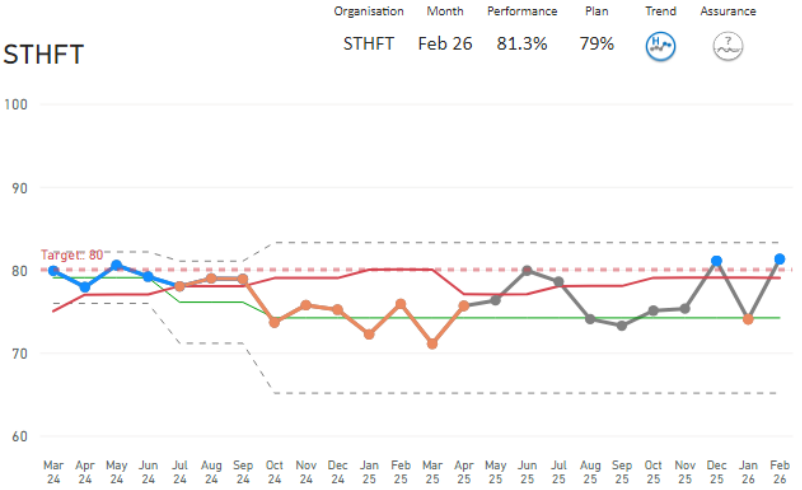
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Cancer Faster Diagnosis Standard (%)	79%	71.1%	75.6%	76.3%	79.9%	78.6%	74%	73.2%	75.1%	75.3%	81.1%	74%	81.3%
Cancer 31 Day Standard (%)	93%	82.6%	86.6%	82.8%	87.1%	86.1%	81.7%	83.9%	83.3%	82.5%	80.7%	77.1%	84.4%
Cancer 62 Day Standard (%)	67.3%	61.2%	63.8%	64.4%	62.3%	68.7%	66.8%	65.2%	65.7%	70.6%	69.4%	68.5%	71.5%
Diagnostic 6 Weeks Standard (%)	95%	87.4%	85%	83%	84.5%	86.9%	82.2%	85.4%	86.6%	85.7%	84.1%	85.7%	88%
RTT Incomplete Pathways (%)	64.3%	60.3%	61.1%	62.1%	62.1%	61.9%	61.1%	61.7%	62.1%	61.8%	61.9%	62.1%	63.1%
RTT 52 Week Waiters Rate	1.1%	2.7%	2.8%	2.8%	2.8%	2.7%	2.9%	2.7%	2.4%	2.2%	1.9%	1.8%	1.6%
Community Over 52 Week Waiters Rate	7.1%	1.7%	1.6%	2.3%	2.2%	2%	1.9%	1.9%	1.8%	2%	2.2%	2%	1.1%
RTT Time to First Appointment (%)	69.8%	64.7%	66.2%	66.2%	65.4%	64.3%	64%	63.8%	64.7%	64.7%	63.8%	64.8%	65.5%

RESPONSIVE Cancer Faster Diagnosis Standard (%)

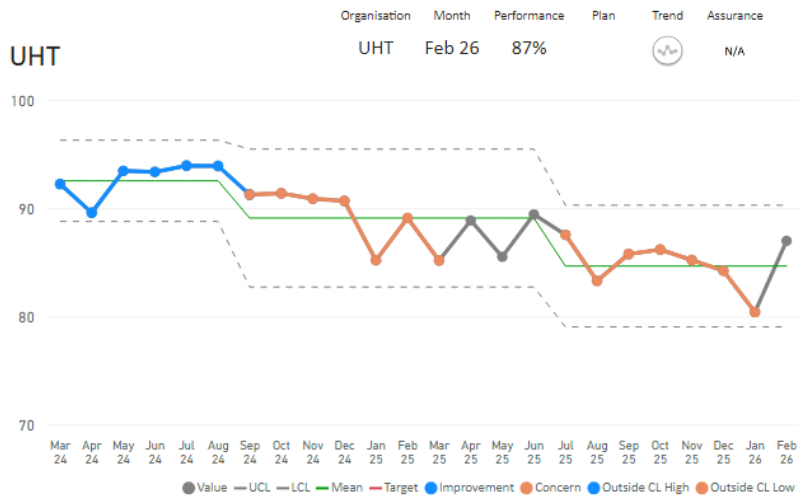


Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 80% (from April 2025). Agreed operational planning trajectories: NTHFT 81%, STHFT 80% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Low outlier in February 2026 . STHFT: Performing above plan in December and February 2026.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT focus on compliance in urology and respiratory pathways, STHFT focus on compliance in urology and gastro-intestinal tumour groups. Performance has been improved by changes in the prostate diagnostic pathway and triage protocols in gastro-intestinal pathways.
Executive lead: **Chief Delivery Officer**
Accountable to: Resources Committee

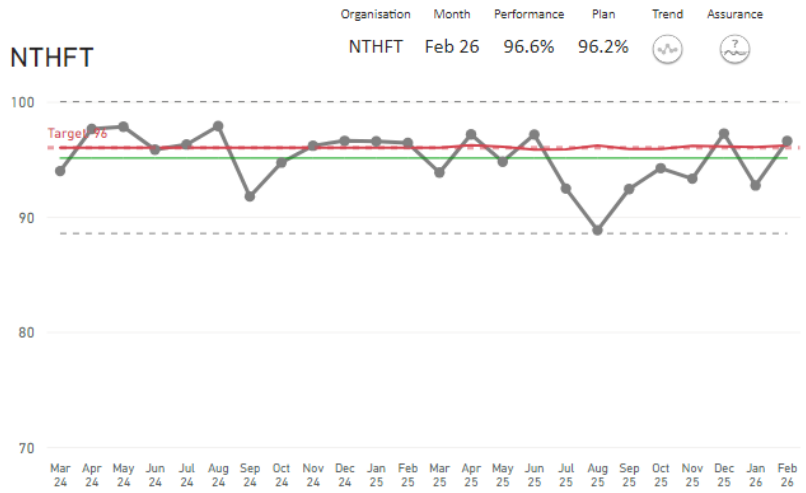


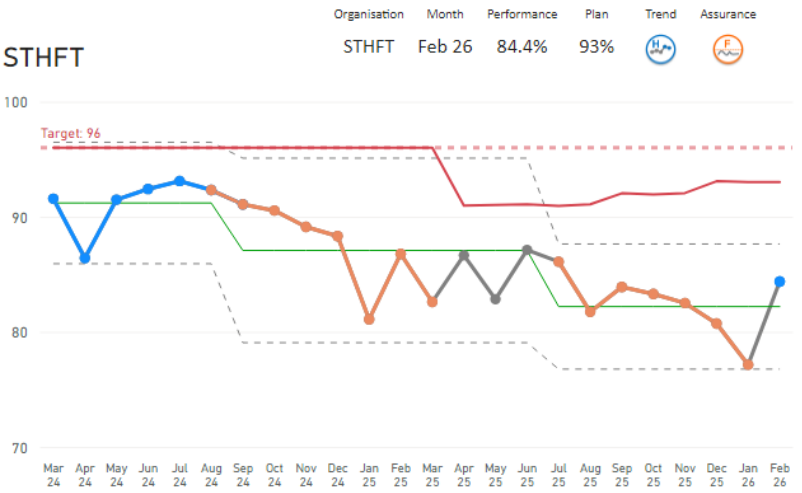


RESPONSIVE Cancer 31 Day Standard (%)



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 96.5% NTHFT, 93.1% STHFT by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Outlier in February 2026, after a 7-month deterioration, plan no longer statistically in range of performance
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: For both NTHFT and STHFT breast pathway demand is challenging to compliance. STHFT focus is the patients waiting longest for treatment and managing constraints of radiotherapy capacity, with a department business case progressing.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





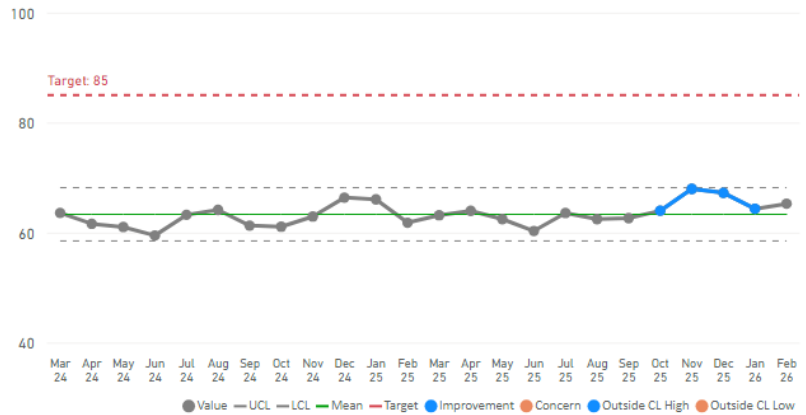
Caring Better Together

RESPONSIVE **Cancer 62 Day Standard (%)**

Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Agreed operational planning trajectories: NTHFT 75%, STHFT 68.3% by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend, deterioration compared to 24/25. STHFT: No trend, improved performance embedded.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT breast pathway demand is challenging to compliance. On going collaboration with CDDFT to support service delivery is taking place. Both Trusts are in NHSE tiered support for cancer 62-day performance with recovery plans including focus on urology, respiratory and gynaecological pathways. Pathway changes implemented at STHFT are noted to have improved performance.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

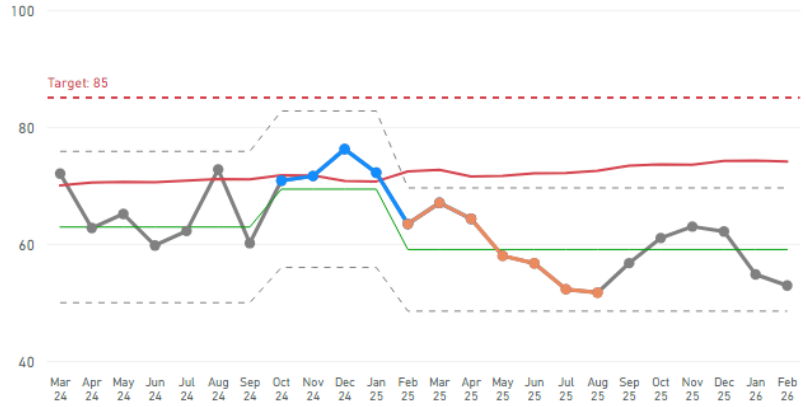
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	65.2%			N/A



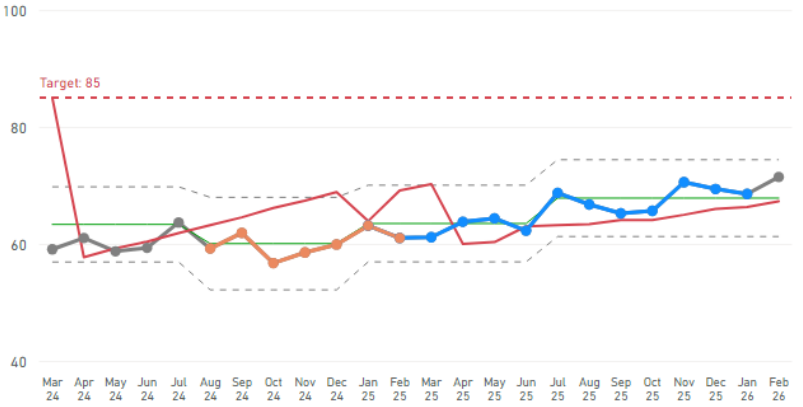
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	52.9%	74.1%		

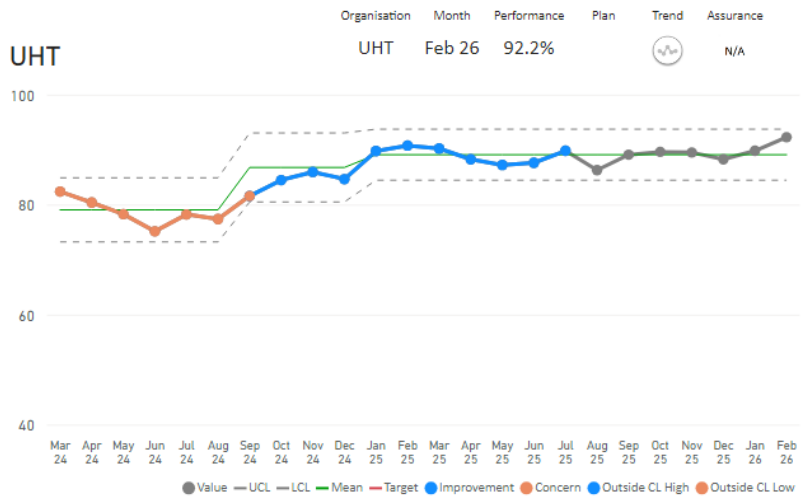


STHFT

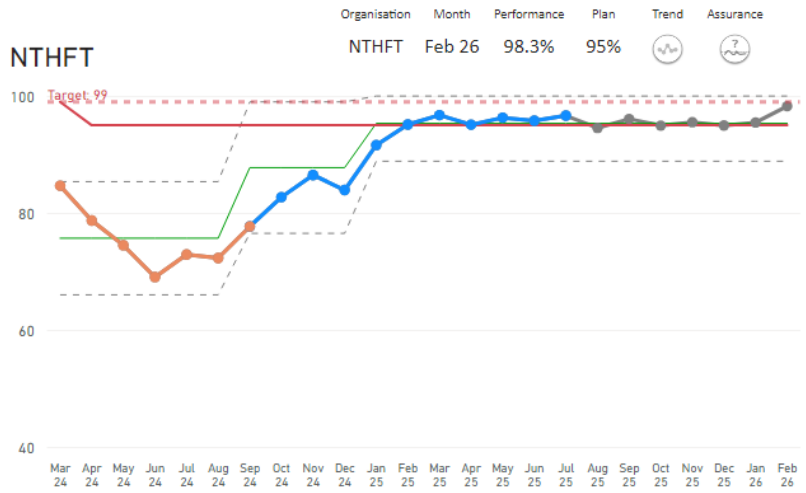
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	71.5%	67.3%		

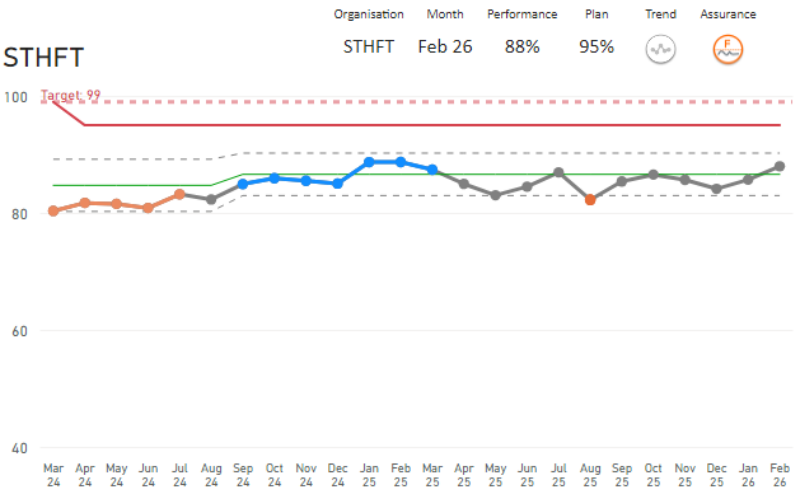


RESPONSIVE Diagnostic 6 Weeks Standard (%)

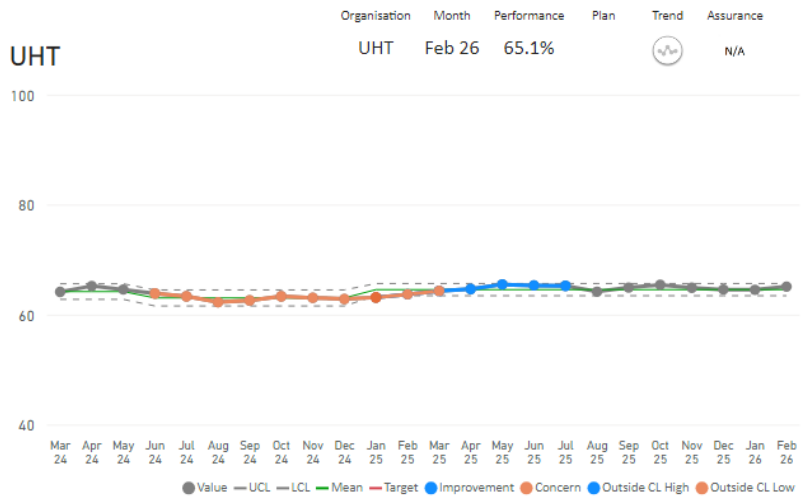


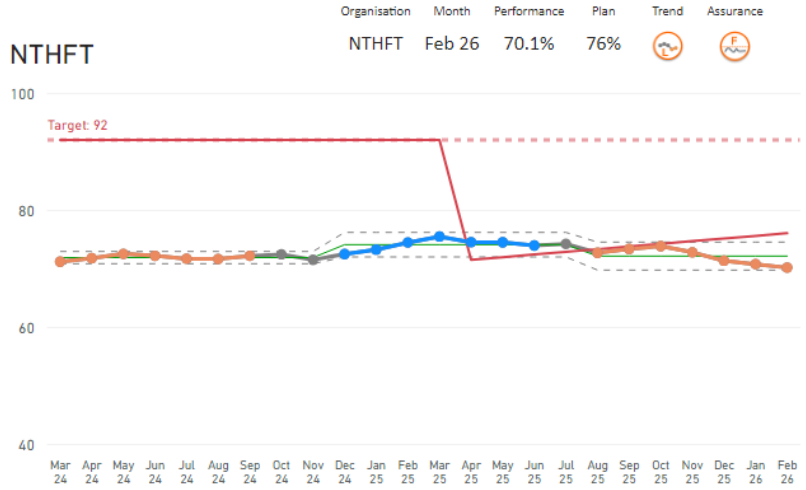
Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Improvement work underway in STHFT specialist services will show only incremental improvement over several months. Previous deterioration in echocardiography due to staffing capacity has been addressed. Performance is improving but will take several months to recover.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

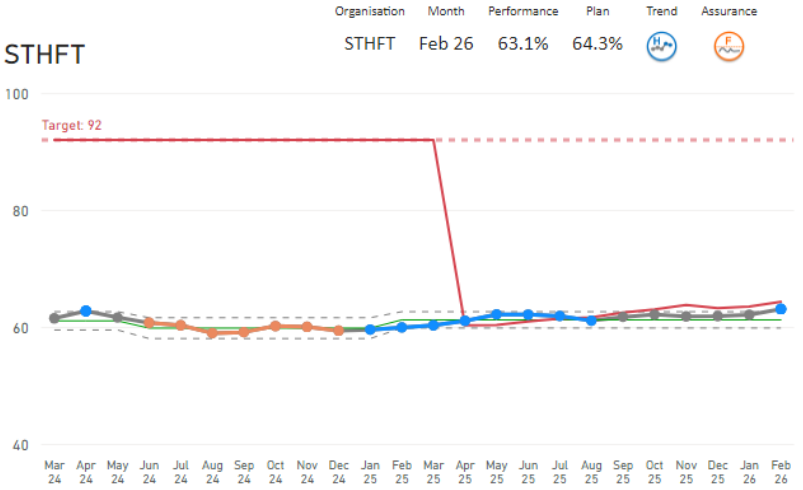




RESPONSIVE RTT Incomplete Pathways (%)

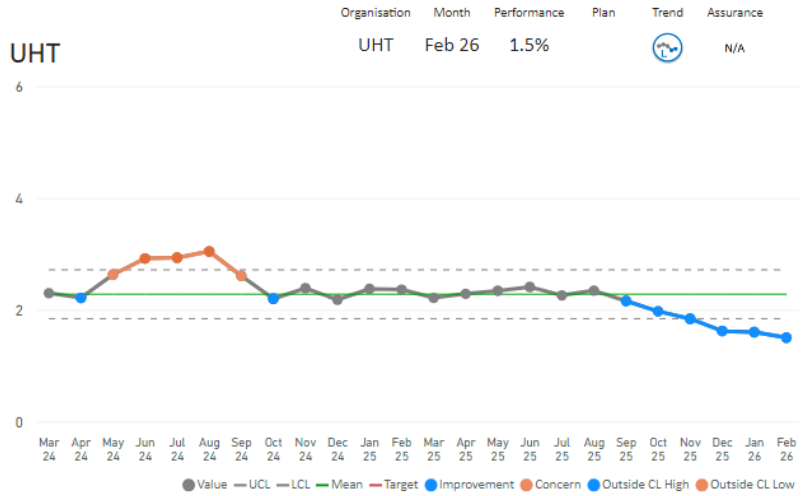


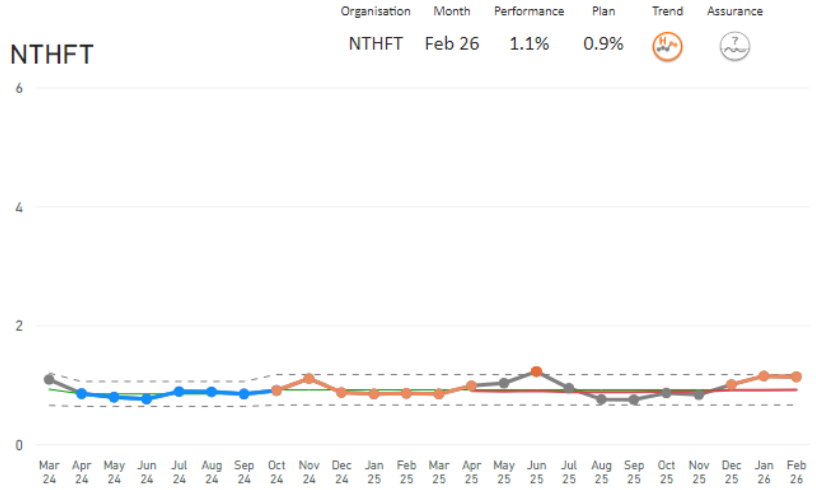


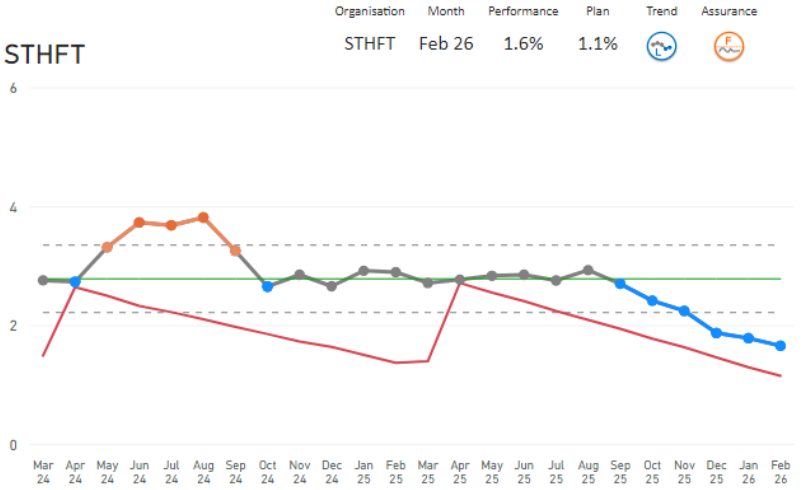


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%. Agreed operational planning trajectories: NTHFT 76.5%, STHFT 65.0% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Deteriorating performance for 5 months, now close to lower limit of expected variance. STHFT: performing above expected variance in February 2026.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks which will support compliance improvements. There is a wider strategic focus in reducing long waits through proactive mutual support. Services have undertaken extra activity as part of the NHSE Q4 Elective Sprint to further recover the RTT position.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE RTT 52 Week Waiters Rate







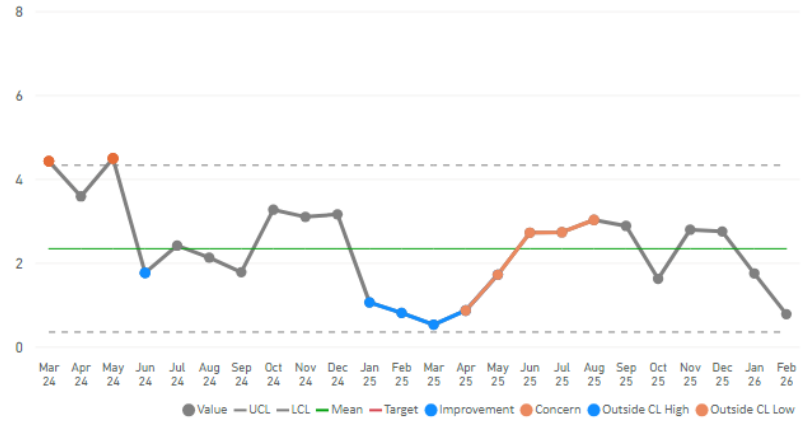
Metric: Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To reduce the number of 52-week waiters to less than 1% of the waiting list by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: January and February 2026 close to upper limit of expected variance. STHFT: Improving trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Both Trusts are focused on return to plan. STHFT has been working towards eliminating 65-week waits through refreshed recovery plans which also reduces 52-week waits. Chronic Pain and Urology services at STHFT and NTHFT continue working together to treat the longest waiters.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE Community Over 52 Week Waiters Rate

Metric: Rate of community patients awaiting treatment who have waited more than 52 weeks from referral.
Plan: No published standard, local plan to perform significantly better than national mean rate March 2025.
Rationale: NHS Oversight Framework metric.
Data quality: Advisory, variation in reported position. further validation may be required.
Trend: NTHFT: No trend. STHFT: Improvement trend, performance better than expected variance in February 2026.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Focused validation of reported position and bringing forward longest waiters. Capacity for paediatric therapy interventions, and specialist weight management, is being addressed.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

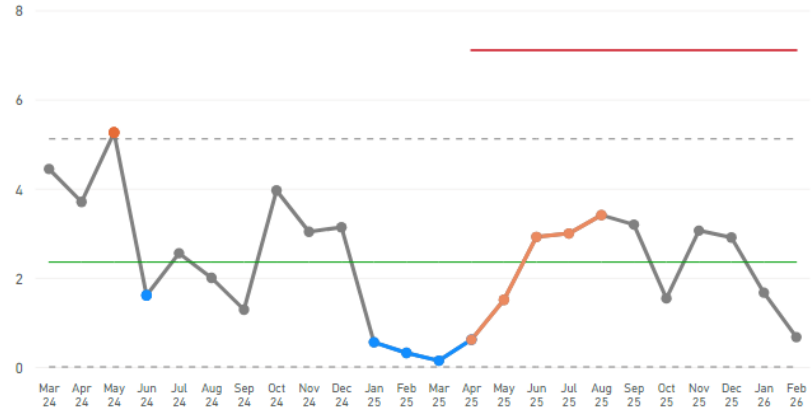
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	0.8%			N/A



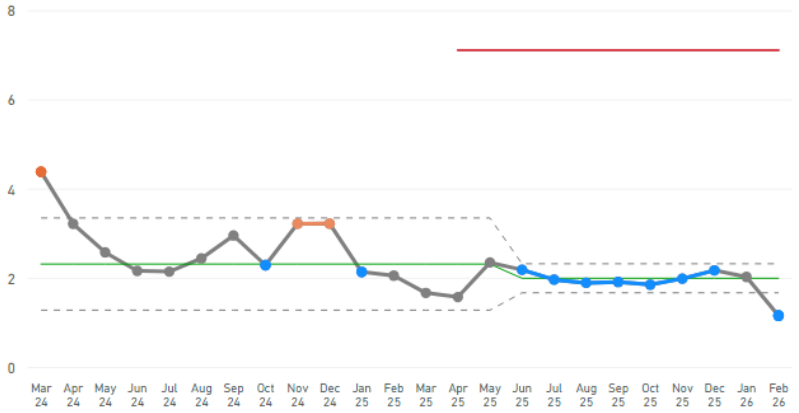
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	0.7%	7.1%		

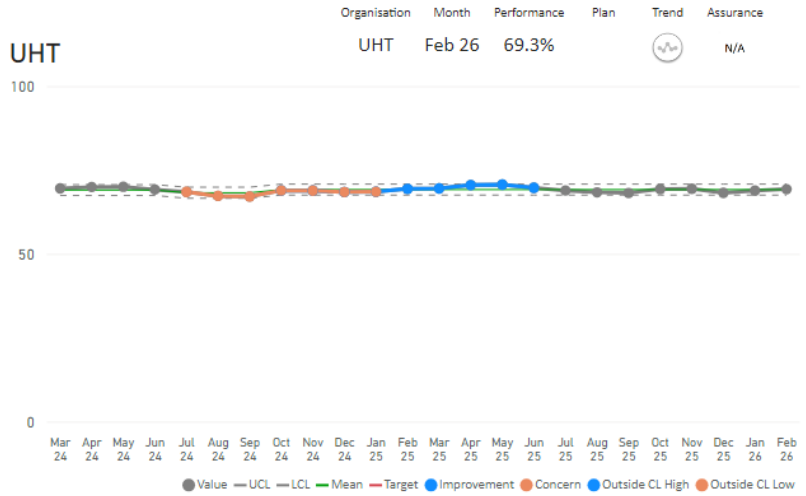


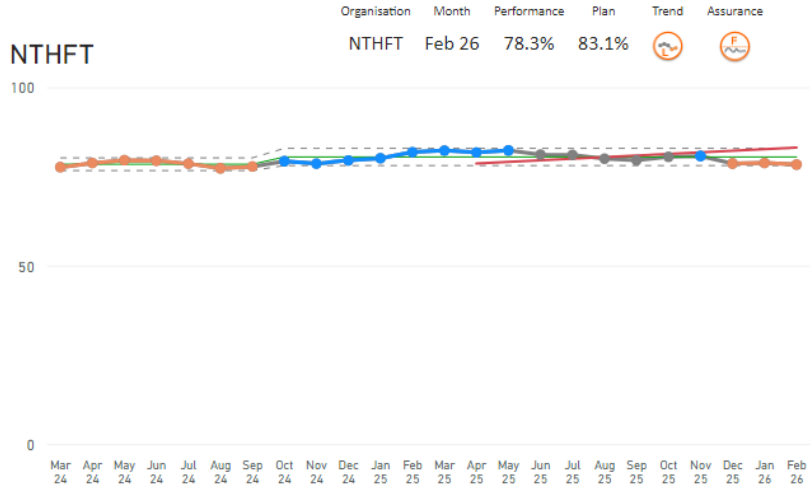
STHFT

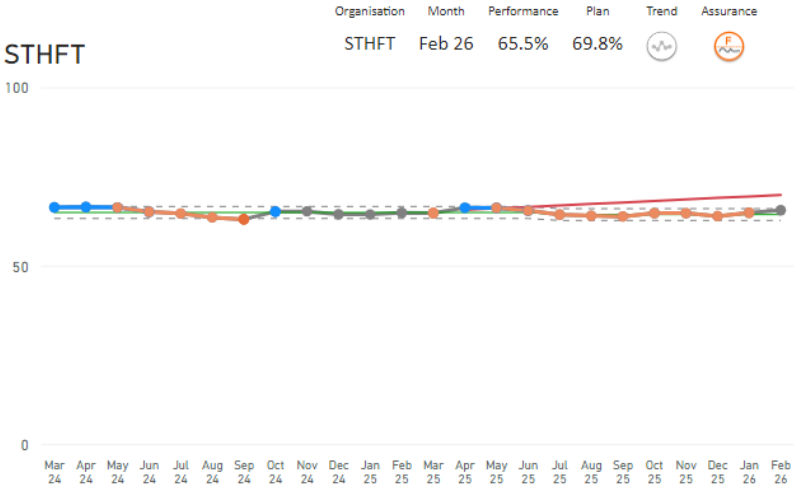
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	1.1%	7.1%		



RESPONSIVE RTT Time to First Appointment (%)







Metric: RTT Referral to First Appointment within 18 weeks.
Plan: Agreed operational planning trajectories: NTHFT 83.57%, STHFT 72.3% by end March 2026.
Rationale: 25/26 NHSE planning guidance priority.
Data quality: assured, validated data.
Trend: NTHFT: December 2025 to February 2026 close to the limit of expected variance. STHFT: No trend
Assurance: NTHFT: Alert. STHFT: Alert, performance not keeping pace with planned trajectory.
Action taken: Outpatient clinic template reviews and resulting clinic template changes being undertaken across UHT to increase capacity. Revisit *Getting it Right First Time* guidance and benchmarking to identify further improvement priorities. At STHFT, majority of waits for 52 and 65 weeks are for outpatients so ongoing recovery plans are expected to also improve time to first appointment.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

CARING DOMAIN SUMMARY

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

Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall very good or good. NTHFT were above plan in four out of the five surveys, inpatient fell below the national average. STHFT were above plan in four of the five surveys, maternity fell below the national average. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care, supported by digital data collection. STHFT are using Healthcare Guardian (HG) for all surveys. NTHFT will transition from an external service provider (Formfinity) to HG.

Consistency in timely responses to complaints remains a key priority. Patient experience teams support and escalate to the clinical and operational teams, those complaints that require their focus on resolving in a timely manner, prioritising the longest in progress. Complaints acknowledged in 3 days remains high at 95-100% across UHT.

North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
A&E Experience (%)	79%	84.2%	88.2%	87.2%	84.8%	84.9%	85.8%	82.3%	82.3%	79.7%	83%	85.1%	85.2%
Inpatient Experience (%)	95%	91.5%	95%	93.5%	95.4%	92.7%	93.4%	96.1%	95.8%	94.3%	94.4%	96.9%	92.1%
Maternity Experience (%)	92%	100%	93.3%	94.1%	84.8%	94.3%	96.2%	95%	93.8%	94.8%	95.3%	97.8%	96.8%
Outpatient Experience (%)	94%	93.1%	99.4%	95.5%	94.1%	94.2%	94.4%	94.1%	94.9%	94.7%	95.7%	94.9%	94.7%
Community Experience (%)	94%	97%	100%	97.7%	96%	94.5%	96%	93.4%	96.8%	96.3%	95.6%	96.1%	96.1%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	67%	71%	78.5%	65.9%	62%	73.6%	76.8%	73.5%	80.5%	69%	70.4%	69.2%

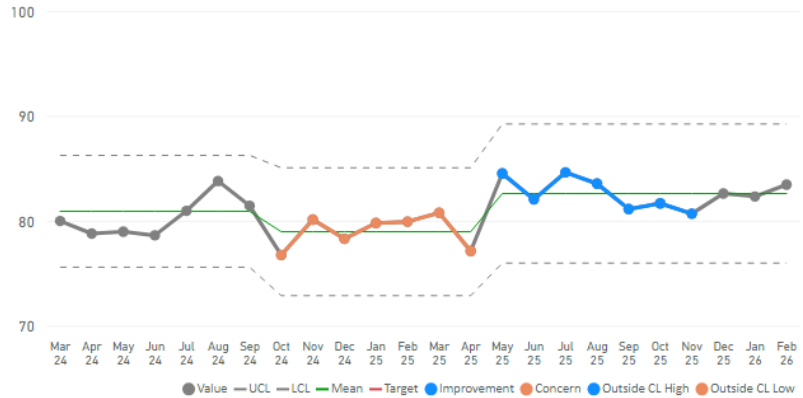
South Tees Hospitals NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
A&E Experience (%)	79%	80%	76.9%	84%	80.1%	84.4%	82.3%	80.4%	81.2%	81.4%	82.3%	80.2%	82.2%
Inpatient Experience (%)	95%	98.2%	96.9%	95.1%	97.8%	98.2%	99.3%	99.3%	95.9%	95.6%	95.6%	94.9%	95%
Maternity Experience (%)	92%	93.4%	93.3%	93.8%	93.2%	89%	91.2%	91.3%	96.6%	91.5%	89.9%	87.8%	86.1%
Outpatient Experience (%)	94%	95.9%	95.2%	95.9%	96.3%	95.8%	95.7%	96%	95.3%	96.6%	93.8%	94.5%	94.6%
Community Experience (%)	94%	100%	100%	100%	100%	100%	100%	100%	100%	96.8%	98.2%	97.3%	97.6%
Feedback Acknowledged in 3 Days (%)	100%	94%	96%	98.3%	99.1%	100%	97.1%	100%	98.4%	95.1%	98.5%	97.7%	95%
Complaints Closed Within Target (%)	80%	48.1%	69.9%	62.6%	65.7%	53.3%	54.9%	48.3%	52.4%	32%	48.1%	59.1%	41.8%

CARING A&E Experience (%)

Metric: Percentage of respondents who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems).
Response rates: NTHFT 6%, STHFT 9.3%.
Trend: NTHFT: No trend, performance has stabilised following outlier in November 2025. STHFT: Improved performance since May 2025 now stabilised.
Assurance: NTHFT: Assure, consistently exceeds national average. STHFT: Advise.
Action taken: Waiting times continues to be the main theme noted in the survey comments. Actions in the Winter Plan will help address patient experience.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

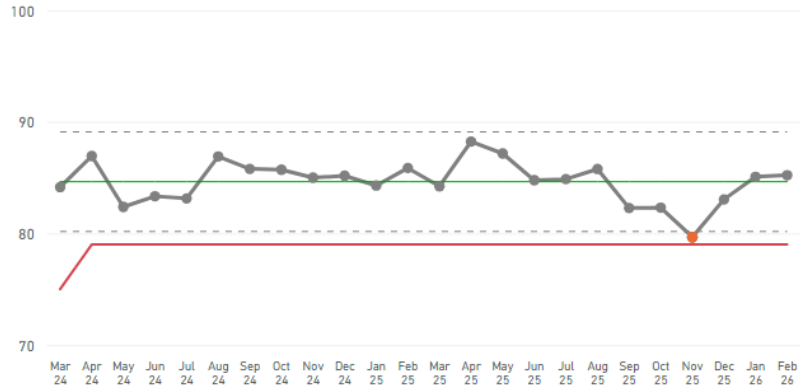
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 26	83.4%			N/A



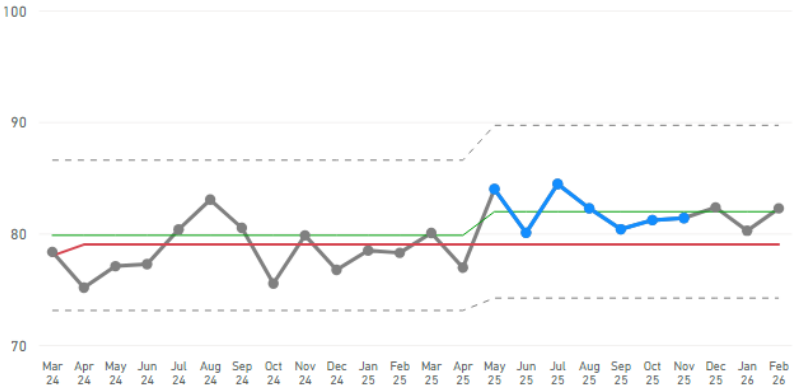
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 26	85.2%	79%		

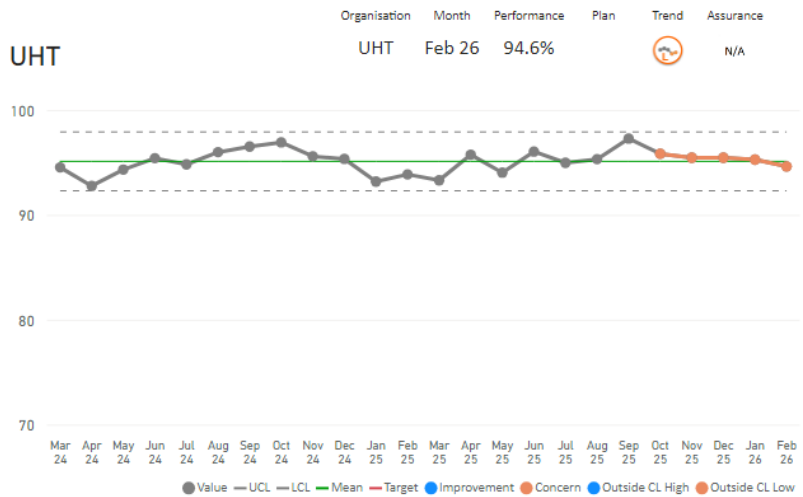


STHFT

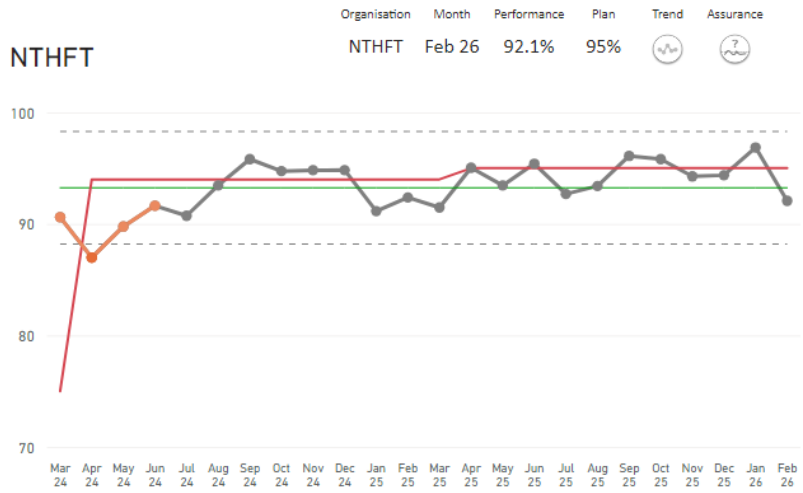
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 26	82.2%	79%		

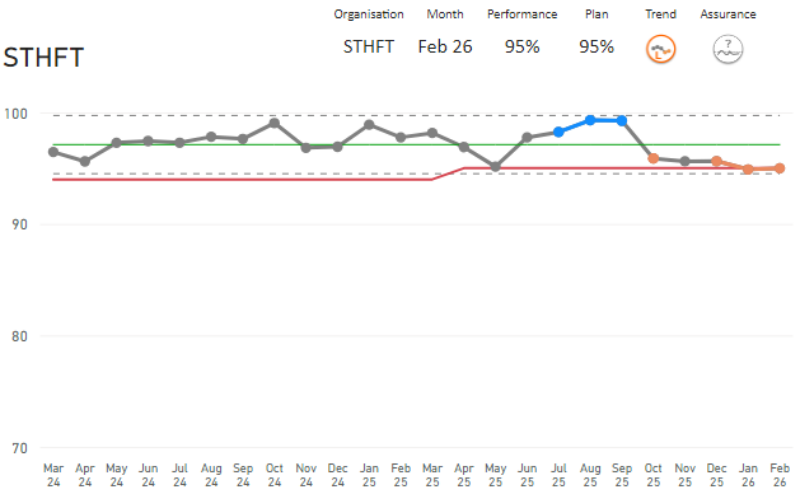


CARING Inpatient Experience (%)



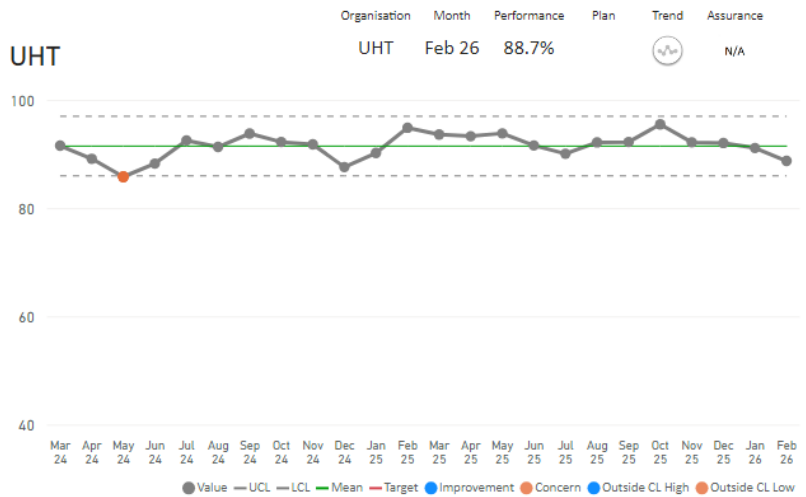
Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 11%, STHFT 29.3%.
Trend: NTHFT: No trend. STHFT: Deteriorating over recent months, close to lower limit of expected variation.
Assurance: NTHFT: Advise. STHFT: Alert
Action taken: STHFT transition to HG is complete, NTHFT transitioning from external service provider to HG. This will standardise patient feedback collection processes and analysis across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



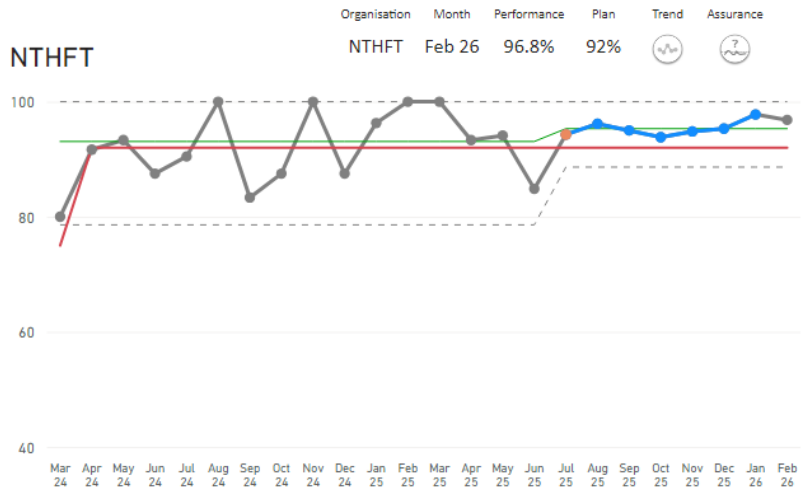


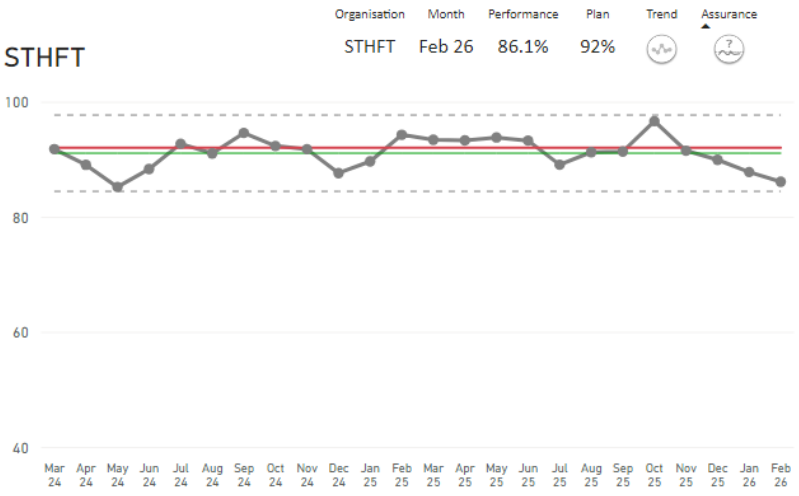
Caring Better Together

CARING Maternity Experience (%)

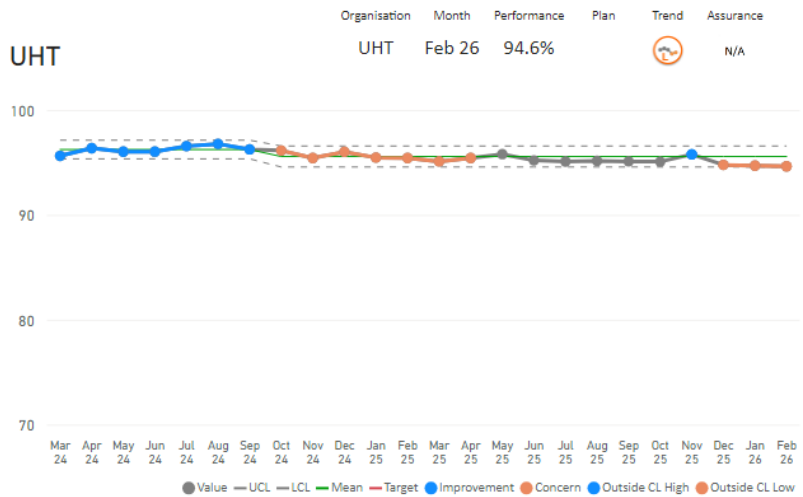


Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, reported figure is Birth only.
Response rates: NTHFT 28%, STHFT 12.7%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Continue to promote engagement with Friends and Family Test. STHFT has transitioned from Meridian to HG. NTHFT: plan to transition to HG.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

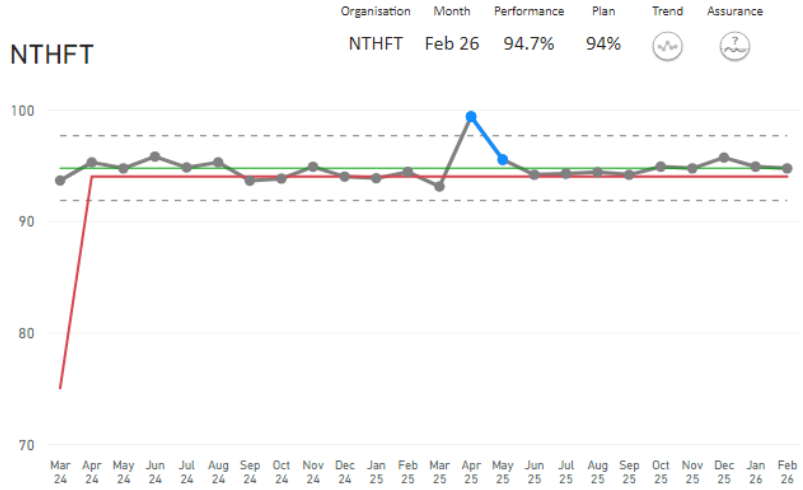


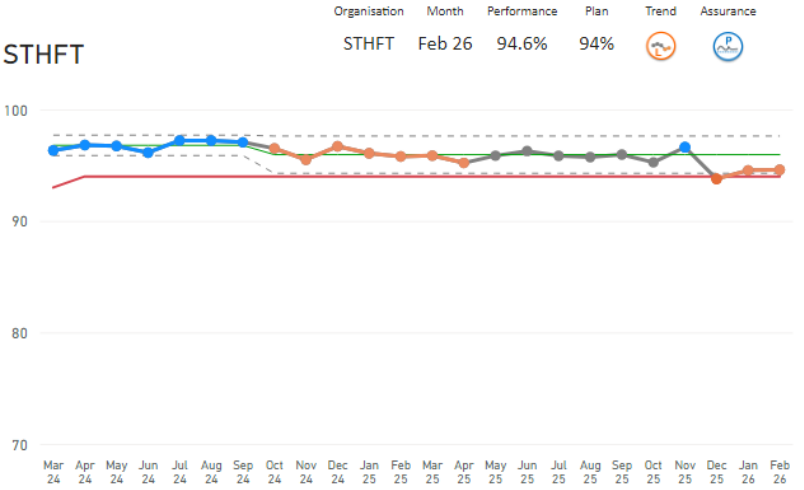


CARING Outpatient Experience (%)

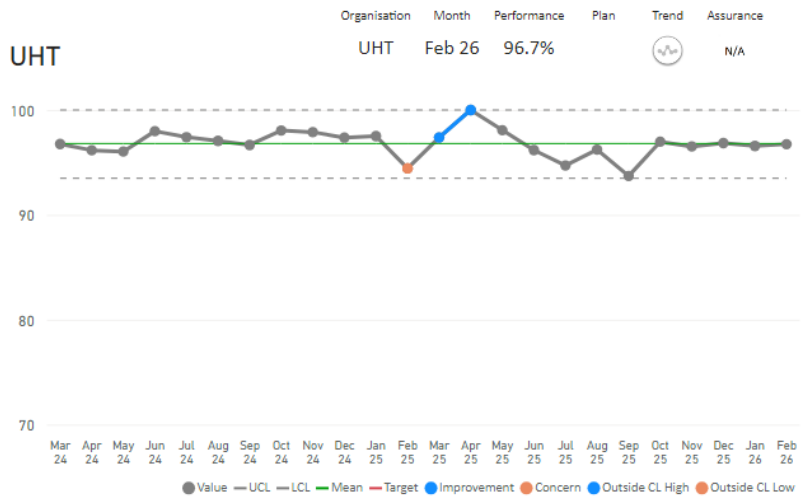


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 24%, STHFT 15%.
Trend: NTHFT: No trend. STHFT: Low outliers from December 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT transitioned to a new digital platform in June 2025 and response rates have improved. STHFT: transitioned from Meridian to HG, patients receive a text message post appointment to seek their feedback.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

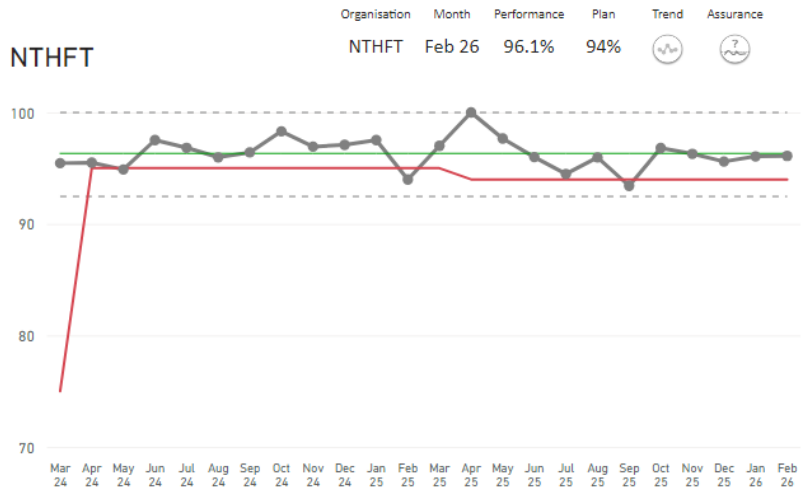


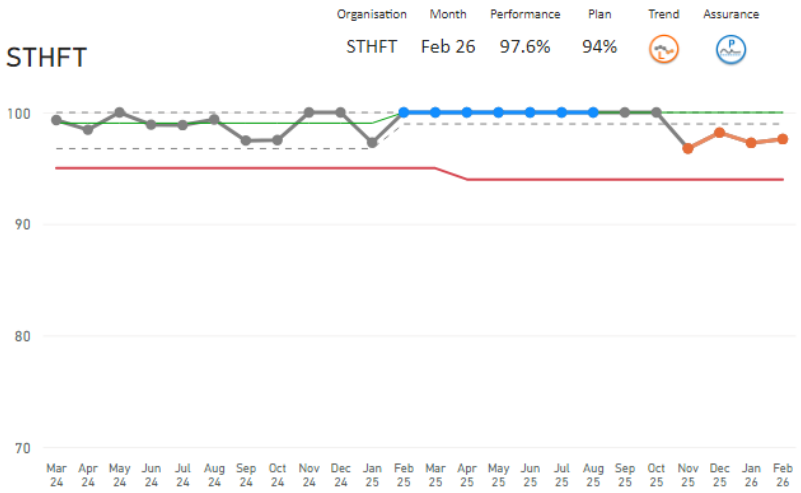


CARING Community Experience (%)



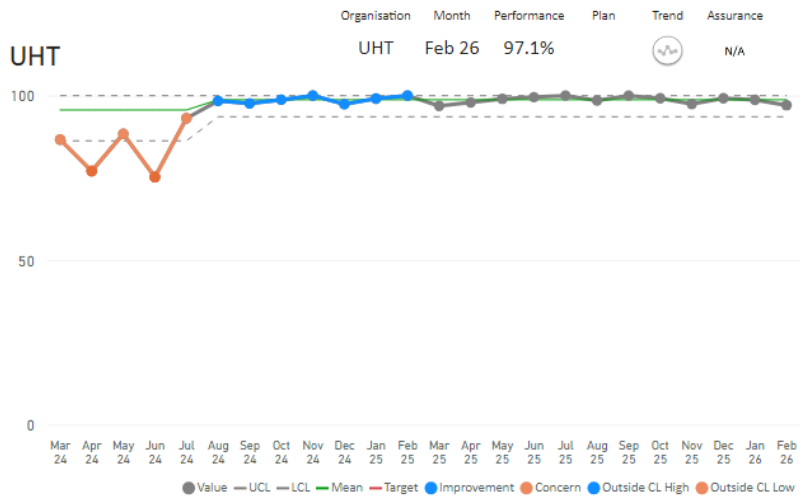
Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 7%, STHFT 5.1%.
Trend: NTHFT: No trend. STHFT: Lower performance from November 2025 but still consistently meets target.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Further work is required at NTHFT and STHFT to improve response rates in community services, a staged transition from Meridian to HG has been completed.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



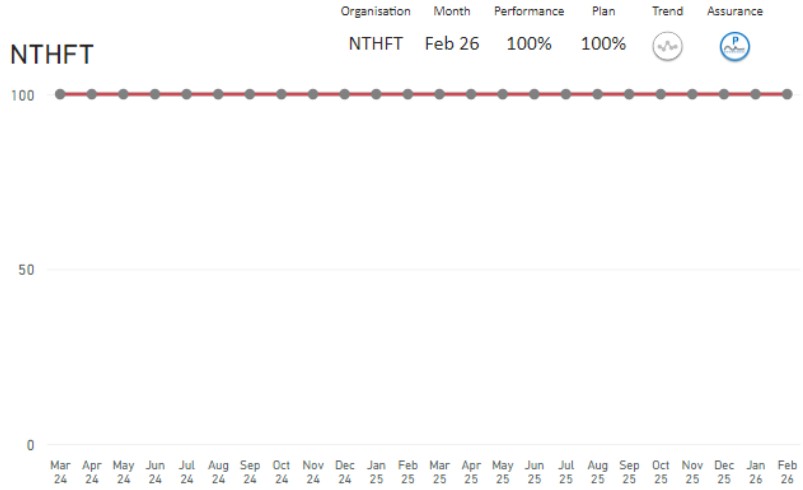


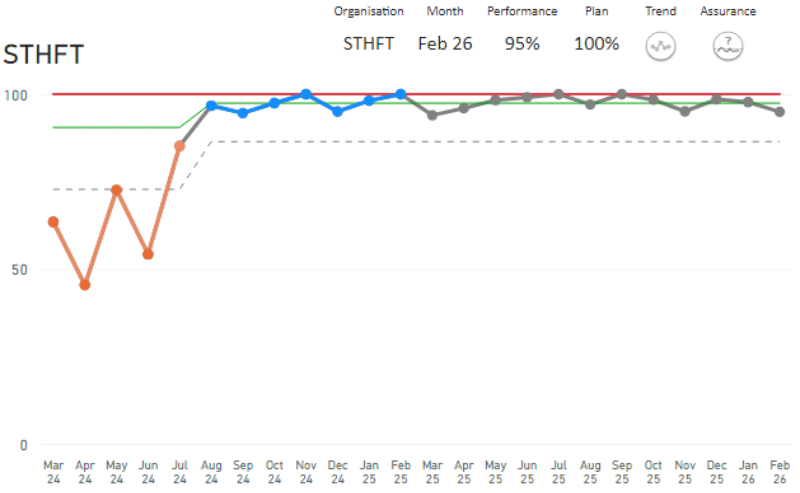
Caring Better Together

CARING Feedback Acknowledged in 3 Days (%)



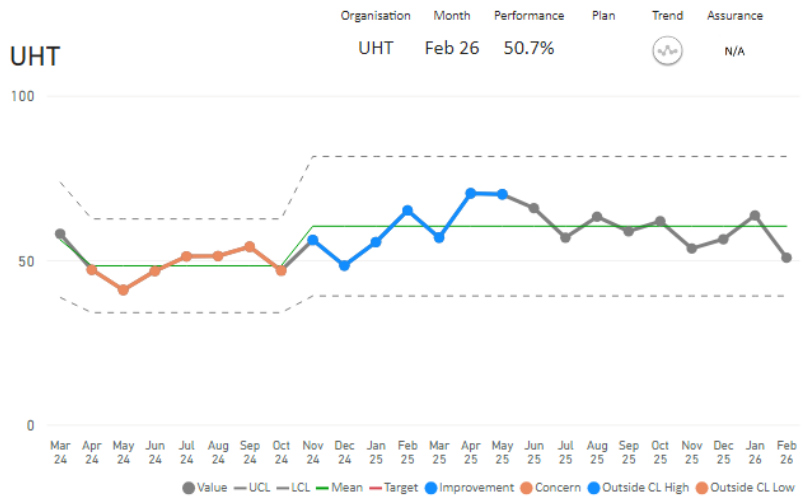
Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: STHFT: mapping process is underway to align NT & ST process to ensure the 3 working day target is met. This is not yet statistically assured due to lower compliance March to August 2024.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

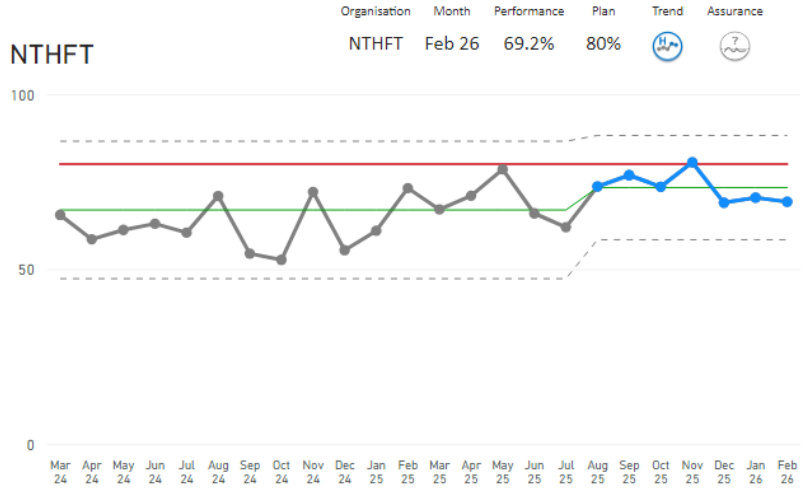


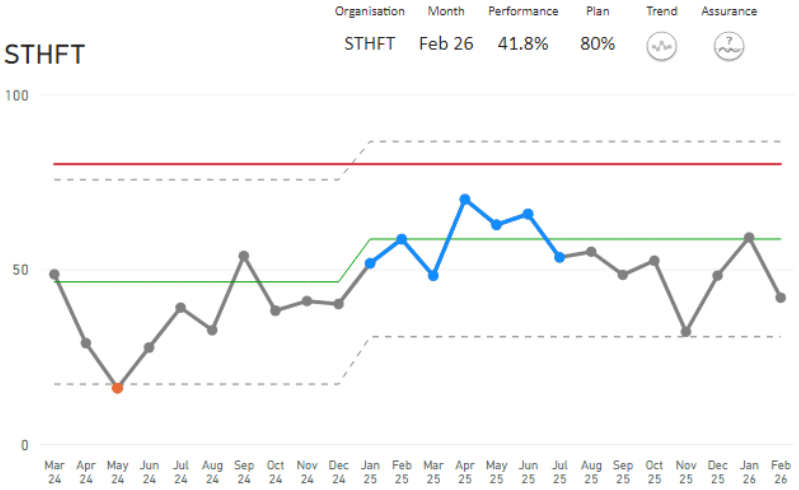


Caring Better Together

CARING Complaints Closed Within Target (%)







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: Improvement trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT: HG reporting functionality to be improved to allow increased performance monitoring within Clinical Service Units (CSUs). STHFT: Additional senior staff support allocated to review off-target complaint responses. 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

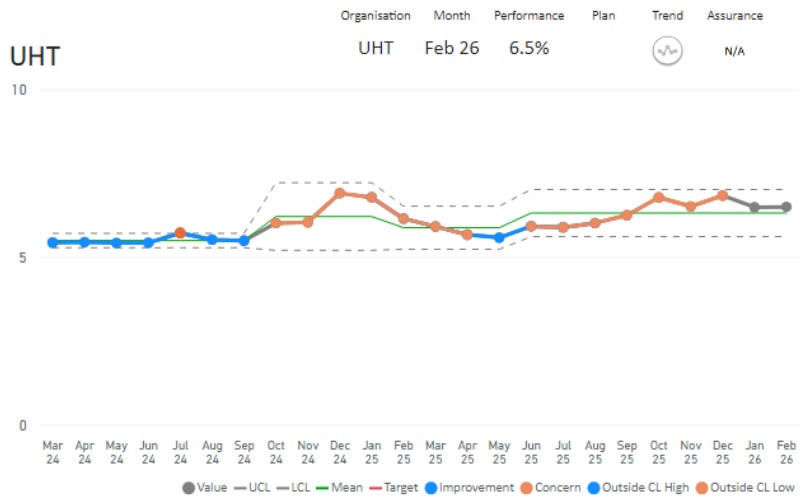
Vacancy freeze is in place and Vacancy Panel terms of reference has been updated and circulated. Voluntary Severance Scheme has concluded with 22 successful applicants, who will exit the organisation by end of April 2026.

At month 11, NTHFT reported a small positive variance to plan and STHFT is on plan.
Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

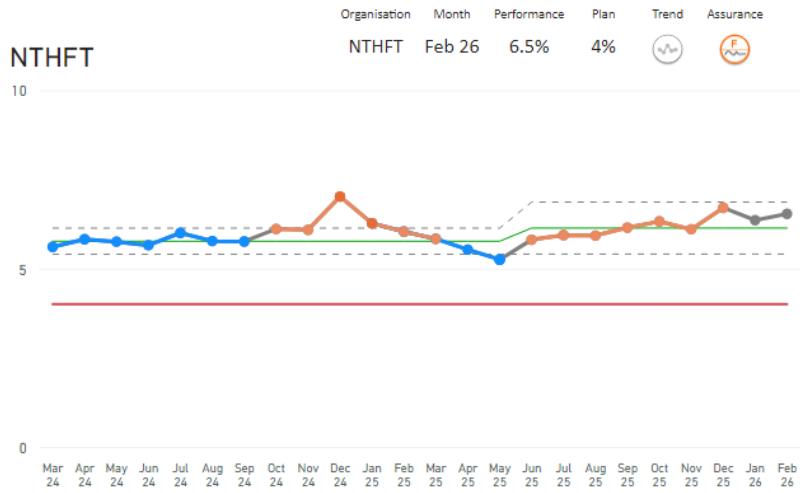
North Tees & Hartlepool NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Sickness Absence (%)	4%	5.8%	5.5%	5.3%	5.8%	5.9%	5.9%	6.1%	6.3%	6.1%	6.7%	6.4%	6.5%
Staff Turnover (%)	10%	7.2%	7.5%	7.6%	7.4%	7.4%	7.6%	7.5%	7.6%	7.7%	7.6%	7.7%	7.7%
Annual Appraisal (%)	85%	85.9%	86.3%	88.5%	88.5%	88.6%	87.9%	88.1%	87.9%	87.5%	86.5%	85.4%	85.6%
Mandatory Training (%)	90%	88.9%	88.7%	88.9%	89.4%	89.8%	90.2%	90%	89.5%	89.1%	89.5%	88.8%	88.5%
Cumulative YTD Financial Position (£'millions)	£0.521	£0.002	£0.117	£0.28	£0.644	£0.416	£0.833	£0.85	£0.693	£0.389	£0.601	£0.176	£0.542

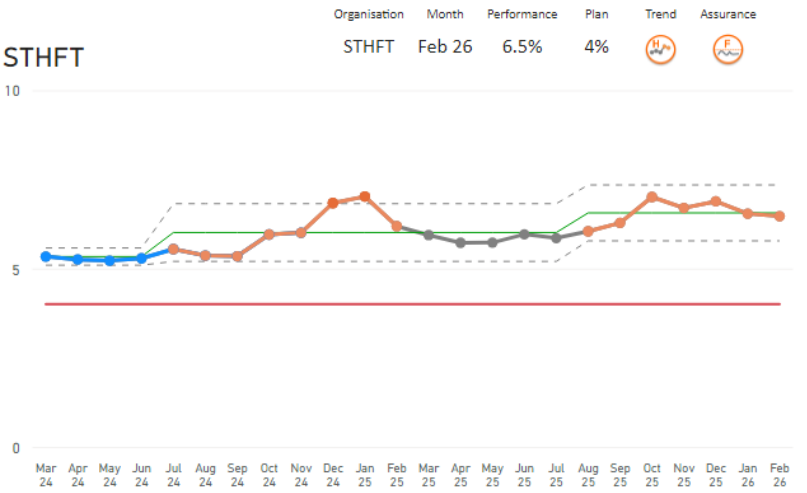
South Tees NHS FT	Plan	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Sickness Absence (%)	4%	5.9%	5.7%	5.7%	6%	5.9%	6%	6.3%	7%	6.7%	6.9%	6.5%	6.5%
Staff Turnover (%)	10%	6.6%	6.7%	6.6%	6.5%	6.5%	6.8%	6.7%	6%	6.8%	6.8%	6.8%	6.8%
Annual Appraisal (%)	85%	82.2%	82%	83.1%	84%	83.1%	83.5%	83.3%	82.9%	81.6%	81.1%	78.2%	74.9%
Mandatory Training (%)	90%	85.6%	85.6%	85.7%	85.7%	86.2%	85.9%	84.7%	84.8%	84.7%	84.6%	83.7%	83.7%
Cumulative YTD Financial Position (£'millions)	-£10.198	-£7.796	-£2.065	-£3.467	-£7.009	-£4.503	-£5.725	-£6.232	-£6.813	-£7.596	-£9.293	-£10.066	-£10.198

WELL LED Sickness Absence (%)

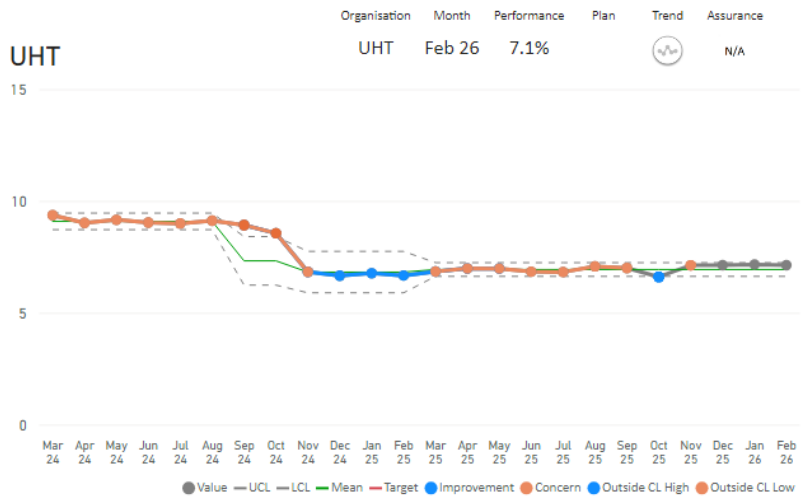


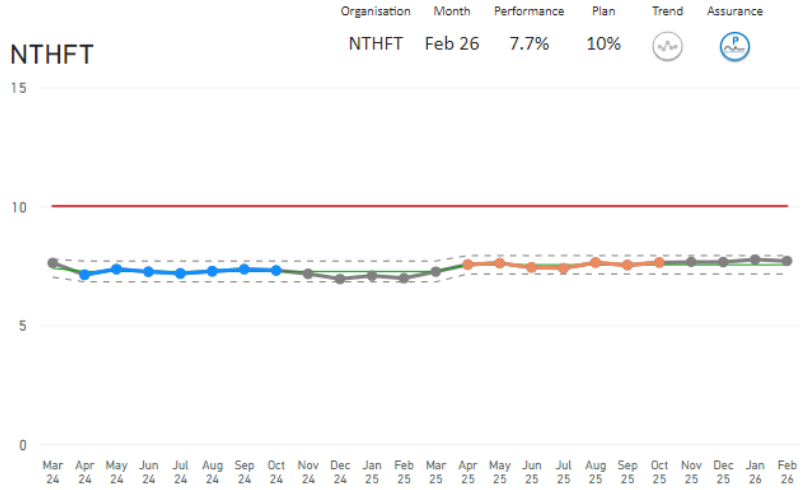
Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Deterioration in last 5 months to February 2026.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: Measures to support managers to reduce absence will be presented at People Group in April 26. A total of 21 final absence hearings have taken place over the last 2 months.
Executive lead: Chief People Officer
Accountable to: People Committee

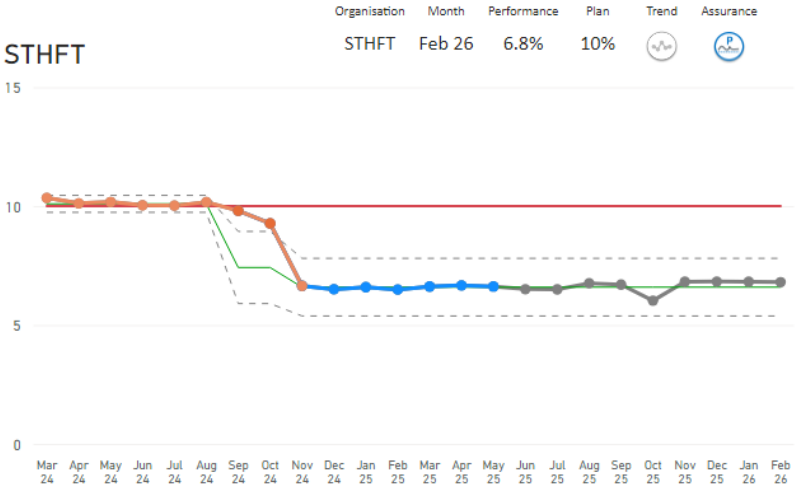




WELL LED Staff Turnover (%)

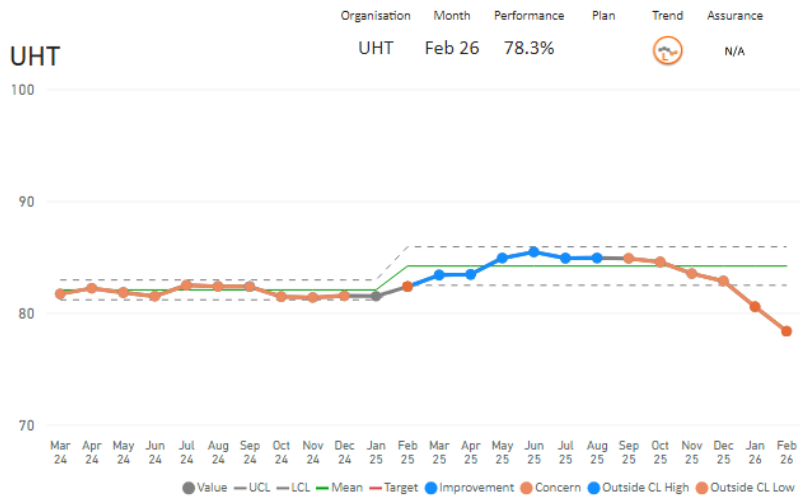




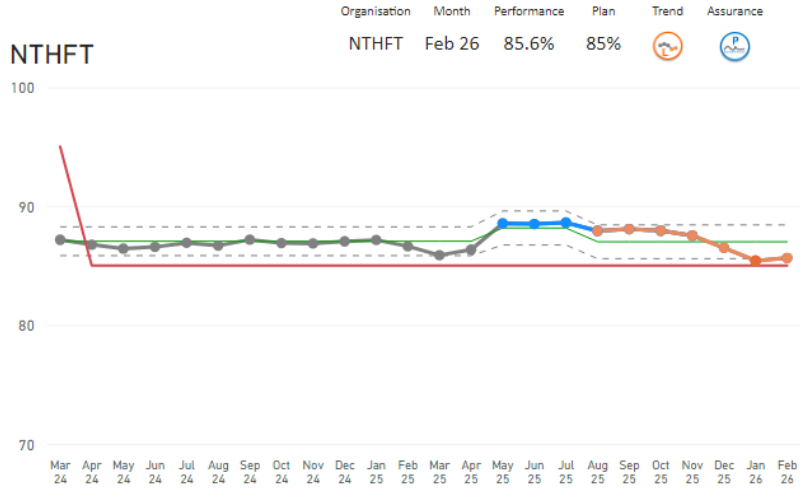


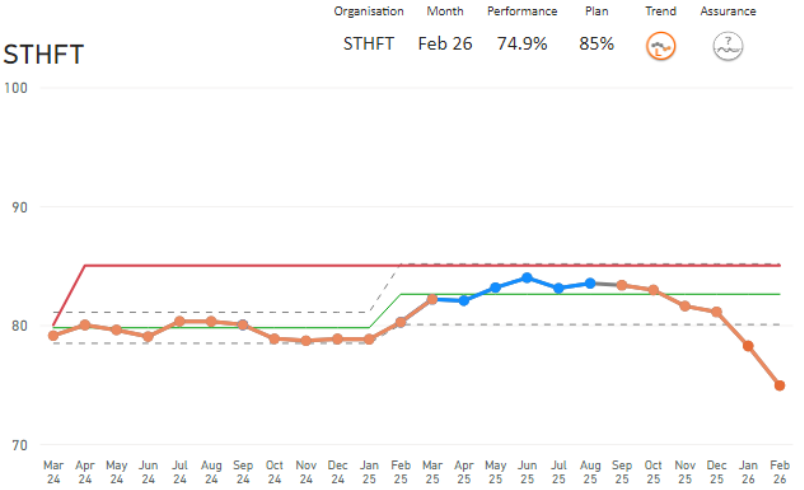
Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: NTHFT: No Trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Turnover remains stable across UHT. A detailed analysis of turnover was completed in March 2026 with HCA identified as an area for further analysis.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Annual Appraisal (%)

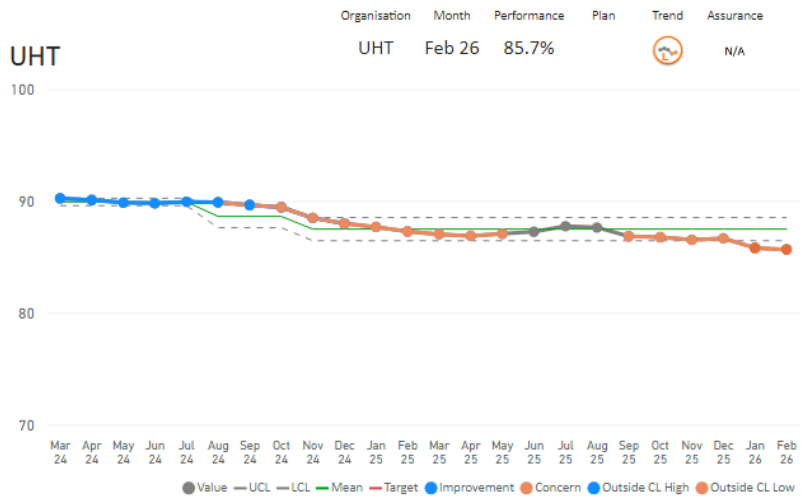


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: December to February compliance flags as low outliers. STHFT: Deteriorating trend for 6 consecutive months, outside of expected variation in January and February 2026.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: A deep dive analysis into appraisal compliance has taken place and will be presented at April People Committee. This has identified circa 700 appraisals completed in 2025 that have not been maintained and are therefore contributing to the recent decline in compliance. A comprehensive action plan has been developed to support managers in improving compliance.

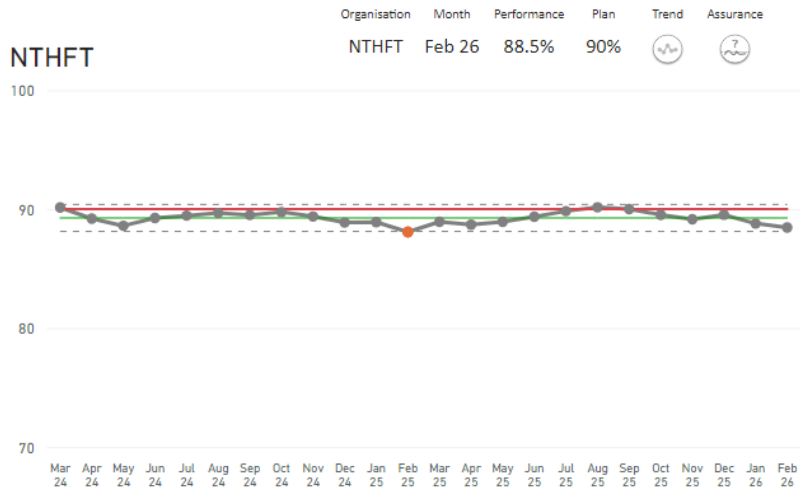


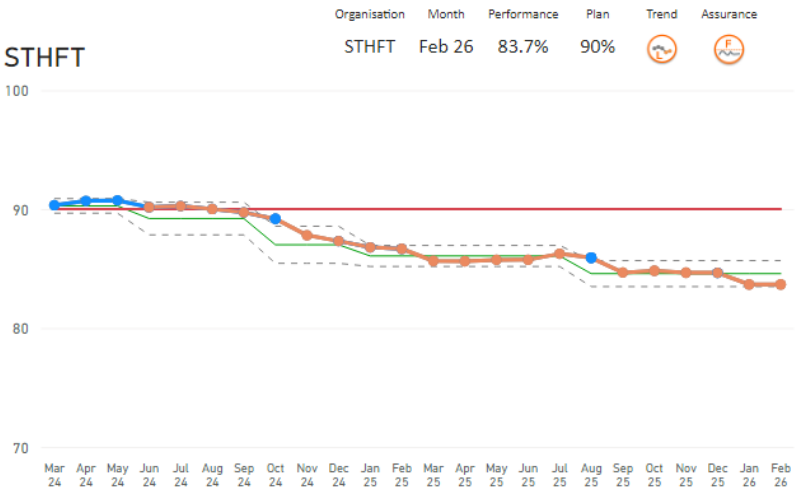


WELL LED Mandatory Training (%)



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: No trend. STHFT: Deteriorating trend, with low outliers January and February 2026.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Progressing with the roadmap that has been developed to improve access to data at CSU level to drive up compliance. Mandatory Learning Oversight Group overseeing alignment to national core framework and reform. Review of resus training needs nearing completion.
Executive lead: Chief People Officer
Accountable to: People Committee





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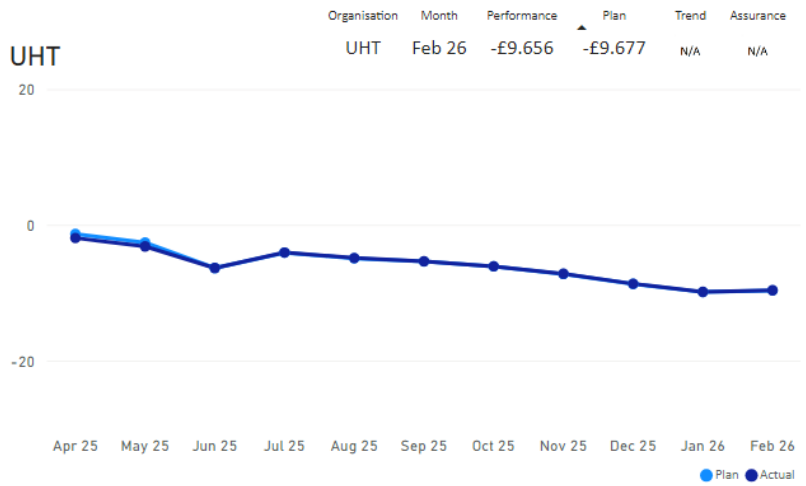
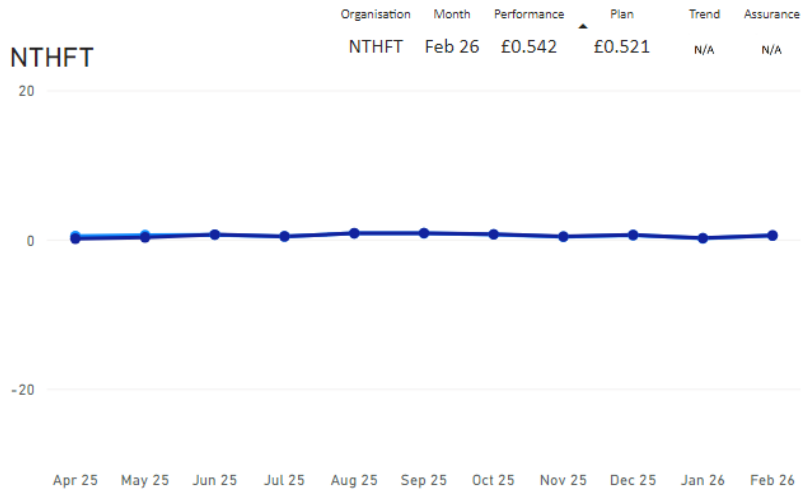
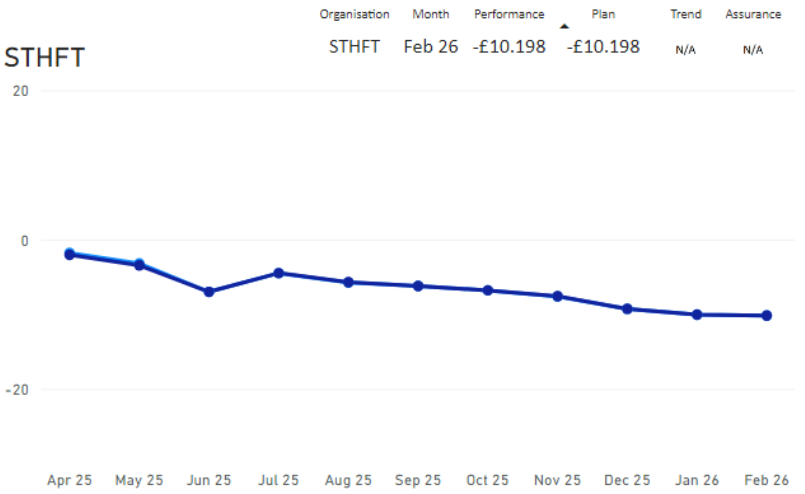
WELL LED Cumulative YTD Financial Position (£'millions)



Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2025/26. The STHFT control total for 2025/26 is a £9.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: At month 11, NTHFT reported a small positive variance to plan and STHFT is on plan.
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





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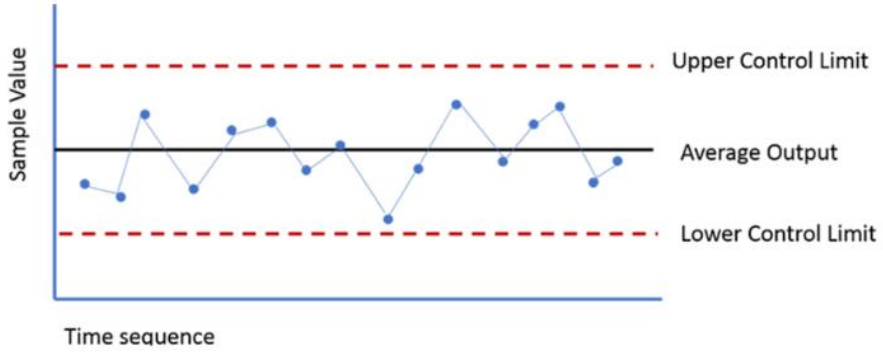
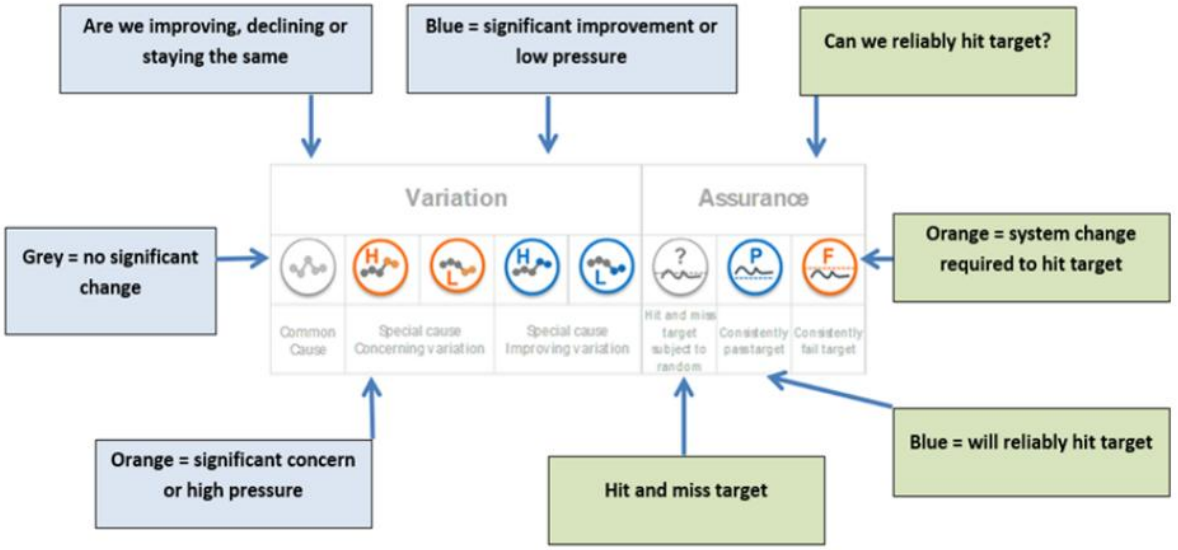
OVERVIEW SPC CHARTS

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



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Thank you

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Fit and Proper Person Report 2025/26

Meeting date: *7 May 2026*

Reporting to: *Board of Directors*

Agenda item No: 5.1

Report author: *Jackie White, Company Secretary*

Executive director sponsor: *Stacey Hunter, Chief Executive*

Action required: *(select from the drop-down list for why the report is being received)*
Assurance

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 / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

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

There are no issues to alert the Board of Directors to in relation to fit and proper.

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

Ongoing monitoring of fit and proper will be undertaken through appraisals and 1:1 meetings. Nominations Committee and Remuneration Committee will have the oversight of any issues which may arise as appropriate within their remit.

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

The Board of Directors can be assured that a robust process has been undertaken and independently audited to ensure compliance with the fit and proper guidance.

Recommendations:

Members of Board of Directors are asked to note the report.

Fit & Proper Person Framework Report – 2025/26
Board of Directors
7 May 2026

1. PURPOSE OF REPORT

The purpose of the report is to provide assurance to the Board of Directors regarding the implementation of the Fit and Proper Person Test process for board members and the outcome of testing against the guidance that related to 2025/26.

2. RECOMMENDATIONS

It is recommended that Board of Directors note the contents of the report.

3. BACKGROUND

On 2 August 2023, NHS England published revised requirements in respect of the Fit and Proper Person Test (FPPT) for board members following recommendations in the Kark Review (2019) by Tom Kark KC. A FPPT Framework was introduced, which sets out requirements for new board appointments, annual review and leavers.

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

All new starters are sent the Privacy Notice Letter to provide the details on the type of personal information which will be collected, processed and stored in relation to the FPPT. The portfolio of evidence for each board member is held locally and entered onto ESR.

The Chair has overall accountability for the FPPT, supported by the Company Secretary and the People Risk and Compliance Manager to assist carrying out and recording each board member's assessment outcome based upon the FPPT requirements and evidence collected.

The two Trusts are required to make an annual submission to NHS England confirming the outcome of FPPT for their board members and declaration that the Leadership Competency Framework has been used as part of individual board members FPPT assessments. Chairs of NHS foundation trusts are encouraged to share the outcomes of their appraisals to provide NHS England with an understanding of the wider support and development needed.

4. DETAILS

The Board of Directors for North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust have applied the FPPT guidance to voting and non-voting Non-Executive Directors and Executive Directors and their direct reports. The Very Senior Manager Pay Framework (VSM) or equivalent has been used as the baseline for determining FPPT scope and signatory beyond the board of directors' membership.

Level 1: Chief executive

Level 2: board director posts that report to the chief executive
Level 3: directors or VSM that report to and deputise for post holders in level 2
Reported Outcomes

The two Trusts have completed the FPPT and the individuals tested are listed below;

Employees of North Tees & Hartlepool NHS Foundation Trust

- Professor Derek Bell
- Ms Stacey Hunter
- Mr Matt Neligan
- Mr Neil Atkinson
- Ms Alison Fellows
- Mr Steven Taylor
- Professor Chris Day – new appointment
- Mr Michael Houghton
- Mr Stuart Irvine
- Ms Fay Scullion
- Mr Ken Anderson
- Ms Ann Baxter
- Mrs Ruth Dalton
- Ms Celia Weldon – new appointment
- Mr Ian Simpson

Leavers - there have been the following leavers during 2025-2026

- Professor Liz Barnes 30-06-2025
- Ms Ann Baxter 31-03-2026
- Rowena Dean 31-10-2025 – stepped down from board role, change in role
- Mr Chris Macklin 30-04-2025
- Ms Alison Fellows 31-03-2026

Employees of South Tees Hospitals NHS Foundation Trust

- Mr Chris Hand
- Ms Ali Wilson
- Dr Michael Stewart
- Mrs Rachael Metcalf
- Mrs Jackie White
- Mrs Lindsay Garcia
- Mr David Redpath
- Ms Miriam Davidson
- Mr Ken Readshaw
- Mr Mark Dias
- Mrs Emma Nunez
- Dr Diane Monkhouse

Leavers - there have been the following leavers during 2025-2026

- Mrs Ada Burns 30-09-2025
- Mr Sam Peate 28-02-2026

Self-Attestation Forms

Self-attestation forms were issued and have been signed and returned by individuals.

FPPT Checklists

A FPPT checklist was completed to evidence the checks performed for each individual. Including checks on being disqualified from being a charity trustee, social media checks and appraisals aligned to the Leadership Competency Framework. This included information in relation to disciplinary matters/complaints/grievances, open/ongoing investigations, upheld findings, discontinued investigations, against the board member that are relevant to FPPT.

ESR Recording

A summary of the checks and declarations have been collated and have been entered onto the respective Trust ESR system for the mandatory fields to record FPPT outcomes.

Outcome Validation

To ensure appropriate and independent checks were performed in relation to individual outcomes, the following approach was undertaken

- Results for **Directors** of the Trusts – a summary of the outcomes and supporting evidence was provided to the **Chief Executive (and where relevant to the level 2 line manager)**.
- Results for the **Chief Executive** of the Trusts – a summary of the outcomes and supporting evidence was provided to the **Chair.**
- Results for **Directors** of the Trusts – a summary of the outcomes and supporting evidence was provided to the **Chair**.
- **Senior Independent Director** (Ken Readshaw) – a summary of the outcomes and supporting evidence was provided to the **Chair**.
- Results for the **Non-Executive Directors** of the Trusts – a summary of the outcomes and supporting evidence was provided to the **Chair**.
- Results for the **Chair** of the Trust – a summary of the outcomes, including the ESR dashboard and supporting evidence has been provided to the **Senior Independent Director.**

Key issues, significant risks and mitigations

The risk relating to this paper is the potential breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 - people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The two Trusts have undertaken a thorough and comprehensive process to apply the FPPT guidance and independent checks have been performed in relating to the outcomes and this can be evidenced by a robust audit trail.

5. CONCLUSION

The two Trusts have strictly followed and applied the FPPT guidance to members of staff.

In accordance with the Fit and Proper Person Test Framework requirements, the Board of Directors of North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust and additional staff tested are compliant with the guidance.

This evidences that the two Trusts are compliant with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 - people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The two Trusts have prepared the documentation that is required to be signed by the Chair in preparation to return to NHSE to confirm the 2025/26 FPPT outcomes and is subject to formal sign off by the Chair. The Chair appraisal outcome will be shared with NHS England.

APPENDICES

Appendix 5: Annual NHS FPPT submission reporting template – NTH
Appendix 5: Annual NHS FPPT submission reporting template – STH

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Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
North Tees and Hartlepool NHS Foundation Trust		Trust	Professor Derek Bell	2025-2026
	√	Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	8	8			4	0
Executive board members	8	8			1	1
Partner members (ICBs)	N/A	N/A		N/A	N/A	N/A
Total	16	16			5	1

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes√	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	SID/Vice Chair	Kennth Readshaw	01-04-2026	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
South Tees Hospitals NHS Foundation Trust		Trust	Professor Derek Bell	2025-2026
	√	Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	6		0	1	0
Executive board members	6	6		0	1	1
Partner members (ICBs)	N/A	N/A		N/A	N/A	N/A
Total	12	12		0	2	1

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes √	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	SID/Vice Chair	Kennth Readshaw	01-04-2026	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

University Hospitals Tees

Going Concern 2025/26 Annual Accounts South Tees Hospitals NHS Foundation Trust

Meeting date: ***7 May 2026***

Reporting to: ***Board of Directors***

Agenda item No: 6.1

Report author: ***Chris Hand, Chief Finance Officer***

Executive director sponsor: ***Chris Hand, Chief Finance Officer***

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:

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.

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a 'going concern'.

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.

The attached report outlines the relevant guidance and rationale as to why it would be appropriate to assume that the Trust will continue to operate for the foreseeable future, and for the annual accounts for 2025/26 to be prepared on a going concern basis.

Recommendations:

The Board are asked to:

- Approve the preparation of the 2025/26 annual accounts for South Tees Hospitals NHS Foundation Trust and accounting group on a 'going concern' basis

Going Concern 2025/26 Annual Accounts
South Tees Hospitals NHS Foundation Trust

1. PURPOSE OF REPORT

The purpose of the report is to outline relevant guidance and rationale as to why it would be appropriate to assume that the Trust will continue to operate for the foreseeable future, and to seek the Board's approval for the annual accounts for 2025/26 to be prepared on a 'going concern' basis.

2. RECOMMENDATIONS

The Board are asked to:

- Approve the preparation of the 2025/26 annual accounts for South Tees Hospitals NHS Foundation Trust and accounting group on a 'going concern' basis

3. BACKGROUND

All public sector and commercial entities are expected to prepare their accounts on a 'going concern' basis, assuming that the entity will continue to operate for the foreseeable future (typically at least for the next 12 months at the date the accounts are signed).

This expectation needs to be tested by management each year and will confirm the basis of the preparation of the Annual Accounts for the 2025/26 financial year.

Disclosures on going concern will impact throughout the annual report in terms of the overview and performance analysis, the governance statement, the accounting officers' statement as well as the accounts themselves and it will therefore be important that the whole document tells a story.

4. DETAIL

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

The Foundation Trust Annual Reporting Manual (FT ARM) states the following:

> ***There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis.***

A typical going concern disclosure, based on guidance from the Accounting Standards Board, would read:

> ***"After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt***

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the going concern basis in preparing the accounts, following the definition of going concern in the public sector, adopted by HM Treasury Financial Reporting Manual."

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in International Accounting Standard (IAS)1:

> ***For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.***

The FreM further outlines that:

> ***DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.***
>
> ***As the continued provision of service approach … applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.***

The management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust

For 2025/26, the Trust has operated under Integrated Care System (ICS) capital and revenue allocations. The Trust delivered its financial plan for 2025/26, ending the year with a cash balance of £86m

For the 2026/27 financial year, the NHS is moving away from system-level to individual organisation-level planning and accountability. The Trust has agreed a medium-term plan with NHSE covering the 3-year period from 2026/27 and has contracts with commissioners to provide NHS services for the foreseeable future. The Trust has a planned turnover of £1.04bn for 2026/27 and expects to maintain sufficient cash available to cover its liabilities as they fall due.

5. CONCLUSION

The Trust has an agreed financial plan and contracts with commissioners to deliver NHS services for the foreseeable future, and the management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust.

Therefore, the accounts for the 2025/26 financial year should be prepared on a going concern basis.

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Audit & Risk Committee

19 March 2026

Connecting to: 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.

None

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.

Medical devices management/training - High Risk. Report to be shared with Quality Committee for follow up.

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

Compliance with regulatory standards (must do actions) – Medium risk.

Pharmacy Stock Control & Dispensing (ward level) – Medium risk. This was a follow up to last year's audit and shows an improvement in controls, largely driven by the maturing digital systems around Omnicell.

There is a delay in commencing the Waiting List Management – 18 week RTT. This needs to be urgently addressed.

External Audit - The South Tees Audit Plan was reviewed and approved. It is in line with previous years.

Recommendations:

It is recommended the Board note the update.

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Audit Committee & Audit & Risk Committee meeting in Common

19 March and 24 March 2026

Connecting to: Board of Directors

Chair of Committee: Ken Readshaw

Key discussion points and matters to be escalated from the meeting

This was the annual meeting in common to review the work done and assurance received from the committees of the Board of Directors.

Overall themes

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.

None

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.

None

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

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The committees are working effectively and providing appropriate levels of assurance to the Board, with limited exceptions which are detailed below.

The Committees systems and processes for obtaining CSU level assurance are developing and not yet embedded.

The controls around the management and delivery of planned WTE do not work consistently.

The assurance systems around performance are not sufficient. This was also noted last year and ad hoc solutions involving committees working together have been implemented. This is an improvement but a more systematic approach is needed.

In addition, specific areas were raised by the Committee Chairs or discussed with Chairs and these are being managed and addressed by the Committees in line with their normal practice.

All committees are reporting an increasing risk environment and this needs to considered by the Board as part of its risk appetite review.

I am grateful for the excellent work done by the committees and the high quality of the reports provided.

Recommendations:

It is recommended the Board note the update.

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Going Concern 2025/26 Annual Accounts North Tees and Hartlepool NHS Foundation Trust

Meeting date: ***7 May 2026***

Reporting to: ***Board of Directors***

Agenda item No: 7.1

Report author: ***Chris Hand, Chief Finance Officer***

Executive director sponsor: ***Chris Hand, Chief Finance Officer***

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:

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.

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a 'going concern'.

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.

The attached report outlines the relevant guidance and rationale as to why it would be appropriate to assume that the Trust will continue to operate for the foreseeable future, and for the annual accounts for 2025/26 to be prepared on a going concern basis.

Recommendations:

The Board are asked to:

- Approve the preparation of the 2025/26 annual accounts for North Tees and Hartlepool NHS Foundation Trust and accounting group on a 'going concern' basis

Going Concern 2025/26 Annual Accounts
North Tees and Hartlepool NHS Foundation Trust

1. PURPOSE OF REPORT

The purpose of the report is to outline relevant guidance and rationale as to why it would be appropriate to assume that the Trust will continue to operate for the foreseeable future, and to seek the Board's approval for the annual accounts for 2025/26 to be prepared on a 'going concern' basis.

2. RECOMMENDATIONS

The Board are asked to:

- Approve the preparation of the 2025/26 annual accounts for North Tees and Hartlepool NHS Foundation Trust and accounting group on a 'going concern' basis

3. BACKGROUND

All public sector and commercial entities are expected to prepare their accounts on a 'going concern' basis, assuming that the entity will continue to operate for the foreseeable future (typically at least for the next 12 months at the date the accounts are signed).

This expectation needs to be tested by management each year and will confirm the basis of the preparation of the Annual Accounts for the 2025/26 financial year.

Disclosures on going concern will impact throughout the annual report in terms of the overview and performance analysis, the governance statement, the accounting officers' statement as well as the accounts themselves and it will therefore be important that the whole document tells a story.

4. DETAIL

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

The Foundation Trust Annual Reporting Manual (FT ARM) states the following:

> ***There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis.***

A typical going concern disclosure, based on guidance from the Accounting Standards Board, would read:

> ***"After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt***

the going concern basis in preparing the accounts, following the definition of going concern in the public sector, adopted by HM Treasury Financial Reporting Manual."

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in International Accounting Standard (IAS)1:

> ***For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.***

The FreM further outlines that:

> ***DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.***
>
> ***As the continued provision of service approach … applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.***

The management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust

For 2025/26, the Trust has operated under Integrated Care System (ICS) capital and revenue allocations. The Trust delivered its financial plan for 2025/26, ending the year with a cash balance of £58m

For the 2026/27 financial year, the NHS is moving away from system-level to individual organisation-level planning and accountability. The Trust has agreed a medium-term plan with NHSE covering the 3-year period from 2026/27 and has contracts with commissioners to provide NHS services for the foreseeable future. The Trust has a planned turnover of £0.47bn for 2026/27 and expects to maintain sufficient cash available to cover its liabilities as they fall due.

5. CONCLUSION

The Trust has an agreed financial plan and contracts with commissioners to deliver NHS services for the foreseeable future, and the management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust.

Therefore, the accounts for the 2025/26 financial year should be prepared on a going concern basis.

Audit Committee

19 March 2026

Connecting to: Board of Directors

Chair of Committee: Ken Readshaw

Key discussion points and matters to be escalated from the meeting

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None

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.

None

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

Internal Audit - 2 reports received

Recording Consent to Treatment – Reasonable Assurance. Gaps in recording were identified which will be alleviated by digital systems in future. In the meantime, this report is being passed to Quality Committee for follow up to ensure appropriate assurance is received in the meantime.

Embeddedness of CQC Must do Actions – Advisory audit. No actions.

Some small amendments to the audit plan were agreed.

Recommendations:

It is recommended the Board note the update.

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Audit Committee & Audit & Risk Committee meeting in Common

19 March and 24 March 2026

Connecting to: Board of Directors

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Recommendations:

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